NDIS Psychology vs Medicare: Which Pathway Fits Your Situation?

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Details:

The short answer is that purpose decides the scheme . Medicare funds clinical mental health treatment. The NDIS funds disability-related supports that build or maintain functional capacity and participation. The NDIS is explicitly barred from funding the treatment or stabilisation of symptoms, because that is the health system's job.

The guide above walks through that distinction and the practical choice. This section goes underneath it, into the parts that decide real cases: the actual test the NDIA applies, the access criteria for psychosocial disability, which support category the money comes from, how long a Better Access referral really lasts, and how to run both schemes at once without a clash.

The test the NDIA actually applies

People argue about which scheme should pay. The NDIA does not argue, it applies criteria. A support has to be reasonable and necessary , which means it must:

Be related to your disability , addressing the functional impact of it

Assist you to achieve your goals and improve your participation

Represent value for money

Be likely to be effective and beneficial , with evidence behind it

Take account of informal supports already provided by family, carers, networks and community

On top of that sits the boundary rule: the NDIS cannot fund supports that are the responsibility of another government system , including supports more appropriately provided through health. And the specific exclusion that decides most psychology disputes is that NDIS supports are excluded for the treatment or stabilisation of symptoms .

So the question to ask about any proposed session is not "is this psychology?" It is: is this treating symptoms, or is it building function? Same profession, same room, sometimes the same person. Different purpose, different scheme.

For psychosocial disability the division is stated directly. The mental health system is generally responsible for clinical services such as diagnosis and treatment. The NDIS is generally responsible for non-clinical supports focused on functional ability, independence, and social and economic participation.

Who is eligible for each

NDIS access with a psychosocial disability

Four requirements have to be met.

Age. You must be under 65 when you apply .

Residence. Australian citizen, permanent resident, or holder of a Protected Special Category Visa.

Permanent or likely to be permanent impairment. Your psychosocial disability must be lifelong or likely to become so. This is where most applications are won or lost. You will need medical reports confirming the permanent nature of the condition and documentation of your treatment history, including what has been tried and what the outcome was. Evidence that the condition is not temporary is the point.

Substantially reduced functional capacity. The impairment must substantially affect your ability to do everyday activities.

That fourth criterion is assessed across six functional domains , and it is worth knowing them by name because reports are read against them:

Self-care — personal hygiene, dressing, grooming

Self-management — routines, finances, daily organisation

Mobility — moving around and accessing the community

Learning — acquiring new skills and knowledge

Communication — expressing needs and interacting with others

Social functioning — maintaining relationships and participating in community

The NDIS looks at functional impact rather than diagnosis alone . A diagnosis on its own does not get you access. Evidence of what the condition stops you doing, across those six domains, is what does.

Useful evidence includes medical reports or specialist letters documenting the disability, records of treatments tried and their outcomes, functional capacity reports from allied health professionals written against the six domains, and diagnostic or cognitive assessments. Bloom offers an NDIS access and readiness service that gathers this material, including a brief functional capacity report covering the six domains. Call 1300 771 465 for current details.

Medicare Better Access

Eligibility rests on a clinically diagnosed mental health condition, a current Medicare card, and the right referral: a Mental Health Treatment Plan prepared by your GP, or a valid referral from a psychiatrist or paediatrician. There is no permanence test and no functional-domain assessment. That is the practical difference. Medicare asks whether you have a condition needing treatment; the NDIS asks whether a permanent impairment substantially reduces what you can do.

Which NDIS budget pays for psychology

When psychology is NDIS-funded, it is a capacity building support. In practice it is usually funded from:

Capacity Building, Improved Daily Living — the most common category

Capacity Building, Improved Relationships — where the focus is social or behavioural

Core Supports occasionally, in flexible situations where capacity building budgets are limited

Which category your funding sits in matters, because stated funding cannot be moved and flexible funding can. Ask your plan manager or support coordinator whether your therapy funding is stated or flexible before you book a block of sessions.

How long a Better Access referral actually lasts

This is the most commonly misunderstood part of the Medicare pathway, and getting it wrong wastes sessions.

A Better Access referral is valid for the number of sessions in that course of treatment, not for a period of time. It does not expire after twelve months. It lasts until the sessions in that course of treatment are used.

What follows from that:

Sessions can cross calendar years. If a course of treatment is part-used when the year ends, the remaining sessions continue into the new year under the same referral.

The initial course of treatment is up to 6 sessions. If your GP refers for fewer, say 4, that lower number is your limit. If a GP writes a referral for all 10 at once, the course of treatment maximum still applies and a re-referral is needed for the rest.

Later courses of treatment are typically 4 sessions , which is how the annual total reaches 10.

The 10-session annual limit resets on 1 January , and unused sessions do not automatically carry over as an entitlement. Only a part-used course of treatment straddles the year.

Separately, a Mental Health Treatment Plan does not expire. Once your GP has processed it with Medicare it stays valid. A GP may write a new one if your clinical picture has changed significantly, but that is their clinical judgement, not a twelve-month requirement. You do not need a new plan every year. You do need a new referral for each new course of treatment.

One practical warning: confirming how many rebated sessions you have left in the calendar year is your responsibility , not your psychologist's and not your GP's. If you have seen more than one provider, check before you book.

If you were discharged with sessions still unused and you come back much later, it is generally better to get a fresh referral so your GP can flag anything new.

These session counts and referral rules come from the Medicare arrangements administered by Services Australia. Rebate amounts are not published here because they change and depend on the item claimed. Ask your provider what the fee and the expected gap will be before your first appointment.

What the six-session review involves

At the end of the initial course of treatment there is a formal review, not just an administrative renewal. It typically involves:

Re-administering the outcome measures used at the start, such as the DASS-21 or K10, to see what has changed

Discussing progress with you and adjusting goals

A clinical judgement about whether further sessions are warranted

A progress letter to the referring GP summarising progress, outcome measures, ongoing concerns and any recommendation for more sessions

If more sessions are needed, you go back to your GP for a review of the plan and a new referral. Book that GP appointment before your sixth session rather than after it, or there will be a gap in treatment while you wait for an appointment.

Telehealth rules under Medicare

Telehealth psychology is a permanent part of Better Access, not a temporary arrangement. To use it you need a Medicare card, a valid Mental Health Treatment Plan or eligible referral, and a diagnosed condition.

Two conditions catch people out:

For telehealth plan preparation , you generally need to have had a face-to-face appointment with your usual GP or medical practitioner within the past 12 months , with some exceptions.

Individual telehealth therapy has no geographic restriction . Group therapy by telehealth is limited to people in Modified Monash Model 4 to 7 areas, meaning regional, rural and remote classifications.

From 1 November 2025, plan preparation, referrals and reviews are linked to your MyMedicare practice or usual medical practitioner, with exceptions for some psychiatrist and paediatrician pathways. If you have moved or changed GP recently, sort that out before you need the referral.

Medicare pathways other than Better Access

Better Access is not the only Medicare route to allied health, and for some people it is not the right one.

Chronic Disease Management is prepared by your GP and covers allied health for a chronic condition. Under it:

Up to 5 individual allied health services per calendar year , and up to 10 for Aboriginal and Torres Strait Islander patients

Eligible professions include psychologists, occupational therapists, physiotherapists, exercise physiologists, speech pathologists and dietitians

Referrals are valid for the stated timeframe, or 18 months from the first service where no timeframe is given

Plans made before 1 July 2025 under the earlier arrangements can generally continue to be used until 30 June 2027

Your provider must send a written report to the referring GP after the first and last service , and more often if clinically needed

Hospital in-patients are not eligible; residential aged care residents with a multidisciplinary care plan are

Better Access also covers eligible occupational therapy for mental health, on a similar referral and planning basis to psychology.

The 5 chronic disease services and the 10 Better Access sessions are separate entitlements with separate purposes. Ask your GP which fits, and do not assume you have to choose only one over the life of a condition.

Running both schemes without a clash

Many people with psychosocial disability legitimately use both. The rules that keep it clean:

One funding source per session. A single session is claimed once, from one scheme. Never both.

Split by purpose, not by convenience. Treatment and symptom stabilisation go to Medicare. Function, independence and participation go to the NDIS.

Make the notes match the purpose. If a session is NDIS-funded, the notes and goals should show functional capacity work. Loose documentation is what triggers questions at a plan reassessment.

Becoming an NDIS participant does not end your health care. The NDIS is explicit that medical and clinical care continues. Do not let a GP or a provider tell you your plan replaces treatment.

Tell each clinician what the other is doing , particularly if the same person is seeing you under both. Coordination is what stops duplicated work and contradictory strategies.

When the schemes change over: turning 65

You must be under 65 to apply for the NDIS. That is an access rule, and it is firm.

What happens to people already in the scheme who turn 65 is more nuanced, and you should not take a general answer as applying to you. Existing NDIS participants over 65 are not automatically transferred out into aged care. Aged care for people 65 and over runs under the Aged Care Act 2024, which commenced 1 November 2025, with services accessed through an aged care assessment via My Aged Care on 1800 200 422 and delivered under Support at Home.

Whichever scheme you are in, Medicare does not stop at 65 . Better Access psychology and chronic disease management allied health remain available, which is usually the continuity people are most worried about losing.

Because individual circumstances vary considerably here, confirm your own position with the NDIA and My Aged Care rather than relying on a general rule. See our Support at Home guide for how the aged care side works.

Common questions about choosing between NDIS and Medicare psychology

Does my referral expire after 12 months?

No. A Better Access referral is valid for the number of sessions in that course of treatment rather than for a period of time, and those sessions can cross calendar years. What resets on 1 January is the 10-session annual limit.

Do I need a new Mental Health Treatment Plan every year?

No. Once your GP has processed the plan with Medicare it does not expire. Your GP may write a new one if your situation has changed significantly, but that is a clinical decision. You do still need a new referral for each new course of treatment.

Why did my GP only refer me for 6 sessions when I get 10?

Because the initial course of treatment is up to 6 sessions. After the review, a further course, typically 4 sessions, takes you to the annual total of 10.

Whose job is it to track how many sessions I have left?

Yours. Confirming that you still have rebated sessions available in the calendar year is the client's responsibility, which matters most if you have seen more than one provider in a year.

What actually happens at the six-session review?

Outcome measures such as the DASS-21 or K10 are re-administered, progress is discussed and goals adjusted, a clinical judgement is made about further sessions, and a progress letter goes to your referring GP. Book the GP review before your last session to avoid a gap.

What evidence do I need for NDIS access with a psychosocial disability?

Evidence that the impairment is permanent or likely to be permanent, and evidence of substantially reduced functional capacity across the six domains: self-care, self-management, mobility, learning, communication and social functioning. That means medical reports, treatment history with outcomes, and functional capacity reports written against those domains. A diagnosis alone is not enough.

Which part of my NDIS plan pays for psychology?

Usually Capacity Building, Improved Daily Living. Sometimes Improved Relationships where the focus is social or behavioural, and occasionally Core Supports where funding is flexible. Check whether your therapy funding is stated or flexible before booking a block.

Can the NDIS fund treatment for my symptoms?

No. NDIS supports are explicitly excluded for the treatment or stabilisation of symptoms, which is a health system responsibility. The NDIS funds non-clinical supports focused on function, independence and participation.

Can I do Medicare psychology by telehealth?

Yes. Telehealth is a permanent part of Better Access, with no geographic restriction on individual therapy. You generally need a face-to-face appointment with your usual GP within the past 12 months for telehealth plan preparation. Group therapy by telehealth is limited to Modified Monash Model 4 to 7 areas.

Is there a Medicare option if I do not have a mental health diagnosis?

Possibly. A Chronic Disease Management plan prepared by your GP covers up to 5 individual allied health services per calendar year, and up to 10 for Aboriginal and Torres Strait Islander patients, across professions including psychology, occupational therapy, physiotherapy, exercise physiology, speech pathology and dietetics. Referrals run for the stated timeframe or 18 months from the first service.

What will I pay?

Providers set their own fees and Medicare covers part of the cost, so a gap is common. Rebate amounts are not published here because they change and depend on the item claimed. Ask your provider for the fee and expected out-of-pocket cost before your first appointment.

Does becoming an NDIS participant mean I lose my GP and treatment?

No. The NDIS does not replace clinical mental health treatment, and medical and clinical care should continue alongside your plan.

What happens when I turn 65?

You must be under 65 to apply to the NDIS. Existing participants are not automatically transferred out at 65. Aged care runs under the Aged Care Act 2024 through My Aged Care on 1800 200 422 and Support at Home. Medicare pathways continue to be available at any age. Circumstances vary, so confirm your own position with the NDIA and My Aged Care.

How do I start with Bloom?

Call 1300 771 465 or make a referral . If you are unsure which scheme fits, say so when you call. Sorting the purpose out first is what stops sessions being claimed from the wrong place.

What is the fundamental difference between NDIS psychology and Medicare psychology?

Medicare is designed for mental health treatment, while the NDIS is designed for disability-related supports that build or maintain functional capacity and participation.

What is required to access Medicare's Better Access initiative for psychology services?

You need to have been assessed with a clinically diagnosed mental disorder and have a Mental Health Treatment Plan (MHTP) created by a GP, psychiatrist, or paediatrician.

How many psychology sessions does Medicare Better Access provide per year?

Medicare Better Access provides up to 10 individual sessions and up to 10 group sessions per calendar year, from 1 January to 31 December.

How are Medicare referrals for psychology sessions typically structured?

Referrals are typically written for up to 6 sessions at a time, and are then reviewed if more sessions are needed.

Will Medicare cover the full cost of psychology sessions?

Not necessarily, because health professionals set their own fees, so Medicare will likely cover only part of the cost, with gap fees applying.

What recent change affects Medicare Mental Health Treatment Plans?

As of 1 November 2025, changes were introduced to link Mental Health Treatment Plan preparation, referrals, and reviews to a patient's MyMedicare practice or their usual medical practitioner.

What treatment approach does Medicare psychology typically focus on?

Medicare services are provided for specific diagnosed mental health illnesses, with treatment focusing on symptom relief and stabilisation through evidence-based approaches such as Cognitive Behavioural Therapy (CBT).

What does NDIS funding for psychosocial disability focus on?

For psychosocial disability, the NDIS funds supports that focus on improving functional ability and participation in social, work, and community life, and it does not replace community mental health services.

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