Australian Government
Department of Health and Aged Care

Complex neurodevelopmental disorder and eligible disability FAQs

Last updated: 16 November 2023

- These questions reflect the changes to Medicare Benefits Schedule (MBS) items that were effective from 1 March 2023. If you cannot find the information you need, please contact the Department of Health and Aged Care (the Department) at AskMBS@health.gov.au where your question relates exclusively to the interpretation of the schedule.
- To subscribe to future Medicare Benefits Schedule (MBS) Online updates, visit www.mbsonline.gov.au and click 'Subscribe'.

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General Questions

How have these changes been communicated to stakeholders?

The 1 March 2023 changes were communicated through published communication materials (including a Factsheet and Quick Reference Guide about the changes) on the MBS Online website. The changes were also communicated to stakeholders through implementation liaison groups and through department newsletters including the Chief Allied Health Officer Newsletter and the MBS Review Newsletter.

What is a complex neurodevelopmental disorder?

Diagnosis of a complex neurodevelopmental disorder requires evidence of requiring support and showing impairment across two or more neurodevelopmental domains. Complexity is characterised by multi-domain cognitive and functional disabilities, delay or clinically significant impairment.

Neurodevelopmental domains include:

- Cognition
- Language
- Social-emotional development
- Motor skills
- Adaptive behaviour: conceptual, skills, practical skills, social skills or social communication skills

Note: Items 135 and 289 are not intended for standalone diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) without other neurodevelopmental comorbidities. This is due to the intention of these items as they relate to the complexity and required level of support for an individual.

What is the list of eligible disabilities?

The *Health Insurance (General Medical Services Table) Regulations 2021* (the GMST) clause 2.6.1, and explanatory notes AR.29.1 and MN.10.3, provide the list of eligible disabilities for the purposes of items 137, 139, and for the allied health assessment and treatment items. This is an exhaustive list of conditions for accessing these services. The list includes the following conditions:

- Sight impairment that results in vision of less than or equal to 6/18 vision or equivalent field loss in the better eye, with correction.
- Hearing impairment that results in:
  - a hearing loss of 40 decibels or greater in the better ear, across 4 frequencies; or
  - permanent conductive hearing loss and auditory neuropathy
- Deafblindness
- Cerebral palsy
- Down syndrome
- Fragile X syndrome
- Prader-Willi syndrome
- Williams syndrome
- Angelman syndrome
- Kabuki syndrome
- Smith-Magenis syndrome
- CHARGE syndrome
- Cri du Chat syndrome

- Cornelia de Lange syndrome
- Microcephaly if a child has:
  - a head circumference less than the third percentile for age and sex; and
  - a functional level at or below 2 standard deviations below the mean for age on a standard developmental test, or an IQ score of less than 70 on a standardised test of intelligence*
- Rett's disorder
- Fetal Alcohol Spectrum Disorder (FASD)
- Lesch-Nyhan syndrome
- 22q deletion syndrome

Does the eligible disability list cover ADHD, intellectual disability or a specific learning disability?

The GMST clause 2.6.1, and explanatory notes AR.29.1 and MN.10.3, provides the list of eligible disabilities for the purposes of items 137, 139 and the allied health assessment and treatment items (82000-82035 and 93032 -93044). This list is exhaustive and lists the 19 disabilities that are eligible for these services. The list includes several intellectual disabilities such as Fragile X, Prader-Willi and Down Syndromes. ADHD is not included and is not considered an eligible disability.

Are these items related to the Helping Children with Autism Program and Better Start for Children with Disability Program?

These MBS items were introduced to the MBS in 2008 as part of the *Helping Children with Autism* Program (HCWA) and *Better Start for Children with Disability* Program. These programs supported early intervention services for children undergoing diagnosis or treatment for Autism Spectrum Disorder (ASD) or an eligible disability. Following diagnosis of ASD or an eligible disability diagnosis, funding was available through the Department of Families, Housing, Community Services and Indigenous Affairs for individuals aged 0-6 years.

From 2021, funding for both the *Helping Children with Autism* and *Better Start for Children with Disability* programs have transitioned to the National Disability Insurance Scheme (NDIS), however, the MBS items continue to be available to eligible patients, as recommended by the MBS Review Taskforce but with changes to improve access, amend outdated terminology and better align the items with current best practice which were implemented on 1 March 2023.

More information about the Taskforce and its Committees is available on the Department of Health and Aged Care's website.

How do these MBS items interact with the NDIS services and how can they be used appropriately?

These MBS items were created under the Helping Children with Autism program and the Better Start for Children with Disability programs which have now ceased. Funding for these programs has transitioned to the National Disability Insurance Agency however the MBS items are still available.

These MBS items have been retained to support the assessment of patients aged under 25 years old that are diagnosed with, or are suspected of having, a complex neurodevelopmental disorder (such as ASD) or eligible disability through patient rebates. The treatment items support access for patients with a diagnosis, providing rebates for patients who may not be eligible for the NDIS or where eligible, provide rebates prior to NDIS approval.

Medical Practitioner Provider Questions

When can items 135, 137, 139 or 289 be claimed?

Items 135, 137, 139 or 289 can be claimed once in an individual's lifetime, following a confirmed diagnosis of a complex neurodevelopmental disorder (such as ASD) for items 135 and 289 or following a confirmed diagnosis of an eligible disability that is provided on the list of eligible disabilities for items 137 and 139.

Who decides eligibility for items 135, 137, 139 or 289?

A patient will become eligible for items 135 or 289 following a confirmed diagnosis of a complex neurodevelopmental disorder. A patient will become eligible for items 137 or 139 following a confirmed diagnosis of an eligible disability. These diagnoses are decided by the consultant paediatrician or psychiatrist and may be informed by prior Allied Health assessment.

Is there a specification for the location of assessments?

The previous reference to "consulting rooms" has been removed from items 135, 137, 139 and 289 which will allow clinician flexibility to provide the attendance outside of consulting rooms at a clinically appropriate venue if required.

What is the ongoing care pathway following a 135?

Following a confirmed diagnosis of a complex neurodevelopmental disorder, an individual will be able to access up to 20 referred Allied Health treatment services.

For the assessment and management trajectory of a child with multiple conditions separate from their complex neurodevelopmental disorder, billing of item 132 may be clinically appropriate, provided the initial referral included the assessment of other conditions separate to their complex neurodevelopmental disorder, and item 132 was billed first (as the initial assessment item). There would be no requirement for a separate referral for either service (132 or 135).

Following a confirmed diagnosis of a complex neurodevelopmental disorder and the development of a treatment plan (item 135), ongoing medical management can occur through subsequent attendance items, provided this is consistent with the details of the referring practitioner and the referral remains valid.

Can paediatricians keep seeing patients above 18 years old if the patient has a treatment and management plan in place?

Whilst it is not expected that a paediatrician would routinely assess adult individuals (item 289 provides for assessments undertaken by a psychiatrist for patients aged under 25 years), item 135 provides an age ceiling which is consistent across all MBS items related to complex neurodevelopmental disorders and related Allied Health services. Where a paediatrician has been referred a patient (under 18 years of age) and the diagnostic formulation is not completed until after their 18th birthday, the higher age limit will allow the completion of the assessment by the paediatrician (as clinically appropriate).

Are there legislative restrictions which prevent a paediatrician billing an MBS item for an adult?

In order to bill item 135, a paediatrician should make a decision that is clinically appropriate and following guidelines such as those relating to continuity of care for a patient older than 18 years.

Why has the language been changed from ‘severe’ to ‘requiring support and showing impairment’?

Severe is not a category that is applicable to psychometric testing. Additionally, ASD is no longer considered a linear spectrum from high functioning to severe, but levels of support requirements are given from level 1 (requiring support), level 2 (requiring substantial support) or level 3 (requiring very substantial support). This language has been updated to reflect current clinical terminology.

Allied health Provider Questions

Can the allied health assessment items be used for diagnosis of autism spectrum disorder in adults?

The allied health items provide rebates for the assessment of patients under 25 years of age, for the purpose of **assisting the referring eligible medical practitioner with the diagnosis** (including a differential diagnosis) of a complex neurodevelopmental disorder (such as ASD) or an eligible disability. After completion of the final assessment service by an eligible allied health practitioner, a written report must be provided to the referring eligible medical practitioner that outlines the assessment findings. This report will assist the referring medical practitioner in formulating a diagnosis. The allied health items **cannot** be used for assessments where the **allied health practitioner diagnoses the patient**.

Is there a diagnosis age limit for access to the allied health treatment items?

Prior to the 1 March 2023 changes, there was a requirement that the patient was diagnosed before the age of 13 years old for the allied health treatment items to be accessed. This requirement was removed with the 1 March 2023 changes. The allied health treatment items are restricted to patients under 25 years old that have a diagnosis of a complex neurodevelopmental disorder and/or an eligible disability, a treatment and management plan is in place and the other requirements of the item/s have been met. Requirements of the item and associated explanatory notes can be found using the search function at MBS Online.

Which allied health practitioners can provide referred treatment services?

The allied health practitioners that can provide treatment services under items 82015, 82020, 82025, 82035, 93035, 93036, 93043 and 93044 include psychologists, speech pathologists, occupational therapists, audiologists, optometrists, orthoptists, and physiotherapists. More information on the items can be found by using the search function on MBS Online.

If a paediatrician requests an allied health assessment but the patient turns 18 years old before the assessment is complete, what happens to the assessment report?

It is a requirement of the allied health assessment items that on completion of the final assessment service by an allied health practitioner, a written report must be provided to the referring medical practitioner which outlines the assessment findings. Providing the assessment is undertaken while the patient is under 25 years old, and the requirements of the MBS item are met (including providing the assessment report to the referring medical practitioner), then the patient is eligible to claim an MBS rebate.

What is the process of submitting a request for a review during the allied health assessment phase?

A single eligible allied health practitioner can provide up to 4 referred assessment services without the need for review and agreement by a referring eligible medical practitioner. For more than 4 allied health assessment services provided by a single practitioner, a request for review from the allied health practitioner will need to be provided to the consultant paediatrician or psychiatrist. An acceptable means of review includes a case conference, phone call, written correspondence, secure online messaging exchange, or attendance. Approval of the request can be provided in many forms of written communication such as written correspondence or secure online messaging exchange or documenting approval (given during a verbal exchange) in the patient's notes.

Can item 82000 be claimed if the child is not present?

For a rebate to be provided for the service described under item 82000, it is a requirement that the service is provided to the patient individually and in person.

Is it possible to claim allied health assessment items following a 135, 137, 139 or 289?

No, all Allied Health assessments under items (82000, 82005, 82010, 82030, 93032, 93040, 93033 or 93041) will need to be undertaken **before** billing item 135. These requirements remain unchanged following the 1 March 2023 changes.

The allied health assessment items provide a dual purpose of either:

- Contributing to the diagnosis; **and/or**
- Where the diagnosis is confirmed, contributing to the treatment and management plan.

Where further information is required to assess support needs and finalise the treatment and management plan, even though the diagnosis is confirmed, the allied health assessment items would need to be claimed prior to billing 135 or 289.

Where additional paediatrician consultations are required during this assessment phase, standard attendance items (110, 116, 119, 122, 128 or 131) can be used if further assessment is required by the paediatrician.

It is important to note, item 135 or 289 should only be billed if a complex neurodevelopmental disorder diagnosis is confirmed, **and** a treatment and management plan is documented.

What is the process for making an interdisciplinary referral for allied health assessment items?

An eligible allied health practitioner can make an interdisciplinary referral where they have received a referral from an eligible medical practitioner, assessed the patient and determined that another type of allied health practitioner assessment is required. The referral of the patient to another eligible allied health practitioner must be undertaken in consultation and agreement with, but without the need for a physical attendance by, the original referring eligible medical practitioner (such as but not limited to, a phone call, written correspondence or secure online messaging exchange). This consultation and agreement should be documented in the patient notes by the eligible allied health practitioner and included in the interdisciplinary referral. The referral may be a letter or note to an eligible allied health practitioner, signed and dated by the referring eligible allied health

practitioner. There is no specific form to refer patients for these services. The referral should include a copy of the original referral by the eligible medical practitioner.

Interdisciplinary referrals will only be valid where the referring eligible medical practitioner's referral (whose original referral initiated the assessment and assisting with a diagnosis service/contribution to a treatment and management plan) remains valid.

Where can I find more information?

The full item descriptor(s) and information on other changes to the MBS can be found on the MBS Online website at www.mbsonline.gov.au. You can also subscribe to future MBS updates by visiting MBS Online and clicking 'Subscribe'.

The Department of Health and Aged Care (the Department) provides an email advice service for providers seeking advice on interpretation of the MBS items and rules and the *Health Insurance Act 1973* and associated regulations. If you have a query relating exclusively to interpretation of the Schedule, you should email askMBS@health.gov.au.

Private health insurance information on the product tier arrangements is available at www.privatehealth.gov.au. Detailed information on the MBS item listing within clinical categories is available on the Department's website. Private health insurance minimum accommodation benefits information, including MBS item accommodation classification, is available in the latest version of the *Private Health Insurance (Benefit Requirements) Rules 2011* found on the Federal Register of Legislation. If you have a query in relation to private health insurance, you should email PHI@health.gov.au.

Subscribe to 'News for Health Professionals' on the Services Australia website and you will receive regular news highlights.

If you are seeking advice in relation to Medicare billing, claiming, payments, or obtaining a provider number, please go to the Health Professionals page on the Services Australia website or contact the Services Australia on the Provider Enquiry Line – 13 21 50.

The data file for software vendors when available can be accessed via the Downloads page.

Please note that the information provided is a general guide only. It is ultimately the responsibility of treating practitioners to use their professional judgment to determine the most clinically appropriate services to provide, and then to ensure that any services billed to Medicare fully meet the eligibility requirements outlined in the legislation.

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