Australian Government
Department of Health

ASKMBS ADVISORY

Allied health services – Part B
Mental health treatment

March 2022

A message from the Chief Allied Health Officer

Australia's 195,000 allied health professionals comprise a significant proportion of the health workforce and provide essential services in primary care generally and mental health treatment specifically. The approximately 200 million allied health MBS services provided annually are an indicator of the value of and strong demand for these services.

I would like to take this opportunity to recognise the major contribution allied mental health professionals have made to supporting Australians with the challenges presented by the COVID-19 pandemic, including patients in regional and rural areas.

The Department of Health's AskMBS email advice service plays a key role in assisting all providers of Medicare Benefits Schedule (MBS) services with the correct billing of MBS items. I am pleased that allied health providers are proactively seeking guidance on the policy settings and billing rules underpinning allied health MBS items. In addition to providing responses to individual enquiries, AskMBS issues regular advisories.

This is the second of two complementary AskMBS advisories on allied health MBS items. The first focussed on chronic disease management services. This issue provides information about the following allied mental health treatment issues in a Q&A format:

1. Bulk billing
2. Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS (Better Access) initiative
3. Bushfire Response initiative
4. Referrals and reports
5. Telehealth services
6. Eating disorder treatment services

I trust you will find this document useful and encourage you to continue to use AskMBS to clarify any issues arising in your practice on the correct use and billing of MBS items.

Dr Anne-marie Boxall
Chief Allied Health Officer

Contents

The AskMBS advice service

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

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

At the end of the advisory we also provide metrics on AskMBS's performance in calendar year 2021. The complete MBS, including item descriptors and explanatory notes as well as a range of related information resources, are available at: MBS Online.

For the sake of brevity, the abbreviation 'AMHP' is used throughout to refer to 'allied mental health professional'. In addition, the term 'Better Access' is used to refer to the Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS initiative.

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

Disclaimer: The information in this advisory is current and accurate as of March 2022. Medicare policy changes over time in response to a range of factors, and providers of MBS services should maintain their awareness of current policy settings and item requirements by monitoring advice issued by the Department of Health through channels such as direct communications and MBS Online, and by seeking clarification from AskMBS when necessary.

1. Bulk billing

1.1 Am I required to bulk bill?

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

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

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

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

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

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

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

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

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

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

- **MN.6.1:** Provision of psychological therapy services by clinical psychologists (items 80000 to 80021)
- **MN.6.2:** Psychological therapy services attracting Medicare rebates
- **MN.6.3:** Referral requirements (GPs, medical practitioners, psychiatrists or paediatricians to clinical psychologists for psychological therapy)
- **MN.6.4:** Clinical psychologist professional eligibility
- **MN.6.5:** Telehealth psychological therapy services
- **MN.7.1:** Provision of focussed psychological strategies services by allied health providers (items 80100 to 80170)
- **MN.7.2:** Telehealth focussed psychological strategies services

2.1 What services are available under the Better Access initiative?

Eligible patients currently have access to:

- up to 20 individual Medicare-rebateable mental health services per calendar year for psychological therapy health services or focussed psychological strategies (FPS) services until 31 December 2022 and
- up to 10 group therapy services per calendar year (involving 6–10 patients and either as part of psychological therapy or focussed psychological strategies).

A calendar year is 1 January to 31 December. The 20 individual services include the temporary 10 ‘additional’ services introduced on 9 October 2020 in recognition of the ongoing effects of the COVID-19 pandemic. These additional services are available until 31 December 2022.

The 20 individual services can include:

- face-to-face consultations; or
- telehealth (video) consultations; or
- telephone consultations; or
- a combination of face-to-face, telehealth or telephone consultations.

Patients may also access up to 10 group therapy services. These services are in addition to the entitlement to individual services.

The 10 group services can include:

- face-to-face consultations; or

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

Psychological therapy health services are provided by clinical psychologists. FPS services are provided by registered psychologists, occupational therapists and social workers. FPS services can also be provided by suitably qualified medical practitioners.

A patient's allocation of individual services can be a combination of psychological therapy health services and FPS services provided either by AMHPs or medical practitioners, as clinically appropriate.

2.2 Will Better Access telehealth services continue to be available?

Yes, with certain exceptions. As part of ongoing MBS telehealth arrangements, the Better Access telehealth and phone items for AMHPs initially introduced in response to the pandemic (i.e the 911xx series items) are now permanent. Furthermore, the 'additional' Better Access items introduced in October 2020 (i.e. the 933xx series items) are available until 31 December 2022.

2.3 What are the eligibility criteria for allied mental health professionals?

To provide Medicare services, AMHPs must be registered with Services Australia and hold a valid provider number. Specific provider eligibility criteria for the Better Access services, as set out in MBS explanatory notes MN.7.1 and MN.6.4, are:

Eligible clinical psychologists

A person is an allied health professional in relation to the provision of a psychological therapy health service if the person:

a) holds general registration in the health profession of psychology under the applicable law in force in the state or territory in which the service is provided; and
b) is endorsed by the Psychology Board of Australia to practice in clinical psychology.

Eligible psychologists, occupational therapists and social workers

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

a) the person holds general registration in the health profession of psychology under the applicable law in force in the state or territory in which the service is provided;
b) the person is a member of the Australian Association of Social Workers (AASW) and certified by AASW as meeting the standards for mental health set out in the document published by AASW titled *'Practice standards for mental health social workers 2014* as in force on 25 September 2014;
c) the person:
    i. is an occupational therapist who is registered as a person who may provide that kind of service under the applicable law in force in the State or Territory in which the service is provided; and
    ii. is accredited by Occupational Therapy Australia as:
        - having a minimum of two years' experience in mental health; and
        - having undertaken to observe the standards set out in the document published by the Occupational Therapy Board of Australia's *Australian occupational therapy competency standards 2018*, and the *National practice standards for the mental health workforce 2013* as in force on 1 January 2022.

2.4 What are the patient eligibility requirements for Better Access services?

To be eligible, a patient must have:

- A referral from a medical practitioner (including a GP, but not a specialist or consultant physician) as part of a GP Mental Health Treatment Plan (MHTP);
- A referral from a medical practitioner (including a GP, but not a specialist or consultant physician) as part of a shared care plan that was prepared on or before 30 June 2021[1];
- A referral from a medical practitioner (including a GP, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or
- A referral from a psychiatrist or paediatrician using an eligible psychiatric or paediatric service.

An AMHP must be in receipt of a referral when providing the first service in that course of treatment.

The conditions classified as mental disorders for the purposes of the Better Access services are informed by the World Health Organisation, 1996, Diagnostic and Management Guidelines for Mental Disorders in Primary Care: ICD-10 Chapter V Primary Care Version. For the purposes of these items, dementia, delirium, tobacco use disorder and mental retardation are not regarded as a mental disorder.

If there is any doubt about a patient's eligibility, Services Australia can confirm whether an MHTP, shared care plan and/or a psychiatrist assessment and management plan is in place and claimed, or an eligible psychiatric or paediatric service has been claimed, as well as the number of Better Access services already accessed by the patient during the calendar year.

AMHPs can contact Services Australia on the Medicare Provider Enquiry Line (13 21 50) or medicare.prov@servicesaustralia.gov.au to check this information.

2.5 What are the strategies approved for use when providing focussed psychological strategies services?

The following are acceptable strategies that have been approved for use in providing FPS services:

1. Psycho-education (including motivational interviewing)

2. Cognitive-behavioural therapy including:

2.1 Behavioural interventions

–Behaviour modification

–Exposure techniques

–Activity scheduling

2.2 Cognitive interventions

–Cognitive therapy

3. Relaxation strategies

–Progressive muscle relaxation

[1] A Health Care Home (HCH) shared care plan means a written plan that is prepared for a patient enrolled at a HCH trial site. The HCH trial ended on 30 June 2021. Shared care plans created after 30 June 2021 cannot be used to access Better Access services. From this date, patients can only be referred via a GP, psychiatrist or paediatrician. HCH trial end factsheet: https://www.health.gov.au/sites/default/files/documents/2021/05/health-care-homes-hch-fact-sheet-for-practices-fact-sheet-for-practices-health-care-homes-is-finishing-on-30-june-2021.pdf

–Controlled breathing

4. Skills training

–Problem solving skills and training

–Anger management

–Social skills training

–Communication training

–Stress management

–Parent management training

5. Interpersonal therapy (especially for depression)

6. Narrative therapy (for Aboriginal and Torres Strait Islander people)

7. Eye-movement desensitisation reprocessing

2.6 How do the 'initial' and 'additional' Better Access services work together?

Currently, under the Better Access initiative, a patient may be eligible to access up to:

- 10 'initial' individual treatment sessions in a calendar year (the '80xxx' or '911xx' items) with a maximum of 6 sessions per referral; and
- 10 additional individual treatment sessions in a calendar year (the '93xxx' items) with a maximum of 10 sessions per referral until 31 December 2022.

If a patient is referred for additional services (up to a maximum of 10) and they do not use any or all of the services stated on the referral by the end of the calendar year, they can continue to use the referral to access remaining services in the next calendar year. Any services accessed in the following calendar year will count towards the maximum of 20 sessions in total in that calendar year.

Once the patient has used all the additional sessions, they are again eligible for the 10 initial Better Access sessions. If their practitioner considers access to the initial services is clinically indicated, the referring practitioner will need to issue a new referral that complies with referral requirements under Better Access–for example, a patient can only be referred for a maximum of 6 services in any one referral, until they have completed all 10 initial Better Access sessions.

For example, if a patient was referred for 10 additional sessions in 2021 and used only 6 sessions before 31 December 2021, they can continue to use this referral to access 4 sessions in 2022. Once they have used all the additional sessions stated on the referral, services revert to initial sessions; the patient can then be referred for a maximum of 6 services in any one referral, until they have completed all 10 initial sessions.

Note that while the common referral pattern for the initial 10 sessions is '6+4', this is not mandatory. The total of 10 can be subdivided as the referring practitioner sees fit, as long as no one referral is for more than 6 sessions. Similarly, a referral for additional sessions can be for fewer than 10 sessions.

Better Access services should be billed using item numbers consistent with the referral. For example, if the referral is for 10 additional sessions then the item number/s for additional services should be used for the full course of treatment. The commencement of a new calendar year has no impact on this. A referral for additional services does not 'reset' to initial services on 1 January.

2.7 What services are available for patients in residential aged care facilities (RACFs)?

Better Access services are temporarily available to aged care residents from 10 December 2020 to 31 December 2022. This means that all eligible aged care residents can access up to 20 Medicare-subsidised individual psychological services each calendar year until 31 December 2022.

Services can be delivered face-to-face in RACFs or an AMHP's rooms, or via telehealth (video) or telephone. To support AMHPs in delivering face-to-face services, a flag-fall item (item 90003) is available for the first resident seen during each attendance at a RACF. This item, with a Schedule fee of $47.45 and an 85% benefit of $40.35, can be claimed only for the first resident attended at a RACF when claiming items 93312, 93313, 93316, 93319, 93322, 93323, 93326, 93327, 93375, 93376, 93381 to 93386.

There are no group therapy services available to patients in residential aged care facilities.

For more information on these RACF services, see the fact sheet on MBS Online at:

www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/factsheet-mental-health-aged-care

3. Bushfire Response initiative

3.1 What support is available for people affected by bushfire?

Any patient who is considered to have had their mental health adversely affected by bushfire in the 2019–20 financial year is eligible for mental health services under the Bushfire Response initiative. For this purpose, from 17 January 2020, new MBS items for allied mental health treatment items were introduced. There are 24 new items, including 8 telehealth items, for:

- Clinical psychologists: Items 91000, 91001, 91005, 91010, 91011 and 91015
- Eligible psychologists: Items 91100, 91101, 91105, 91110, 91111 and 91115
- Occupational therapists: Items 91125, 91126, 91130, 91135, 91136 and 91140
- Social workers: Items 91150, 91151, 91155, 91160, 91161 and 91165

Medicare rebates are available for up to 10 individual mental health services in a calendar year. This quota may consist of any combination of services, but also includes Bushfire Response services provided by medical practitioners. Note in particular that mental health services received under the Bushfire Response initiative do not count against a patient's quota of services under the Better Access initiative. These services are available until 30 June 2022.

For more information see the factsheet on MBS Online at:

www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-BushfireResponse

3.2 What are the differences between the Bushfire Response services and Better Access services?

The main differences relate to referral and reporting requirements for the Bushfire Response services. For these services, eligible patients may be identified by a medical or allied health practitioner. Alternatively, they may identify themselves and request a mental health service. The services are available to anyone whose mental health has been affected by the bushfire crisis, including residents of residential aged care facilities. Access is not restricted to people living in areas directly affected by bushfire. **Patients are not required to have a diagnosed mental health condition, GP mental health treatment plan or a referral to access the Bushfire Response services.**

AMHP reporting requirements that apply to Better Access services do not apply to the Bushfire Recovery services. **There are no reporting requirements for the Bushfire Response items.**

In addition, there are no group therapy services available under the Bushfire Response initiative.

4. Referrals and reports

4.1 Is there a difference between a mental health treatment plan and a referral?

Yes. A GP mental health treatment plan (MHTP) is a structured framework for GPs to undertake the management of patients with clinically diagnosed mental disorders. A referral is a separate document described in section 4.2.

Practitioners should provide a copy of the MHTP to the AMHP along with the referral form.

There is no fixed time limit on an MHTP. Many patients will not require a new plan after their initial plan has been prepared. As MHTPs do not expire, patients may still be referred for further mental health services for as long as the referral is consistent with what is in the MHTP and the referring practitioner has determined that further services are required.

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

There is no standard form for allied mental health referrals. The referral should be in writing (signed and dated by the referring practitioner) and include:

- the patient's name, date of birth and address;
- the patient's symptoms or diagnosis;
- a list of any current medications;
- the number of sessions the patient is being referred for (the 'course of treatment');
- a statement about whether the patient has an MHTP, a shared care plan (prepared on or before 30 June 2021), or a psychiatrist assessment and management plan; and
- a statement about whether the referral can be used for group therapy or individual therapy.

A referral should include all of these details, to assist with any auditing undertaken by the Department of Health. For the same reason, it is a legislative requirement that the AMHP retain the referral for 2 years (24 months) from the date the service was rendered.

Please note if a referral does not specify whether the referral is for individual or group therapy, the patient can use a referral to access either individual or group therapy treatment option. It would however be best practice for the patient to speak to their referring practitioner if they intend to use a referral for group therapy services, because this is important information that may help inform the referring practitioner's future decisions regarding their treatment.

A referring practitioner can verbally refer a patient for Better Access services only if:

- in their clinical judgement they consider it is necessary for the patient to have immediate access to support from an AMHP, and
- it is not practicable in the circumstances to provide a written referral – for example, to do so would cause delays in treatment to the patient's detriment, and
- the AMHP documents in writing that they are treating the patient based on the referring practitioner's verbal referral, and
- the referring practitioner provides a written referral to the AMHP as soon as possible afterwards.

While waiting for the referring practitioner to provide a written referral, the AMHP can provide treatment according to the verbal referral until the referred number of sessions have been completed. If there is any doubt about the number of sessions the patient was verbally referred for, the AMHP should follow the guidance provided below under section 4.3 – 'Does a referral for Better Access services have to specify the number of services being referred?'.

A verbal referral does not replace the requirement for the referring practitioner to review the patient's progress (taking into account the written report from their AMHP) after each course of treatment.

AMHPs are not obliged to accept a referral about which they have concerns and should contact the referring practitioner for clarification where there is any doubt about the intent or content of the referral. Clarification of any ambiguity could be provided in the form of an amended referral, via email, or by other correspondence. It may also be possible to obtain this confirmation verbally and to record this within the patient notes.

4.3 Does a referral for Better Access services have to specify the number of services being referred?

A referral for Better Access services should specify the number of sessions a patient is being referred for. Specifying the number of sessions helps to:

- ensure the AMHP can treat the patient in line with their clinical need, as assessed by the referring practitioner;
- provide certainty and clarity for both patients and AMHP in relation to the course of treatment to be delivered; and
- support the practitioner to manage the patient's care within their annual allocation of sessions.

Where an AMHP receives a referral that:

- Does not specify the number of sessions
- Specifies a number of sessions above the maximum allowed for the course of treatment, or
- Specifies a number of sessions above the maximum allowed for the calendar year (including any sessions the patient has already received that year)

The AMHP can use their clinical judgment to provide services under the referral, noting the patient cannot receive more than:

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

In these circumstances, the AMHP must provide a report at the end of a course of treatment in line with standard practice for these services. This enables the referring medical practitioner to consider the treating practitioner's report on the services provided to the patient, and the need for further treatment.

The maximum number of sessions allowed in a calendar year for each course of treatment is as follows:

- Initial course of treatment – a maximum of 6 sessions.
- Subsequent course/s of treatment – a maximum of 6 sessions up to the patient's cap of 10 'initial' sessions. For example, if the patient received 6 sessions in their initial course of treatment, they can only receive 4 sessions in a subsequent course or courses of treatment.
- Additional 10 COVID-19 sessions (until 31 December 2022) – a maximum of 10 sessions (with up to 10 sessions in a single referral).

If the patient reaches the maximum number of sessions allowed in a calendar year during a course of treatment, the AMHP can continue to use the referral to complete the course of treatment the following calendar year – where clinically appropriate.

Where the patient's maximum allocation is unknown, providers may contact Services Australia on the Medicare Provider Enquiry Line (13 21 50) or medicare.prov@servicesaustralia.gov.au to confirm the patient's remaining allocation of services.

4.4 What are the reporting requirements for Better Access services?

AMHPs who perform psychological therapy health services or FPS services under the Better Access initiative must provide a report back to the referring practitioner after each course of treatment. This report will help the referring practitioner consider the patient's need for further sessions.

If a patient does not complete treatment, the AMHP should write a report after the last service provided. If the patient returns later and completes the course of treatment, another report should be completed and provided to the referring practitioner.

Furthermore, it is considered best practice to send a report to the referring practitioner when clinically indicated–that is, if there is a significant change in the patient's condition or the treatment approach.

A report must be written and include:

- assessments carried out on the patient;
- treatment provided; and
- recommendations on future management of the patient's disorder.

A verbal review and/or report is not sufficient.

Further information about the reporting requirements relating to these services can be accessed in MBS explanatory notes MN.6.2 and MN.7.1, available by searching MBS Online for the note number at www.mbsonline.gov.au.

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

Where a referral states the name of a specific AMHP, there is no legislative barrier preventing a patient from changing to a different AMHP, either before or during a course of treatment. A copy of the referral should be given to the patient to take to the new AMHP.

However, it would be best practice for the patient to make an appointment to speak to their referring practitioner, where they do choose to change AMHP during a course of treatment, as this is important information that may help inform the referring practitioner's future decisions regarding a patient's treatment.

Any new AMHP should check the number of services the patient has already received with Services Australia (on 13 21 50) or medicare.prov@servicesaustralia.gov.au) so they can ensure compliance with the legislative requirement that a patient be reviewed by the referring practitioner following the completion of the course of treatment.

5. Telehealth services

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

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

- **MN.6.5:** Telehealth psychological therapy services
- **MN.7.2:** Telehealth focussed psychological strategies services

5.1 What are the requirements for the ongoing telehealth items?

All Medicare-eligible persons other than admitted hospital patients can receive these services.

For the purposes of the ongoing telehealth items, a telehealth attendance means a professional attendance by video conference where the health practitioner:

(a) has the capacity to provide the full service through this means safely and in accordance with professional standards; and
(b) is satisfied that it is clinically appropriate to provide the service to the patient; and
(c) maintains a visual and audio link with the patient; and
(d) is satisfied that the software and hardware used to deliver the service meets the applicable laws for security and privacy.

A telephone attendance means a professional attendance by telephone where the health practitioner:

(a) has the capacity to provide the full service through this means safely and in accordance with professional standards; and
(b) is satisfied that it is clinically appropriate to provide the service to the patient; and
(c) maintains an audio link with the patient.

No specific equipment is required to provide Medicare-compliant telehealth services. AMHPs must ensure that their chosen telecommunications solution meets their clinical requirements and does not conflict with any obligations under the *Privacy Act 1988* and the Australian Privacy Principles Guidelines established under section 28(1)(a) of this Act. To assist providers with their privacy obligations, a privacy checklist for telehealth services has been made available on MBS Online at:

www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-TelehealthPrivChecklist

Further information can be found on the Office of the Australian Information Commissioner website and the Australian Cyber Security Centre website

5.2 Can I use a phone service even if the patient and I have the capacity to videoconference?

Videoconference services are the preferred substitute for a face-to-face attendance. However, providers are also able to offer audio-only (i.e. phone) services, where they have deemed it clinically appropriate. There are separate items available for audio-only services.

5.3 What are the differences between the pre-COVID telehealth services and the ongoing telehealth services?

All Medicare-eligible Australians, regardless of location, can access Better Access services via telehealth, where safe and clinically appropriate. The same limits with respect to the number of services available in a calendar year apply to these services. Existing individual telehealth and phone attendance items, introduced in response to COVID-19, will continue to be available to AMHPs. These items are set out below:

Service	Video items	Telephone items
Clinical psychologists		
Initial attendance lasting more than 30 minutes but less than 50 minutes	91166	91181
Additional 10 attendance lasting more than 30 minutes but less than 50 minutes	93331	93332
Initial attendance lasting at least 50 minutes	91167	91182
Additional 10 attendance lasting at least 50 minutes	93334	93335
Psychologists		
Initial attendance lasting more than 20 minutes but less than 50 minutes	91169	91183
Additional 10 attendance lasting more than 20 minutes but less than 50 minutes	93351	93352
Initial attendance lasting at least 50 minutes	91170	91184
Additional 10 attendance lasting at least 50 minutes	93354	93355
Occupational therapists		
Initial attendance lasting more than 20 minutes but less than 50 minutes	91172	91185
Additional 10 attendance lasting more than 20 minutes but less than 50 minutes	93357	93358
Initial attendance lasting at least 50 minutes	91173	91186
Additional 10 attendance lasting at least 50 minutes	93360	93361
Social workers		
Initial attendance lasting more than 20 minutes but less than 50 minutes	91175	91187
Additional 10 attendance lasting more than 20 minutes but less than 50 minutes	93363	93364
Initial attendance lasting at least 50 minutes	91176	91188
Additional 10 attendance lasting at least 50 minutes	93366	93367

5.4 Group therapy via telehealth

There are a number of items for the provision of group psychological therapy health services (PT) and focussed psychological strategies (FPS) services via videoconference to improve access to services for people in rural, remote and very remote locations.

These are:

80021	Group PT services a clinical psychologist (6–10 patients)
80121	Group FPS services by a psychologist (6–10 patients)
80146	Group FPS services by an occupational therapist (6–10 patients)
80171	Group FPS services by a social worker (6–10 patients)

Geographic eligibility for these services is determined according to Modified Monash Model (MMM) classifications. Telehealth eligible areas are within MMM classifications 4 to 7, and patients must be located in such an area at the time of the service. Patients and providers are able to check patient eligibility using the MMM locator on the Department of Health's website at: www.health.gov.au/internet/otd/publishing.nsf/Content/MMM_locator

While there are no restrictions on the AMHP's location, there is also a requirement that the patient and AMHP be located a minimum of 15 kilometres apart at the time of the service, as measured by the most direct route by road. The patient or AMHP is not permitted to travel to an area outside the minimum 15 kilometre distance in order to claim a video attendance item when using these items.

Additionally, it should be noted that these items are for video attendances only; these items cannot be used for telephone attendances.

6. Eating disorder treatment services

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

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

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

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

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

For the purposes of counting a patient's allocation of EDPT services, services provided under the following items are included: 90271, 90272, 90273, 90274, 90275, 90276, 90277, 90278, 90279, 90280, 90281, 90282, 2721, 2723, 2725, 2727, 283, 285, 286, 287, 371, 372 and items in Groups M6, M7 and M16 (excluding items 82350 and 82351). Note that if any services are provided to a patient using the Better Access items after the EDP is in place, these services are counted towards the patient's allocation of EDPT services.

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

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

6.2 What is an eating disorder psychological treatment service?

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

- Family-based treatment for eating disorders (EDs), including whole family, parent-based therapy, and parent-only or separated therapy
- Adolescent-focussed therapy for EDs
- Cognitive behavioural therapy for EDs (CBT-ED)
- CBT-anorexia nervosa (AN) (CBT-AN)
- CBT for bulimia nervosa (BN) and binge-eating disorder (BED) (CBT-BN and CBT-BED)
- Specialist supportive clinical management (SSCM) for EDs

- Maudsley model of anorexia treatment in adults (MANTRA)
- Interpersonal therapy (IPT) for BN, BED
- Dialectical behavioural therapy (DBT) for BN, BED
- Focal psychodynamic therapy for EDs

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

6.3 Can a patient with an eating disorders treatment plan also have a GP mental health treatment plan?

It is preferable that wherever possible patients have only one plan for primary care management of their disorder. Once a patient has a claim for an eating disorder treatment and management plan (EDP), the patient should not have a claim for the development or review of a mental health treatment plan (MHTP) within the following 12 months, unless there are exceptional circumstances or the managing practitioner is of the opinion that the patient no longer meets the eligibility criteria for the eating disorder items.

However, if a patient has an MHTP but subsequently meets the eligibility criteria for the EDP items, they can have an EDP as well. Any services provided under the Better Access items (including psychological therapy and focussed psychological strategies (FPS) services) prior to the date of the EDP will not count towards the patient's allocation of 40 eating disorder psychological treatment (EDPT) services. Any services provided under Better Access after the EDP is developed will count towards the patient's allocation of 40 EPDT services.

If the patient no longer meets the eligibility criteria for the eating disorder items, and the practitioner is of the clinical opinion that the patient should be managed under the standard MHTP arrangements, then the patient can access psychological therapy and FPS services under the relevant items. Any psychological therapy or FPS services that were provided in the calendar year prior will count towards the patient's allocation of Better Access services, but any services provided under the EDPT items will not count towards the allocation of Better Access services.

Further information on EDPs and their interaction with other treatment plans can be found on the Services Australia education guide at:

www.servicesaustralia.gov.au/organisations/health-professionals/topics/education-guide-eating-disorder-treatment-and-management-plans/51726

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

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

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

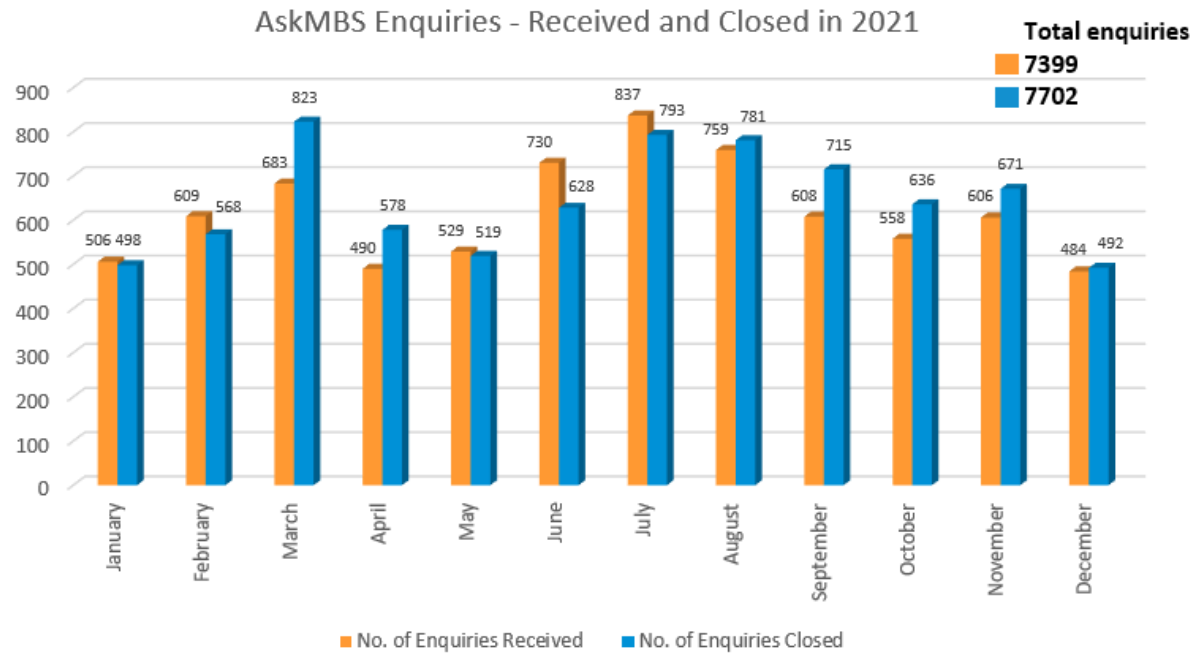
Written reports should include, at a minimum:

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

AskMBS metrics:
1 January – 31 December 2021

AskMBS receives enquiries from medical practitioners and health professionals providing MBS services as well as practice managers, billing agents, professional organisations, and a range of other stakeholders.

The service averages around 150 enquiries per week. Between commencing in the Department of Health and the end of December 2021, AskMBS received 23,139 enquiries and finalised responses to 22,949. Between January 2021 and December 2021 AskMBS received 7,399 enquiries and finalised responses to 7,702. The chart below shows a monthly breakdown of enquiries received and responses sent.



Appendix A–Better Access services for patients in the community

Psychological therapy services by clinical psychologists – Initial

Item No.	Service Type	Service length (mins)
80000	Face to face (consultation rooms)	30-50
80005	Face to face (call-out)	30-50
80001	Telehealth (geographic eligibility applies)	30-50
91166	COVID-19 telehealth (video)	30-50
91181	COVID-19 (phone)	30-50
80010	Face to face (consultation rooms)	50+
80015	Face to face (call out)	50+
80011	Telehealth (geographic eligibility applies)	50+
91167	COVID-19 telehealth (video)	50+
91182	COVID-19 (phone)	50+

Psychological therapy services by clinical psychologists - Additional

Item No.	Service Type	Service length (mins)
93330	Face to face (consultation rooms)	30-50
93331	Telehealth (video)	30-50
93332	Phone	30-50
93333	Face to face (consultation rooms)	50+
93334	Telehealth (video)	50+
93335	Phone	50+

Focussed psychological services by registered psychologist – Initial

Item No.	Service Type	Service length (mins)
80100	Face to face (consultation rooms)	20-50
80105	Face to face (call out)	20-50
80101	Telehealth (geographic eligibility applies)	20-50
91169	COVID-19 telehealth (video)	20-50
91183	COVID-19 (phone)	20-50
80110	Face to face (consultation rooms)	50+
80115	Face to face (call out)	50+
80111	Telehealth (geographic eligibility applies)	50+
91170	COVID-19 telehealth (video)	50+
91184	COVID-19 (phone)	50+

Focussed psychological services by registered psychologist – Additional

Item No.	Service Type	Service length (mins)
93350	Face to face (consultation rooms)	20-50
93351	Telehealth (video)	20-50
93352	Phone	20-50
93353	Face to face (consultation rooms)	50+
93354	Telehealth (video)	50+
93355	Phone	50+

Focussed psychological services by occupational therapists - Initial

Item No.	Service Type	Service length (mins)
80125	Face to face (consultation rooms)	20-50
80130	Face to face (call out)	20-50
80126	Telehealth (geographic eligibility applies)	20-50
91172	COVID-19 telehealth (video)	20-50
91185	COVID-19 (phone)	20-50
80135	Face to face (consultation rooms)	50+
80140	Face to face (call out)	50+
80136	Telehealth (geographic eligibility applies)	50+
91173	COVID-19 telehealth (video)	50+
91186	COVID-19 (phone)	50+

Focussed psychological services by occupational therapists - Additional

Item No.	Service Type	Service length (mins)
93356	Face to face (consultation rooms)	20-50
93357	Telehealth (video)	20-50
93358	Phone	20-50
93359	Face to face (consultation rooms)	50+
93360	Telehealth (video)	50+
93361	Phone	50+

Focussed psychological services by social workers - Initial

Item No.	Service Type	Service length (mins)
80150	Face to face (consultation rooms)	20-50
80155	Face to face (call out)	20-50
80151	Telehealth (geographic eligibility applies)	20-50
91175	COVID-19 telehealth (video)	20-50
91187	COVID-19 (phone)	20-50
80160	Face to face (consultation rooms)	50+
80165	Face to face (call out)	50+
80161	Telehealth (geographic eligibility applies)	50+
91176	COVID-19 telehealth (video)	50+
91188	COVID-19 (Phone)	50+

Focussed psychological services by social workers - Additional

Item No.	Service Type	Service length (mins)
93362	Face to face (consultation rooms)	20-50
93363	Telehealth (video)	20-50
93364	Phone	20-50
93365	Face to face (consultation rooms)	50+
93366	Telehealth (video)	50+
93367	Phone	50+

Appendix B–Better Access services for patients in residential aged care facilities

Psychological therapy services by clinical psychologists – Initial

Item No.	Service Type	Service length (mins)
93375	Face to face	30-50
93376	Face to face	50+

Psychological therapy services by clinical psychologists – Additional

Item No.	Service Type	Service length (mins)
93312	Face to face	30-50
93313	Face to face	50+

Focussed psychological services by registered psychologists - Initial

Item No.	Service Type	Service length (mins)
93381	Face to face	20-50
93382	Face to face	50+

Focussed psychological services by registered psychologists- Additional

Item No.	Service Type	Service length (mins)
93316	Face to face	20-50
93319	Face to face	50+

Focussed psychological services by occupational therapists - Initial

Item No.	Service Type	Service length (mins)
93383	Face to face	20-50
93384	Face to face	50+

Focussed psychological services by occupational therapists - Additional

Item No.	Service Type	Service length (mins)
93322	Face to face	20-50
93323	Face to face	50+

Focussed psychological services by social workers - Initial

Item No.	Service Type	Service length (mins)
93385	Face to face	20-50
93386	Face to face	50+

Focussed psychological services by social workers - Additional

Item No.	Service Type	Service length (mins)
93326	Face to face	20-50
93327	Face to face	50+

Flag fall incentive

Item No.	Service Type
90003	A flag fall service for the initial attendance at one residential aged care facility on one occasion, applicable to a maximum of one patient attended on.

Appendix C–Better Access group therapy services

Item No.	Service provider	Service Type	Service length (mins)
80020	Clinical psychologist	Face to face	60+
80021	Clinical psychologist	Telehealth (geographic eligibility applies)	60+
80120	Psychologist	Face to face	60+
80121	Psychologist	Telehealth (geographic eligibility applies)	60+
80145	Occupational therapist	Face to face	60+
80146	Occupational therapist	Telehealth (geographic eligibility applies)	60+
80170	Social worker	Face to face	60+
80171	Social worker	Telehealth (geographic eligibility applies)	60+