POSITION STATEMENT

Allied Health Professions Australia

Improving the effectiveness of the Helping Children with Autism Spectrum Disorder and Pervasive Development Disorder MBS items

This position statement has been developed by Allied Health Professions Australia (AHPA) and its member associations to support the work of the Medicare Benefits Schedule (MBS) Review Allied Health Reference Group. We particularly acknowledge the work of the Australian Psychological Society (APS) in the development of this statement.

1. Introduction

The Subgroup M10 MBS items are a critical source of support for children with either Autism Spectrum Disorder (ASD) or Pervasive Development Disorder (PDD) and their families. These items provide essential access to assessment and treatment services. Assessment services can provide families with a means of determining eligibility and supporting access to treatment and intervention services under the National Disability Insurance Scheme (NDIS). However, they also provide vital access to care for children who may not be eligible for services under the NDIS.

AHPA acknowledges that there is a degree of crossover in the client groups covered by these MBS items and the services that may be funded under the NDIS. However, we note that there is still significant uncertainty about eligibility criteria for the NDIS for people with ASD and for many families, these items will be their only source of access to funded care. One option to address this overlap may be to ensure that assessment items are available to any child referred by an appropriate health practitioner but that the treatment items are only available to children who are unable to access NDIS-funded services.

2. Recommendations

AHPA and its members strongly recommend that the subgroup M10 *Helping children with ASD/PDD* MBS items are retained as a minimum. However we recommend changes are made to ensure equity of access for allied health services for families who may not be able to pay the significant out of pocket costs that arise from the current service duration limits and schedule fees.

Recommendation 1: Increase service duration and schedule fees for assessment items.
The current assessment items are based around a 50-minute consultation and are remunerated at the same level as the 30-minute treatment sessions. The consultation length is insufficient for an appropriate assessment to be made and the fee paid far too low.

AHPA recommends that:

- **Service durations are reviewed and amended to include longer sessions of up to 180 minutes. A full assessment should include one session (120 minutes) for the completion of a full developmental history interview with the parents or guardians of the child and one to two sessions (180 minutes total) for the completion of a cognitive assessment with any child diagnosed with ASD/PDD prior to school entry to inform learning and development needs.**
- **Capacity is built into the item for a review assessment, when required, as requested by the assessing eligible practitioner.**
- **The schedule fee is brought into line with the rate paid for treatment items (based on an hourly rate of $175.90/$199.50) and based on the assessment service durations recommended.**
- **General practitioners should be added to the list of eligible referrers for these items.**

Recommendation 2: Adjust service conditions for treatment items.
AHPA notes the importance of these items for children who will not be eligible for service under the NDIS and believes they must be retained. However, we recommend adjustments are made to the service conditions to support improved outcomes for eligible children and their families.
AHPA recommends that:

- **Remove current age restrictions (13 for assessment and 15 for treatment) and instead limit access to treatment items to people not also receiving psychological services under the NDIS.**
- **Remove lifetime limits are removed and instead provide access to up to ten annual sessions with a duration of 50 minutes each to support interventions targeted at social functioning and behavioural management.**
- **Provide access to additional services through a new group item number that allows people to access an additional ten sessions per annum, delivered in a group setting.**

Recommendation 3: Case conferencing support
AHPA notes that multidisciplinary care is shown to improve outcomes for people with ASD/PDD.
AHPA recommends that:

- **A case conferencing item should be introduced to allow practitioners to participate in case conferencing and improve coordination of care.**

Recommendation 4: Broaden access to ASD/PDD items for appropriate allied health professions
AHPA notes that multidisciplinary care is shown to improve outcomes for people with ASD/PDD. On that basis AHPA recommends that other disciplines be invited to put a case for inclusion under the MBS Review process.

- **The list of eligible allied health professions able to provide services to children with ASD/PDD should be broadened to include those that can demonstrate appropriate clinical competence and training.**

3. Rationale

Supporting appropriate assessment and diagnosis

AHPA notes that there is significant evidence around the appropriate diagnostic assessments that should be provided by eligible psychologists, speech pathologists, occupational therapists or other appropriate allied health professionals. The time required for these assessments to be undertaken is significantly higher than that currently funded by the MBS and results in significant additional out of pocket expenses for families. Appropriate assessment activities include the following:

- 60-90 minutes (one session) to undertake observation and functional assessment including utilising standardised assessment measures.
- 90-120 minutes (one session) to undertake a comprehensive interview with the parents or guardians of the child including the administration of standardised measures as appropriate.

In addition to these requirements, significant time is required to enable the practitioner to write up an appropriate report detailing the results of the assessment sessions with the child and family to inform the treatment plan**.** Current MBS rebates do not cover the duration of these assessment sessions or report writing which results in significant out of pocket costs.

Evidence also shows that a cognitive assessment prior to school entry is critical for children with ASD or PDD. This assessment helps to establish the child's cognitive strengths and weaknesses so that education and psychosocial interventions can be better targeted to assist with their learning and development. A cognitive assessment informs the most appropriate learning and education options and also acts as a foundation for developing learning plans for a child with ASD.

Currently cognitive assessments are not covered under the MBS and this means families are dependent on their ability to pay for cognitive assessments for their children. Without these, teachers and other service providers are unlikely to be aware of the appropriate services and supports required to meet the child's developmental needs. This can have a significant impact on longer term outcomes for the child. A basic cognitive assessment includes 180 minutes total (one-two sessions) for a face-to-face assessment as well as additional report-writing time.

Assessment reviews are not currently covered under the MBS. The recommended clinical management of children with ASD is to review their diagnosis to confirm the stability of the symptoms.[i] Whilst there is generally high stability of autism symptoms over time, children diagnosed under the age of three years, and/or children diagnosed with high functioning ASD often require a follow up assessment during ensuing years to confirm the correct diagnosis has been provided, and that the severity of symptoms through developmental stages.[ii]

Providing access to evidence-based treatment

For people with ASD who are not eligible to access treatment under the NDIS, the MBS is a vital source of funding for appropriate and necessary care that can significantly improve outcomes for the child. The subgroup M10 items are the only Medicare-funded option as ASD/PDD does not provide eligibility to the Better Access item numbers.

The age threshold of 15 years for receipt of treatment services in the existing item descriptor provides very limited access to services at a time when they are most needed. As an individual with an ASD diagnosis transitions from childhood to adolescence and then on to adulthood, social functioning becomes more salient, with adolescents becoming increasingly aware of their social status and skill deficits, having more academic stress, and being at risk for social avoidance and peer victimisation[iii]. Further, the increase in the child's size during adolescence can make behaviour management more challenging; for example, aggressive or self-injurious behaviour can be more difficult to physically manage in order to avert any risk of harm to self or others[iv].

As young people with ASD transition into adulthood there is a demonstrated significant risk that these individuals will become involved with the Justice and Corrections systems within their lifetime[v], presenting a significant financial burden on Government. The risk of involvement in the Justice system is heightened by not providing adequate intervention for adolescents and young adults when it is required.

Key transition points and life events make individuals with ASD/PDD particularly vulnerable to increased levels of behavioural problems, aggression, distress and risk. The current lifetime and age limits on the subgroup M10 items mean that individuals with an ASD/PDD diagnosis are at risk of not having access to important services at times where these are required. By adjusting the limits currently applied to these items, those in need would be far better placed to receive intervention targeted at social functioning and behavioural management throughout their development.

In addition, changes to the service conditions to allow greater flexibility in how services are delivered could improve outcomes and provide more cost-effective outcomes. AHPA notes that some individuals and families may benefit from group intervention, as this is a cost-effective approach, particularly for facilitating social skills.[vi] AHPA further notes that some therapy sessions should be available for use by the practitioner to provide parent/family education without the child being present. Evidence demonstrates the effectiveness of supporting the client's social network, and the role of parent/family in early intervention[vii]. It also shows that group intervention and parent/communication partner approaches may reduce therapist time (and therefore cost) with no/little impact on outcomes[viii].

AHPA notes that allied health involvement in multi-disciplinary team approaches is indicated for some conditions such as autism spectrum disorder and in these cases, the presence of all disciplines at case conferences is needed[ix]. Currently there is no structure to support case conferencing to support patient care. AHPA recommends that an item is introduced to support case conferencing. The current MBS item – 855, which supports the involvement of a psychiatrist in a case conference, provides an example of how this could be structured.

4. References

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