Australian Government
Department of Health, Disability and Ageing

Upcoming Changes to Chronic Disease Management Framework – Referral Arrangements for Allied Health Services

Last updated: 22 May 2025

- Referral requirements for most MBS-supported allied health services written on or after 1 July 2025, will change. These changes will ensure that the requirements are more consistent with the arrangements for referrals to medical specialists.
- Any referrals for allied health services written prior to 1 July 2025 will remain valid until all services under the referral have been provided (see separate factsheet on transition arrangements).
- From 1 July 2025, referral forms will no longer be used for referrals to allied health services. Referral letters will be used, consistent with the referral process for medical specialists.
    - There is no requirement for allied health providers to confirm acceptance of the referral or otherwise provide input into the preparation of the GP chronic condition management plan (GPCCMP). However, the requirements for allied health providers to provide a written report back to the GP after the provision of certain services (e.g. the first service under a referral) are unchanged.
- Unless otherwise specified by the referring medical practitioner, referrals to allied health services for patients with a chronic condition will be valid for 18 months.
- The new referral requirements apply to all allied health referrals under the chronic conditions management framework, as well as some other MBS-supported allied health services.

What are the changes?

- From 1 July 2025, the requirements for referrals to the following allied health services (and their video and phone equivalent items) are changing:
    - Group M3 (subgroup 1) – individual allied health services for patients with a chronic condition (referred under the chronic conditions management arrangements)
    - Group M8 – pregnancy support counselling allied health services
    - Group M9 – allied health group services for patients with type 2 diabetes (referred under the chronic conditions management arrangements)
    - Group M10 (subgroup 1) – complex neurodevelopmental disorders and eligible disabilities allied health services

- Group M11 – allied health services for Aboriginal and Torres Strait Islander people (referred under the chronic conditions management arrangements or following a health assessment).

- The new referral requirements will apply whether the referral is written under the new GP chronic condition management plan, a multidisciplinary care plan, or GP management plan or team care arrangements that was put in place prior to 1 July 2025.
- The use of a prescribed referral form for allied health services will no longer be required. Allied health referrals will now be provided via referral letters, consistent with the arrangements for referrals to medical specialists.
- The minimum requirements for a valid referral to an allied health provider will be that the referral:
  - includes the name of the referring practitioner
  - includes the address of the practice, or the practitioner's provider number at that practice, of the referring practitioner
  - includes the date on which the referring practitioner made the referral
  - the validity of the referral (if relevant)
    - NB for referrals to individual or group allied health services (Group M3 Subgroup 1, Group M9 and Group M11) referrals will be valid for 18 months from the date of the first service provided under the referral, unless otherwise specified by the referring practitioner
  - be in writing
  - be signed by the referring practitioner (which may be by electronic signature)
  - be dated
  - explain the reasons for referring the patient, including any information about the patient's condition that the referring practitioner considered necessary to give the allied health professional.

- One of the objectives of the changes is to provide patients with greater choice and flexibility. Referrals do not need to:
  - Specify the name of the allied health provider to provide the services. For example, a patient can take a referral to physiotherapy services under their GP chronic condition management plan to a physiotherapist of their choice.
    - NB Acceptance of a referral is at the discretion of the individual practitioner, subject to anti-discrimination legislation.
  - Specify the number of services to be provided. However, nothing prevents the referring medical practitioner from specifying the number of services to be provided under the referral, if they choose to do so. Referrals can be signed and transmitted electronically. Where the intended allied health provider is known, referring practitioners are encouraged to send referrals electronically where possible to minimise the risk of lost referrals.

- Requirements for allied health providers to report back to the referring practitioner at certain points (e.g. after the first and last service under a referral) have not changed.

- As of 1 July 2025, these requirements do not apply to other MBS-supported allied health services, including Better Access psychological therapy services, focussed psychological strategies (allied mental health) services, eating disorder allied health services, or diagnostic audiology services.

Why are the changes being made?

These changes are a result of a review by the MBS Review Taskforce, which was informed by the General Practice and Primary Care Clinical Committee. More information about the Taskforce and associated Committees is available in the Medicare Benefits Schedule Review in the consumer section of the Department of Health, Disability and Ageing (the department) website.

A full copy of the General Practice and Primary Care Clinical Committee's final report can be found in the Publications section of the department website.

What does this mean for providers?

For medical practitioners, the changes to referral requirements will improve consistency of processes. Wherever possible the new referral requirements for allied health referrals have been aligned with the requirements and processes for referrals to medical specialist services.

For allied health providers, the new referrals will include more information about the patient and the reason that allied health services are being sought.

How will these changes affect patients?

The new arrangements will empower patients and provide them with more choice by allowing referrals for allied health services to be taken to a provider of their choice.

Who was consulted on the changes?

The General Practice and Primary Care Clinical Committee (GPPCCC) was established in 2016 by the MBS Review Taskforce (the 'Taskforce'), to provide broad clinician and consumer expertise. The MBS Review included a public consultation process on the proposed changes from December 2018 to March 2019. Feedback was received from a broad range of stakeholders and considered by the GPPCCC prior to making its final recommendations to the Taskforce.

Following the MBS Review, ongoing consultation occurred through an Implementation Liaison Group which included, amongst other stakeholders, the Australian Medical Association, the Royal Australian College of General Practitioners, the Rural Doctors Association, Allied Health Professionals Australia, the Australian Primary Health Care Nurses Association, and the National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners. A Communications Working Group was also established which included representatives of the affected health professions to support communications to health professionals.

How will the changes be monitored and reviewed?

Changes to MBS items are subject to post-implementation review. Post-implementation reviews typically occur around 2 years after implementation of the change.

Providers are responsible for ensuring Medicare services claimed using their provider number meet all legislative requirements. All Medicare claiming is subject to compliance checks and providers may be required to submit evidence about the services they bill. More information about the department's compliance program can be found on its website at Medicare compliance.

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. You can also subscribe to future MBS updates by visiting 'Subscribe to the MBS' on the MBS Online website.

Providers seeking advice on interpretation of MBS items, explanatory notes and associated legislation can use the department's email advice service by emailing 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 to 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 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 factsheet is current as of the Last updated date shown above and does not account for MBS changes since that date.