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Speech Pathology Australia

FAQs from SPA members
Accessing Medicare M10 Items for Speech Sound Disorders, Stuttering, and Cleft Lip/Palate.

This document provides responses to questions about accessing services under the Medicare 'Complex neurodevelopmental disorders and eligible disabilities' program, also known as the M10 item group.

Although this program includes 'neurodevelopmental disorders' (e.g. autism), this FAQ focuses on the expanded 'eligible disabilities' of speech sound disorders, stuttering, and cleft lip/palate.

This information should only be used as a general guide. Consult Services Australia for advice specific to your individual circumstances.

For questions about this document, please contact Speech Pathology Australia on 1300 368 835 or Contact us.

What are the steps for consumers to access speech pathology services under this program?

STEP 1: Is the person eligible?

Under 25 years.	Has (or may have) a **speech sound disorder, stuttering, cleft lip/palate**.

STEP 2: Consult a GP or Medical Practitioner.

If the GP needs more information: Refer to a speech pathologist for assessment.	**Once the GP has enough information** to confirm the diagnosis: Proceed.

STEP 3: The GP confirms the diagnosis and creates a plan.

Confirms the diagnosis.	Creates a Treatment and Management Plan.	Refers for speech pathology treatment.

STEP 4: The speech pathologist provides treatment.

Reviews the Treatment and Management Plan.	Provides the treatment.	Monitors the number of remaining sessions.

STEP 5: The speech pathologist provides a written report.

Sends a written report to the GP.	Recommends additional sessions if needed.

Who is eligible for this program?

People **under 25 years** who have, or may have, **certain conditions**.

These include new conditions that relate to speech pathology.

Consumers can learn more about these conditions here:

Speech sound disorders: • Speech sound development 0-3 years • Speech sound development 4+ years • Childhood apraxia of speech (CAS) • Dysarthria	Stuttering	Cleft lip and/or palate

What if the person is not eligible for the M10 program?

They can explore other pathways for support like a Medicare Chronic Conditions Management plan. Consumers can learn more about Fees, rebates and funded programs here.

What medical practitioner provides the referral?

There are 2 referral pathways in the M10 program. Who provides the referral depends on the eligible condition:

Eligible disabilities	Complex neurodevelopmental disorders
This includes: • Speech sound disorders • Stuttering • Cleft lip/palate	This includes: • Autism
GPs, consultant physicians and specialists can consult and refer.	**Paediatricians or psychiatrists** must consult and refer.

What happens during STEP 2?

The consumer tells the GP why they think the person has an eligible condition.

- Talk about **why** the person may have a **speech sound disorder, stuttering, cleft lip/palate.**
- Share any **previous assessments or reports**.

The GP decides if there is enough information to make or confirm a diagnosis.

- **If the GP has enough information**, proceed to STEP 3.
- **If the GP needs more information**, they can refer the person to a speech pathologist for assessment.

If the GP refers the person to be assessed by a speech pathologist:

The speech pathologist can provide up to 4 assessment sessions. → If more assessment sessions are needed, the GP can refer for up to 4 more. → The speech pathologist sends a report to the GP. → **Once there is enough information, proceed to STEP 3.**

Find detailed information about **referrals, assessment and diagnosis** on the DHDA FAQs.

Medicare *does not* specify:

- **Which assessments tools or approaches** to use.
- **What criteria** speech pathologists and GPs use to diagnose an eligible disability.

The GP must make a referral.

- Medicare will not rebate M10 speech pathology assessment sessions without a referral.

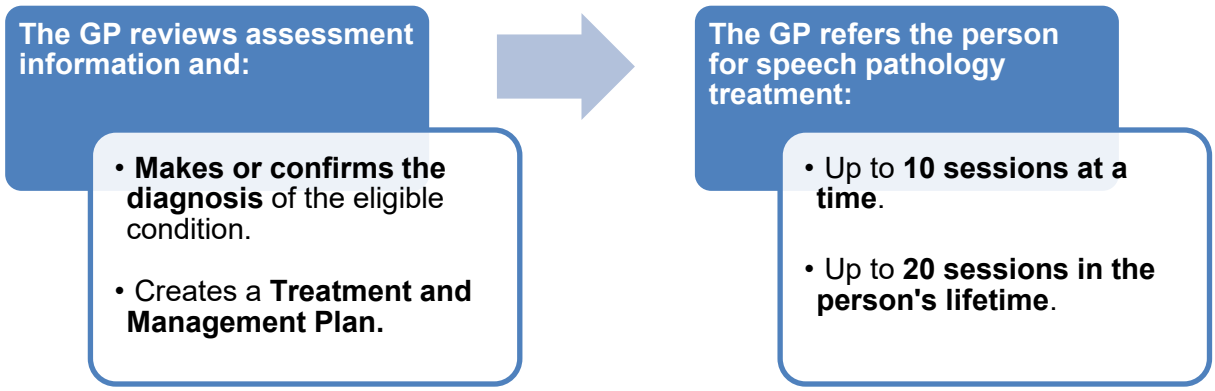
There is no referral form.

- **Referrals must include:**
  - GP name
  - Practice address or Medicare Provider Number
  - Date
  - Reason for referral + relevant clinical info
- **It could help to include:**
  - That the referral is for a speech pathology assessment under the M10 program.
  - How many assessment sessions the person is referred for. If not stated, the speech pathologist can provide up to 4 before a new referral is needed.
  - Item numbers to be used *(82005, 93033, and/or 93041)*

Claiming **Medicare rebates** for **STEP 2**:

GP Consult If there is enough info to confirm a diagnosis	**GP Consult** If the GP refers for speech pathology assessment.	**Speech Pathology Assessment Sessions**
See STEP 3. **Medical Practitioners must bill** a **Treatment and Management Plan item.** Note: This is a **45-minute** consult.	**Medical Practitioners can bill** under a **standard attendance item.** Note: These include a **range of consult times** and rebates.	**Speech pathologists bill** under items: • 82005 (in-person) or • 93033, 93041 (telehealth)
GPs: • 139 (in person) or • 92142 (telehealth)	**GPs:** • 3 to 47 (in person) or • 91790, 91800 to 91802, 91890, 91891 (telehealth)	
Specialists and consultant physicians: • 137 (in person) or • 92141 (telehealth)	**Specialist or consultant physicians:** • 104, 105, 107, 108, 110, 116, 119, 122, 128, 131 or 296, 297, 299, 300, 302, 304, 306, 308, 310, 312, 314, 316, 318 to 341 (in person) or • 91822 to 91839, 91868 to 91884, 92437 (telehealth)	

What happens during STEP 3?



Find detailed information about **Treatment and Management Plans** at MBS Item 139.

The plan should include:

Diagnosis

- A **confirmed diagnosis** of an eligible condition *(e.g. speech sound disorder, stuttering, cleft lip/palate)*
- A summary of any **assessment results** that helped make the diagnosis

Risk assessment

- Any **health conditions** that could affect the client
- **Other factors** that may impact care, such as:
  - Environment (e.g. home or school)
  - Physical health
  - Social or emotional needs

Treatment plan

- Recommended care using a **whole-person (biopsychosocial) approach**
- Treatment **goals and milestones**

Follow-up and review

- When the plan should be **reviewed**
- Signs that treatment may need to be **changed**

Find detailed information about **treatment referrals** at MBS Note AN.15.6.

Referrals *must* include:

- Name of the referring GP
- GP's practice address or Medicare Provider Number
- Date of the referral
- Goals of the treatment
- Copy of the Treatment & Management Plan
- Number of sessions (max 10 at a time)

It *could help* to include:

- That the referral is for speech pathology treatment under the M10 program.
- Item numbers to be used *(82020, 93036, and/or 93044).*

Referrals *do not need* to include:

- **The name of the speech pathologist** who will provide the service. The person can use the referral with any eligible speech pathologist.

Session and timeframe requirements

- The GP can **refer for up to 10 treatment sessions** at a time.
- **If more treatment sessions are needed**, the GP must make another referral.
- A person can claim up to **20 treatment sessions in their lifetime**.
- A referral is valid for the **timeframe the GP states** in the referral.
- If the GP does not state a timeframe, the referral is valid for **18 months from the date of the first service,** (not from the date of the referral).

Claiming **Medicare rebates** for **STEP 3**:

GP Consult	Item Numbers
Medical Practitioners must bill a **Treatment and Management Plan item** (137, 139, 92141, or 92142)**.** Note: This is a **45-minute** consult.	**GPs**: • 139 (in person) or • 92142 (telehealth)
A person **can only claim one of the Treatment and Management Plan items** in their lifetime.	**Specialists and consultant physicians:** • 137 (in person) or • 92141 (telehealth).

What happens during STEP 4?

Find detailed information about **speech pathology treatment** at MBS Item 82020.

The speech pathologist provides the treatment.

- Treatment sessions must be at least **30 minutes**.
- The M10 program **does not specify**:
  - **Which treatment approaches** to use.
  - **What support needs** to address. *(e.g. speech sound treatment vs feeding treatment for a person with cleft lip/palate).*
- The M10 program **does specify:**
  - That treatments and approaches **must be consistent with** the Treatment and Management Plan.

The speech pathologist and the service user monitor the number of remaining sessions.

- The GP should **allocate the number of treatment sessions** to use.
- The speech pathologist can provide **up to 10 sessions** before a new referral is needed.
- The person can claim **up to 20 sessions** in their lifetime.
- Once the allocated treatment sessions are complete, **proceed to STEP 5.**

Claiming **Medicare rebates** for **STEP 4**:

Speech Pathology Treatment Sessions	The GP must claim the Treatment and Management Plan consult.
Speech pathologists bill under items: • 82020 (in-person) or • 93036, 93044 (telehealth)	Medicare **will not rebate** speech pathology treatment sessions **until the GP's Treatment and Management Plan consult** (137, 139, 92141, or 92142) is processed through the Medicare claiming system.

What happens during STEP 5?

Find detailed information about **written reports** at MBS Note AN.0.73.

The speech pathologist sends a written report to the GP.

- **The report should include**:
  - Information about the **treatments and outcomes**.
  - **Recommendations** on future management.
  - **Advice** to caregivers.
- **If more treatment is needed**, the speech pathologist can recommend:
  - That remaining **M10 treatment sessions** be used.
  - **Other treatment pathways**, like the Medicare Chronic Conditions program.

The GP reviews the report and refers for additional treatments if needed.

- If the GP decides **more treatment is needed**, they can **write a referral** for:
- Remaining **M10 treatment sessions** (up to 10 at a time; 20 per lifetime)
- **Other treatment pathways** if appropriate (e.g. the Chronic Conditions Management program.)

Claiming **Medicare rebates** for **STEP 5**:

Speech Pathologist	Additional GP Consults
Time the speech pathologist spends writing the report is **not counted towards the rebated service time** under M10 treatment items. Find detailed information at MBS Note MN.10.2.	If the person needs additional referrals, the GP can bill this consult under a **standard attendance item.** **GPs:** • 3 to 47 (in person) or • 91790, 91800 to 91802, 91890, 91891 (telehealth) **Specialist or consultant physicians:** • 104, 105, 107, 108, 110, 116, 119, 122, 128, 131 or 296, 297, 299, 300, 302, 304, 306, 308, 310, 312, 314, 316, 318 to 341 (in person) or • 91822 to 91839, 91868 to 91884, 92437 (telehealth)

What can a consumer do if their GP doesn't schedule 45-minute consults for the Treatment and Plan Management (STEP 3)?

Medicare **will not rebate** speech pathology treatment sessions **until the GP's Treatment and Management Plan consult** (137, 139, 92141, or 92142) is processed through the Medicare claiming system. These consults must be at least 45 minutes in length.

The person might provide information to the GP about:

- Why they need a 45-minute consult
- Details required for the Treatment and Management Plan
- Fee ($156.95) and Benefit amount (100% = $156.95)

The M10 treatment claim was rejected for 'Error Code 550'. What does this mean?

Error code 550 means a required consult item was not claimed.

Medicare **will not rebate** speech pathology treatment sessions **until a Treatment and Management Plan consult** item (137, 139, 92141, or 92142) is processed through the Medicare claiming system.

The consumer can speak to the GP to make sure that one of these items has been claimed. They may need to book a Treatment and Management Plan consult that meets the requirements of items 139 or 92142 before they can proceed with treatment sessions that are rebated under the M10 program.

Can the person receive speech pathology treatment before the GP creates a Treatment and Management Plan?

Yes, but these will not be rebated under the M10 program. Treatment sessions can only be claimed after STEPs 1 – 3 (above) are complete and the GP's consult has been processed by Medicare.

Can the consumer use both the M10 and Chronic Conditions Management programs for treatment sessions?

Yes, but not for the same session on the same day.

If the person is eligible for both the M10 and CCM programs, they can use either pathway. Be mindful that the Chronic Conditions Management program has different requirements and rebate amounts.

Is Developmental Language Disability (DLD) included in the M10 program?

No. Developmental Language Disorder (DLD) is not an eligible condition of the M10 program.

The program recently expanded to include stuttering, speech sound disorders and cleft lip and/or palate. But DLD has not been added to the M10 eligibility list at this time.

SPA advocated for DLD to be included, and we will continue to advocate for funding systems that increase the opportunities for people with communication and swallowing needs to access care.

Where can I learn more about the M10 program?

These resources may be helpful:

- SPA: M10 expansion for speech pathology
- Department of Health, Disability and Ageing:
  - Referral pathway for allied health treatment for eligible disabilities
  - Medicare services for eligible disabilities
- Services Australia: Billing for M10 items

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