Australian Government
Department of Health and Aged Care

Complex Neurodevelopmental Disorders and eligible disabilities changes to MBS items for medical practitioners

Date of change: 1 March 2023

Amended items: 135 137 139 289

What are the changes

From 1 March 2023, changes will be made across all medical practitioner items for the assessment and development of a treatment and management plan for individuals diagnosed with a Complex Neurodevelopmental Disorder (such as Autism Spectrum Disorder) or an eligible disability. MBS items 135 (for consultant paediatricians), 137 (for specialist and consultant physicians), 139 (for GPs) and 289 (for consultant psychiatrists) will be amended to:

- Expand the age eligibility for MBS rebates from under 13 years of age to under 25 years for Complex Neurodevelopmental Disorders and eligible disabilities;
- Update terminology from Pervasive Developmental Disorders to Complex Neurodevelopmental Disorders (such as Autism Spectrum Disorders);
- Expand the eligibility disability list to include Fetal Alcohol Spectrum Disorder, Lesch-Nyhan Syndrome and 22q deletion Syndrome.

These changes will ensure the items align with contemporary clinical practice and address recommendations endorsed by MBS Reviews Taskforce (the Taskforce).

Patient impacts

These MBS items were introduced to the MBS in 2008 as part of the *Helping Children with Autism Program* (HCWA) and the *Better Start for Children with Disability Program*. These programs were early intervention services for children undergoing diagnosis or treatment for Autism or an eligible disability. Following diagnosis of Autism or an eligible disability diagnosis, funding was available through the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) 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, however the MBS items continue to be available to eligible patients, as recommended by the Taskforce but with changes to improve access, amend outdated terminology and better align the items with current best practice.

From 1 March 2023, patient eligibility will expand, from under 13 years of age to under 25 years of age. Where an individual is diagnosed with a Complex Neurodevelopmental Disorder or an eligible disability, and a treatment and management plan is developed under items 135, 137, 139 or 289 Individuals can be referred for up to 20 eligible Allied Health treatment services if applicable. Eligibility for these items is based on functional impairment rather than diagnosis alone.

Restrictions or requirement

Patient eligibility

Items 135 (or telehealth equivalent item 92140) and 289 (or telehealth equivalent item 92434) are intended for complex conditions, characterised by multi-domain cognitive and functional impairment. Patient eligibility (up to 25 years of age) is for neurodevelopmental disorders, assessed to be complex and where patients will require support across multiple domains. The diagnosis of a Complex Neurodevelopmental Disorder requires evidence of requiring support and showing impairment across two or more neurodevelopmental domains; with complexity characterised by multi-domain cognitive and functional disabilities.

These items provide access to treatment, through the development of a treatment and management plan by a paediatrician (item 135) or a psychiatrist (item 289) once in a patient's lifetime for individuals up to 25 years of age.

Items 137 (or telehealth equivalent item 92141) and 139 (or telehealth equivalent item 92142) are intended for assessment and development of a treatment management plan for individuals diagnosed with an eligible disability. A list of the eligible disabilities which are intended under this item are included in the "amended item descriptor" section of this document.

These items provide access to treatment, through the development of a treatment and management plan by a specialist or consultant physician (item 137) or a GP (item 139) once in a patient's lifetime for individuals up to 25 years of age.

It is important to note, that items 135, 137, 139 and 289 require the relevant medical practitioner to make a diagnosis, when the diagnosis is not conclusive these items are not appropriate to bill.

A patient's eligibility for an item with frequency restrictions should be checked online using the MBS items checker in the Health Professional Online Services (HPOS) prior to providing a service. HPOS is a fast and secure way for health professionals and administrators to check if a patient is eligible for a Medicare benefit for a specific item on the date of the proposed service. This system will return advice that the item is payable or not payable.

Services Australia has published a guide on how to use this service which can be found at the following link: www.servicesaustralia.gov.au/organisations/health-professionals/services/medicare/hpos/services/using-mbs-items-online-checker-hpos

Please note that the HPOS system is managed by Services Australia. AskMBS cannot comment on its content or management. For any future enquiries relating to HPOS, please contact Services Australia on 132 150 and select Option 6 - electronic claiming or Health Professional Online Services (HPOS).

Multi-disciplinary assistance with assessment and/or contribution to the treatment and management plan:

Depending on a range of factors, not limited to the patient's age and nature of suspected disabilities, the relevant medical practitioner may require a multi-disciplinary approach to complete a comprehensive assessment and formulate a diagnosis.

Where the medical practitioner determines the patient requires additional assessments, through the assistance of an Allied Health practitioner, to formulate a diagnosis or assist with the development of a management plan, they are able to refer the patient to an eligible Allied Health provider from standard attendance items. The table below demonstrates the appropriate pre-requisite MBS items that medical practitioners can refer for Allied Health assessment services.

Type of Medical Practitioner	Suspected disorder/disability	Pre-requisite MBS items to refer to Allied Health Assessment MBS services
Consultant Paediatrician	Complex Neurodevelopmental Disorder	110, 116, 119, 122, 128, 131, 91824 - 91826 or 91836.
Consultant Psychiatrist	Complex Neurodevelopmental Disorder	296-308, 310, 312, 314, 316, 318, 319 - 352, 91827 - 91831, 91837 - 91839, 92437, 92455 - 92460
Specialist or Consultant physician	Eligible Disability	104, 105, 110, 116, 119, 122, 128, 131, 296 - 308, 310, 312, 314, 316, 318, 319 - 352, 91822, 91823, 91824 - 91826, 91833, 91827 - 91831, 91836, 91837 - 91839, 92437, 92455 - 92460
GP	Eligible Disability	3-51, 91790 - 91802

Whilst Medicare rebates can be provided for a total of 8 Allied Health assessment services per patient per lifetime, the same eligible Allied Health practitioner can only provide **up to 4**

services before the need for a review (the type of review can be specified in the referral to the eligible Allied Health professional) by the referring medical practitioner, who must agree to the need for any additional Allied Health services prior to the delivery of the remaining 4 Allied Health assessment services.

Eligible Allied Health Assessment practitioners include:

- Psychologist (MBS items 82000, 93032, 93040)
- Speech Pathologist (MBS items 82005, 93033, 93041)
- Occupational Therapist (MBS items 82010, 93033, 93041)
- Audiologist, Optometrist, Orthoptist, Physiotherapist (MBS items 82030, 93033, 93041)

Requirements of the referral to Allied Health practitioners

The medical practitioner can refer to multiple eligible Allied Health practitioners concurrently, but a separate referral letter must be provided to each Allied Health practitioner. The referral should specify the intent of the assessment and if appropriate, specify the number of services to be provided. Where the number of sessions is not specified, each Allied Health practitioner can provide up to 4 assessment services without the need for review or agreement to provide further assessment services.

Review requirements following delivery of 4 Allied Health Assessment services

Where an eligible Allied Health practitioner has provided 4 assessment services (through items 82000, 82005, 82010, 82030, 93032, 93040, 93033 or 93041) and considers additional assessment services are required, they must ensure the referring medical practitioner undertakes a review. If the type of review is not specified by the referring medical practitioner an acceptable means of review includes: a case conference, phone call, written correspondence, secure online messaging exchange or attendance of the patient with the referring medical practitioner.

Inter-disciplinary Allied Health referral

Eligible Allied Health practitioners are also able to make inter-disciplinary referrals to other eligible Allied Health practitioners as clinically necessary to assist with the formulation of the diagnosis or contribute to the treatment and management plan. Inter-disciplinary referrals must be undertaken in consultation and agreement with the referring medical practitioner. Whilst they do not require the need for an attendance with the patient (face-to-face or telehealth) by the referring medical practitioner, they do require an agreement from the referring medical practitioner. This can be undertaken (but is not limited to) an exchange by phone, written communication or secure online messaging.

Contribution to the Treatment and Management Plan through Allied Health referral

In addition to referring to Allied Health practitioners for assistance with formulating a diagnosis, the Allied Health assessment items may be used for assistance with developing a treatment and management plan. Even if a medical practitioner is clear that a specific diagnosis can be made, it would not be appropriate to bill the relevant assessment and treatment and management plan item (135, 137, 139, 289 and telehealth equivalents) should Allied Health assessment be required to finalise the treatment and management plan. Once the Allied Health assessments are completed and the medical practitioner is able to finalise the treatment and management plan, then treatment and management plan items can be billed.

Allied Health assessment MBS items 82000, 82005, 82010, 82030, 93032, 93040, 93033 or 93041 provide a dual function for this purpose. It is important to note that the service limit of a total of 8 services per patient per lifetime apply regardless of whether the items are used for assistance with diagnosis or contribution to the treatment and management plan, and the referring medical practitioner should be mindful of this when referring to eligible Allied Health practitioners.

Development of the Treatment and Management Plan

Once the medical practitioner has made a diagnosis of a Complex Neurodevelopmental Disorder (item 135, 289 or telehealth equivalent item 92140 or 92434) or eligible disability (137, 139 or telehealth equivalents item 92141, 92142), to complete the item requirements they must develop a treatment and management plan which includes:

- Written documentation of the patient's confirmed diagnosis, including any findings of assessments performed (which assisted with the formulation of the diagnosis or contributed to the treatment and management plan).
- A risk assessment which means assessment of:
    - the risk to the patient of any contributing co-morbidity and
    - environmental, physical, social and emotional risk factors that may apply to the patient or to another individual.
- Treatment options which include:
    - Recommendations using a biopsychosocial model
    - Identify major treatment goals and important milestones and objectives
    - Recommendation and referral for treatment services provided by eligible Allied Health practitioners (where relevant) and who should provide this, specifying number of treatments recommended (to a maximum of 20 treatment services)
    - Indications for review or episodes requiring escalation of treatment strategies.

- Documenting the Treatment and Management plan and providing a copy to the referring medical practitioner (where relevant) and relevant Allied health practitioner/s.

Referral for Allied Health Treatment services

Once a treatment and management plan is in place (after item 135, 137, 139, 289 or 92140, 92141, 92142 or 92434 has been claimed) the medical practitioner can refer the individual to eligible Allied health practitioners for the provision of treatment services. Treatment services address the functional impairments identified through the comprehensive medical assessment which are outlined in the treatment and management plan. Treatment services focus on interventions to address developmental delays/disabilities or impairments.

Eligible Allied Health treatment practitioners include:

- Psychologist (MBS items 82015, 93035, 93043)
- Speech Pathologist (MBS items 82020, 93036, 93044)
- Occupational Therapist (MBS items 82025, 93036, 93044)
- Audiologist, Optometrist, Orthoptist, Physiotherapist (MBS items 82035, 93036, 93044)

A total of 20 Allied Health Treatment services per patient per lifetime are available through the MBS, which may consist of any combination of items 82015, 82020, 82025 or 82035 or equivalent telehealth items. Whilst the medical practitioner can refer to multiple eligible Allied Health practitioners concurrently, a separate referral letter must be provided to each Allied Health practitioner.

The referral should specify the goals of the treatment and if appropriate, specify the number of services to be provided. It is the responsibility of the referring medical practitioner to allocate the number of treatment services (up to a maximum of 10 services per course of treatment) in keeping with the individual's treatment and management plan.

It is important to note, that a benefit will not be paid for the MBS Allied Health Treatment services unless one of the pre-requisite items (135, 137, 139, 289 or telehealth equivalents 92140, 92141, 92142 or 92434) have been processed through the Medicare claiming system.

On the completion of a "course of treatment" (specified by the referring psychiatrist, up to maximum of 10 services), the eligible Allied Health practitioner must provide a written report to the referring medical practitioner, which should include information on the treatment provided, recommendations for future management of the individual's disorder and any advice to caregivers (such as parents, carers, teachers). This written report from the Allied Health provider will inform the referring medical practitioner's decision to refer for further

treatment services. Where subsequent courses of treatment after the initial 10 services are required (up to a maximum of 20 services per patient per lifetime) a new referral is required.

Amended item descriptors (from 1 March 2023)

Amended item 135 and telehealth equivalent item 92140 – Assessment and development of a treatment and management plan of a Complex Neurodevelopmental Disorder following a confirmed diagnosis by a consultant paediatrician

Item: Item 135 and telehealth equivalent item 92140 are intended for complex conditions, characterised by multi-domain cognitive and functional impairment. Patient eligibility is for Neurodevelopmental Disorders, which are assessed to be complex and mean that individuals require support across multiple domains.

Overview: The amended item provides Medicare rebates for the medical assessment and development of a treatment and management plan, including the diagnosis of a Complex Neurodevelopmental Disorder, for individuals under 25 years of age. The assessment and diagnosis of a Complex Neurodevelopmental Disorder should be evaluated in the context of both a physical and developmental assessment. The paediatrician may require a number of separate attendances (through usual time-tiered or subsequent attendance items 110, 116, 119, 122, 128, 131 or telehealth equivalent items 91824, 91825, 91826 or 91836) to complete a comprehensive assessment and formulate a diagnosis, exclude other disorders or assess for co-occurring conditions

Service/Descriptor:

Professional attendance lasting at least 45 minutes by a consultant physician in the practice of the consultant physician's specialty of paediatrics, following referral of the patient to the consultant paediatrician by a referring practitioner, for a patient aged under 25, if the consultant paediatrician:

(a) undertakes, or has previously undertaken in prior attendances, a comprehensive assessment in relation to which a diagnosis of a Complex Neurodevelopmental Disorder (such as autism spectrum disorder) is made (if appropriate, using information provided by an eligible Allied Health provider); and

(b) develops a treatment and management plan, which must include:
  (i) documentation of the confirmed diagnosis; and
  (ii) findings of any assessments performed for the purposes of formulation of the diagnosis or contribution to the treatment and management plan; and
  (iii) a risk assessment; and
  (iv) treatment options (which may include biopsychosocial recommendations); and

(c) provides a copy of the treatment and management plan to:
  (i) the referring practitioner; and
  (ii) one or more Allied Health providers, if appropriate, for the treatment of the patient;

(other than attendance on a patient for whom payment has previously been made under this item or item 137, 139, 289, 92140, 92141, 92142 or 92434)

Applicable only once per lifetime

Indication: Patient eligibility is based on functional impairment and complexity rather than diagnosis alone. The development of the treatment and management plan, follows a comprehensive medical assessment and once item 135 is claimed, provides the opportunity to refer to Allied Health practitioners for up to 20 MBS Allied health treatment services.

The 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

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 over 18 years to 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).

Billing requirement: This item is claimable once in an individual's lifetime.

MBS fee: $283.20 (No change).

Benefit: 75% = $212.40 85% = $240.75

Private Health Insurance clinical category: Common list

Private Health Insurance procedure type: Type C

Amended item 289 and telehealth equivalent item 92434– Assessment and development of a treatment and management plan of a Complex Neurodevelopmental Disorder following a confirmed diagnosis by a consultant psychiatrist

Item: Item 289 and telehealth equivalent item 92434 are intended for complex conditions, characterised by multi-domain cognitive and functional impairment. Patient eligibility is for neurodevelopmental disorders, which are assessed to be complex and mean that individuals require support across multiple domains .

Overview: The amended items provide Medicare rebates for the medical assessment and development of a treatment and management plan, including the diagnosis of a Complex

Neurodevelopmental Disorder for individuals under 25 years of age. The assessment and diagnosis of a Complex Neurodevelopmental Disorder should be evaluated in the context of both a physical and developmental assessment. The psychiatrist may require a number of separate attendances (through usual attendance items, such as 296-308, 310, 312, 314, 316, 318, 319 - 352, 91827 - 91831, 91837 - 91839, 92437, 92455 - 92460) to complete a comprehensive assessment and formulate a diagnosis, exclude other disorders or assess for co-occurring conditions.

Service/Descriptor: Professional attendance lasting at least 45 minutes, by a consultant physician in the practice of the consultant physician's specialty of psychiatry, following referral of the patient to the consultant psychiatrist by a referring practitioner, for a patient aged under 25, if the consultant psychiatrist:

(a) undertakes, or has previously undertaken in prior attendances, a comprehensive assessment in relation to which a diagnosis of a Complex Neurodevelopmental Disorder (such as autism spectrum disorder) is made (if appropriate, using information provided by an eligible Allied Health provider); and

(b) develops a treatment and management plan, which must include:
  (i) documentation of the confirmed diagnosis; and
  (ii) findings of any assessments performed for the purposes of formulation of the diagnosis or contribution to the treatment and management plan; and
  (iii) a risk assessment; and
  (iv) treatment options (which may include biopsychosocial recommendations); and

(c) provides a copy of the treatment and management plan to:
  (i) the referring practitioner; and
  (ii) one or more Allied Health providers, if appropriate, for the treatment of the patient;

(other than attendance on a patient for whom payment has previously been made under this item or item 135, 137, 139, 92140, 92141, 92142 or 92434)

Applicable only once per lifetime

Indication: see indication for item 135

Billing requirement: This item is claimable once in an individual's lifetime.

MBS fee: $283.20 (No change)

Benefit: 75% = $212.40 85% = $240.75

Private Health Insurance clinical category: Hospital Psychiatric Services

Private Health Insurance procedure type: Type C

Amended item 137 and telehealth equivalent item 92141 - Assessment and development of a treatment and management plan of an eligible disability following a confirmed diagnosis by a specialist or consultant physician

Item: Item 137 and telehealth equivalent item 92141 are intended for assessment and development of a treatment and management plan for patients under 25 years of age with an eligible disability by a specialist or consultant physician.

Overview: The amended items provide Medicare rebates for the medical assessment and development of a treatment and management plan, following the diagnosis of an eligible disability for individuals under 25 years of age.

Service/Descriptor: Professional attendance lasting at least 45 minutes by a specialist or consultant physician (not including a general practitioner), following referral of the patient to the specialist or consultant physician by a referring practitioner, for a patient aged under 25, if the specialist or consultant physician:

(a) undertakes, or has previously undertaken in prior attendances, a comprehensive assessment in relation to which a diagnosis of an eligible disability is made (if appropriate, using information provided by an eligible Allied Health provider); and

(b) develops a treatment and management plan, which must include:
- (i) documentation of the confirmed diagnosis; and
- (ii) findings of any assessments performed for the purposes of formulation of the diagnosis or contribution to the treatment and management plan; and
- (iii) a risk assessment; and
- (iv) treatment options (which may include biopsychosocial recommendations); and

(c) provides a copy of the treatment and management plan to:
- (i) the referring practitioner; and
- (ii) one or more Allied Health providers, if appropriate, for the treatment of the patient;

(other than attendance on a patient for whom payment has previously been made under this item or item 135, 139, 289, 92140, 92141, 92142 or 92434)

Applicable only once per lifetime

Indication: 'Eligible disabilities' for the purpose of these services means any of the following conditions: (This list is legislated and can be found on MBSONLINE at AR.29.1)

(a) 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;

(b) hearing impairment that results in:

(i) a hearing loss of 40 decibels or greater in the better ear, across 4 frequencies; or

(ii) permanent conductive hearing loss and auditory neuropathy;

(c) deafblindness;

(d) cerebral palsy;

(e) Down syndrome;

(f) Fragile X syndrome;

(g) Prader-Willi syndrome;

(h) Williams syndrome;

(i) Angelman syndrome;

(j) Kabuki syndrome;

(k) Smith-Magenis syndrome;

(l) CHARGE syndrome;

(m) Cri du Chat syndrome;

(n) Cornelia de Lange syndrome;

(o) microcephaly, if a child has:

(i) a head circumference less than the third percentile for age and sex; and

(ii) a functional level at or below 2 standard deviations below the mean for age on a standard development test or an IQ score of less than 70 on a standardised test of intelligence*;

(p) Rett's disorder;

(q) Fetal Alcohol Spectrum Disorder (FASD);

(r) Lesch-Nyhan syndrome;

(s) 22q deletion syndrome.

Billing requirement: This item is claimable once in an individual's lifetime.

MBS fee: $ $283.20 (No change)

Benefit: 75% = $212.40 85% = $240.75

Private Health Insurance clinical category: Common list

Private Health Insurance procedure type: Type C

Amended item 139 and telehealth equivalent item 92142 – Assessment and development of a treatment and management plan of an eligible disability following a confirmed diagnosis by a GP

Item: Item 139 and telehealth equivalent item 92142 are intended for assessment and development of a treatment and management plan for patients under 25 years of age with an eligible disability by a GP.

Overview: The amended items provide Medicare rebates for the medical assessment and development of a treatment and management plan, following the diagnosis of an eligible disability for individuals under 25 years of age.

Service/Descriptor: Professional attendance lasting at least 45 minutes, at a place other than a hospital, by a general practitioner (not including a specialist or consultant physician), for a patient aged under 25, if the general practitioner:

(a) undertakes, or has previously undertaken in prior attendances, a comprehensive assessment in relation to which a diagnosis of an eligible disability is made (if appropriate, using information provided by an eligible Allied Health provider); and

(b) develops a treatment and management plan, which must include:
    (i) documentation of the confirmed diagnosis; and
    (ii) findings of any assessments performed for the purposes of formulation of the diagnosis or contribution to the treatment and management plan; and
    (iii) a risk assessment; and
    (iv) treatment options (which may include biopsychosocial recommendations); and

(c) provides a copy of the treatment and management plan to one or more Allied Health providers, if appropriate, for the treatment of the patient;

(other than attendance on a patient for whom payment has previously been made under this item or item 135, 137, 289, 92140, 92141, 92142 or 92434)

Applicable only once per lifetime

Indication: see indication for item 137

Billing requirement: This item is claimable once in an individual's lifetime.

MBS fee: $142.20 (No change)

Benefit: 100% = $142.20

Private Health Insurance clinical category: N/A (Not hospital treatment)

Private Health Insurance procedure type: Type C

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.