Exercise Physiology Under the NDIS | Bloom Healthcare

Canonical: https://bloom-healthcare.com.au/blog/ndis-exercise-physiology-goals-outcomes/

Details:

Exercise physiology is funded from the Capacity Building part of an NDIS plan, most often under Improved Daily Living, and also under Improved Health and Wellbeing. It is recognised in the NDIS Pricing Arrangements and Price Limits, and you generally do not need a specific line item for it unless your Capacity Building budget is made up of stated supports for another service. What decides whether it gets funded, and stays funded, is not the therapy itself but the evidence chain: a disability-related goal, a baseline measure, an outcome measure that moves, and a report that shows the NDIA both.

The article above covers what exercise physiology is, who it suits, what sessions look like and how it compares with physiotherapy and occupational therapy. This section covers the mechanics underneath: the funding rules, the reasonable and necessary test applied specifically to exercise, how to build a baseline, what to measure, what a reassessment report has to show, and where exercise physiology sits when the NDIS is not the right scheme.

Which budget pays, and what that means in practice

Exercise physiology sits in the Capacity Building support budget. Two categories are relevant. Capacity Building - Improved Daily Living is the main pathway, covering therapeutic work aimed at building functional capacity and independence in everyday activities. Capacity Building - Improved Health and Wellbeing covers services supporting physical and mental health, including exercise programs. Depending on how a plan is built and on individual needs, exercise physiology may in some circumstances be covered under Core Supports, but Capacity Building is the standard route.

The useful detail for participants and support coordinators is that you do not need exercise physiology named as its own line item. The funding can be used flexibly within the broader Capacity Building budget. The exception is where your Capacity Building budget is made up of stated supports for another service, in which case that money is locked to the named service and cannot be redirected. If you are unsure which situation you are in, your plan manager, support coordinator or the NDIA can tell you by reading the plan.

How your plan management type changes the process

All three management types can access exercise physiology. What changes is the administration.

If you are self-managed, you control the budget directly. You pay the provider, keep your own records and invoices, and claim from the NDIS. This gives the widest choice of provider and the most flexibility over scheduling, and the most paperwork.

If you are plan-managed, an independent plan manager handles the financial administration. You still choose your provider. The plan manager processes invoices and payments and keeps the records, and providers work within the NDIS Pricing Arrangements and Price Limits.

If you are NDIA-managed, the NDIA pays registered providers directly, providers must be NDIS registered, and pricing arrangements apply strictly.

None of this changes whether exercise physiology is a valid support for you. It changes who you talk to about money and how quickly invoices move.

The reasonable and necessary test, applied to exercise

This is where most requests succeed or fail. The NDIA applies the reasonable and necessary criteria to every therapy support. A support must be related to your disability, help you pursue your goals, represent value for money, be likely to be effective and beneficial, and take account of the informal supports already around you from family, carers and community.

The NDIA's focus is on supports that improve, maintain, or reduce decline in functional capacity, and that help you take part in daily life, work, study and community activities.

Applied to exercise, the practical test is simple. If the program is helping you do everyday life more safely or more independently, it is easier to justify. If it is general fitness with no clear link to a disability-related goal, it is harder to justify.

So a request built around walking to the shops safely, getting off the floor after a fall, standing long enough to cook a meal, managing fatigue across a school day, or reducing falls risk at home is arguing from function. A request built around getting fitter, losing weight or building general strength is arguing from health, and health alone is not the NDIS test.

What the NDIS will not fund

Being clear about the exclusions saves time:

General fitness that is not tied to a disability-related functional goal.

Gym memberships and standard gym access without a direct therapeutic purpose related to your disability.

Supports that are the responsibility of another system. Recovery from an acute event is generally a mainstream health responsibility, often through Medicare, rather than an NDIS one. Ongoing disability-related functional support is the part that may be NDIS funded where the criteria are met.

That last distinction catches people out after surgery or a hospital stay. Rehabilitation from the acute event usually belongs to the health system. What may belong to the NDIS is the longer-term work of rebuilding capacity that is affected by your disability.

Turning a plan goal into a fundable exercise physiology goal

NDIS goals are often written broadly, along the lines of wanting to be more independent at home or more active in the community. That wording is fine for the plan, but it does not on its own justify a support. The work is translating it into something specific enough to measure.

A useful pattern is: the everyday task, the current barrier, the target, and the measure.

Take a plan goal of being more independent at home. Translated, that might become standing to prepare a meal safely, where the barrier is fatigue and standing balance, with a target of preparing a simple meal with fewer rest breaks, and measures of standing time at the bench, number of rest breaks, a confidence rating and a pain rating after the activity.

A plan goal of getting out into the community might become walking to the local shop and back safely, where the barrier is endurance and balance confidence, measured by distance walked, use of a gait aid, balance confidence and the number of stops.

A plan goal about school or work might become managing fatigue across a full school day, measured by adherence to a pacing plan, energy levels at set points in the day, and recovery time afterwards. A goal about safety at home might become reducing falls risk, measured by balance tests, leg strength

markers, the number of near misses and confidence with transfers.

The pattern in all of these is the same. A named everyday activity, a stated barrier, and numbers that can be taken again in six months.

Baseline measures: the step people skip

Baseline measures are the quantitative assessments taken at your first exercise physiology consultation. They serve two purposes: safety, by establishing what is currently manageable before any program starts, and evidence, by fixing the starting point everything later is compared against.

Without a baseline you cannot demonstrate progress. You can describe it, and clients often do describe real improvements convincingly, but description is weaker evidence than a number that has changed. If you are starting exercise physiology with a plan reassessment somewhere ahead of you, ask at the first appointment what baseline measures are being taken and ask for them in writing.

A GP's approval may be requested before a program begins where that is clinically appropriate, particularly where there are cardiovascular, respiratory or other medical considerations.

What actually gets measured

Outcome measures are the assessment tools used to track, evaluate and document progress towards intervention goals. In exercise physiology and rehabilitation they typically fall into four groups.

Time and distance measures: how far you walked, how long you stood at a particular task, how long an activity took.

Confidence ratings: perceived safety and self-efficacy scores, which matter because confidence often limits participation as much as physical capacity does.

Symptom scores: pain ratings, fatigue scores, or other functional capacity markers.

Performance indicators: balance tests, leg strength markers, the number of near misses, transfers completed with less assistance.

Using measures systematically is not paperwork for its own sake. It is what lets a clinician tell whether a program is working, adjust it when it is not, and show the NDIA that the support is producing something.

What a report for plan reassessment has to show

The NDIA requires that reports supporting a plan reassessment explain the therapy approach and provide evidence of outcomes achieved and progress made towards goals. A report that does that well covers:

Your goals, and the functional impact of your disability day to day: how it affects daily activities, learning, work, safety and community participation.

What was assessed, and what the findings mean in practical terms rather than clinical ones.

What has already been tried, and what worked and what did not.

Measurable outcomes, including the baseline measures and the targets.

The recommended frequency and focus of continued supports, tied back to your goals.

The NDIA uses that evidence to work out whether the support remains reasonable, necessary, safe, legal and value for money. A report showing a clear line from a documented functional limitation, through a specific intervention, to a measured change, is doing the job. A report that describes sessions attended is not.

One practical point on timing. Ask your exercise physiologist for the report well before your reassessment date, not in the week before it. Reports take clinician time, that time is drawn from your plan, and a rushed report is a weaker one.

Why an exercise physiologist rather than a personal trainer

The article above sets out how exercise physiology differs from physiotherapy and occupational therapy. The comparison more people actually need is with a gym program, because on the surface the activity can look similar.

The difference is qualification and scope. Accredited Exercise Physiologists hold university degrees in exercise science or a related field followed by graduate qualifications in clinical exercise physiology. Programs accredited by Exercise and Sports Science Australia include more than 500 hours of supervised clinical practice. Personal trainers typically hold certificate-level fitness qualifications, which do not carry the same clinical depth.

The practical differences follow from that:

	Accredited Exercise Physiologist	Personal trainer or gym program
Qualification	University degree, ESSA accredited	Certificate-level fitness course
Focus	Clinical management of health conditions	General fitness, weight, strength
Assessment	Comprehensive health assessment before starting	Often minimal or skipped
Programs	Individualised, evidence-based, condition-specific	Often generalised
Safety	Designed for complex or higher-risk needs	Not suited to many chronic conditions
Position	Allied health, working alongside GPs and other clinicians	Not part of the clinical team

Accredited Exercise Physiologists are the professionals in Australia trained to deliver exercise therapy for people with medical conditions as part of the healthcare system. For NDIS purposes this matters twice over: for safety, and because NDIS-funded supports must be evidence-based, goal-aligned and therapeutic, which a gym program is not.

Conditions exercise physiologists work with

AEPs work across a wide range of conditions. Cardiovascular and metabolic conditions including heart disease, hypertension, type 2 diabetes, metabolic syndrome and obesity. Musculoskeletal conditions including arthritis and osteoarthritis, osteoporosis, chronic pain and musculoskeletal rehabilitation. Neurological conditions including stroke and acquired brain injury, Parkinson's disease, multiple sclerosis, cerebral palsy and peripheral neuropathy. Mental health conditions including depression, anxiety and post-traumatic stress disorder, through clinical exercise prescription. Physical, intellectual and neurological disabilities, including tailored programs for autistic people. And other conditions including cancer before and after treatment, chronic fatigue, post-surgical rehabilitation and injury recovery.

AEPs also conduct functional assessment and exercise testing to identify what is limiting exercise capacity, such as cardiovascular or respiratory constraints, which is what makes programs safe for

people with complex needs.

This breadth is why exercise physiology sometimes appears in a plan for reasons that are not obviously about exercise. Fatigue management, pain, confidence, routine and sleep are all legitimate territory when they connect to a disability-related goal.

Frequency, duration and the work between sessions

How often you should be seen is not something we can put a number on here, and any provider quoting a standard schedule before assessing you is guessing. Frequency depends on your goals, your current capacity, how much support you need to progress safely, what else is in your week, and how much funding you have available. Bloom sets frequency with you and your support coordinator against your plan and goals.

What is worth understanding is that a good program is designed to be mostly done without the clinician present. Sessions teach, progress and adjust. The rest of the week is where change actually happens. When you are comparing providers, ask what you will be doing between sessions and how they will support you to keep it up, because a program that only exists inside appointments is expensive and slow.

Over a course of work, sessions usually move from assessment and program design, to practising in real settings, to progressing load and complexity, to handover, where you carry more of it yourself and the clinician steps back. Handover is the goal, not a sign that support is being withdrawn.

Where sessions happen, and where Bloom works

Bloom delivers exercise physiology in homes, in community settings including local gyms and places you choose, in schools where that is appropriate and agreed, in consulting rooms, and by telehealth through secure platforms. Telehealth is particularly useful for people in rural or remote areas, people with mobility barriers, and anyone who would rather do the review from home.

Where a gym or other facility is used, any facility hire may be an additional cost. Ask for it to be set out in your service agreement before you start, along with fees and any travel arrangements. Commercial terms belong in the agreement, not on a web page.

Coverage includes New South Wales, Queensland, Victoria, South Australia, Western Australia, Tasmania and the Australian Capital Territory, with local presence across key cities and regional areas.

To start, call 1300 771 465, email hello@bloom-healthcare.com.au, or use the referral form . More detail on the service is on the exercise physiology page . Send your NDIS goals as written in your plan, a short description of what is hard day to day, and your funding management type, and the process moves faster.

If the NDIS is not your scheme

Exercise physiology is not only an NDIS service, and the rules differ by scheme. Do not carry an assumption from one across to another.

Aged care. Under Support at Home, which replaced the Home Care Packages Program on 1 November 2025, exercise physiology sits within Clinical Supports, and Clinical Supports are fully funded by the government with no participant contribution. Access runs through an aged care assessment arranged by My Aged Care on 1800 200 422. The Commonwealth Home Support Programme continues to operate separately for now. Aged care exercise physiology focuses on mobility, chronic condition management, falls risk and maintaining independence at home.

Medicare. A GP can initiate a GP chronic condition management plan (previously called a chronic disease management plan), which provides a structured pathway to allied health services including exercise physiology for people managing ongoing conditions. Bloom accepts referrals through this pathway. How many services are subsidised, and whether there is a gap to pay, depends on the plan your GP writes and on current Medicare arrangements, so ask your GP and Services Australia rather than assuming.

Children. For young children the support pathway is changing. See Thriving Kids: Eligibility, Rollout, and Support Overview and confirm the current position with the NDIA or your early childhood partner before making plans.

What we cannot tell you here

Some answers depend on your own plan and your own situation, and guessing would not help you:

how much Capacity Building funding you have left, and whether it covers a course of exercise physiology

how many sessions you need

fees, travel and cancellation terms, which are set out in your service agreement

whether the NDIA will accept a particular report for a particular request

current appointment availability in your suburb

For these, call 1300 771 465, or speak to your plan manager or support coordinator.

Common questions about NDIS exercise physiology funding and evidence

Do I need exercise physiology written into my plan as a line item?

Generally no. Exercise physiology is recognised in the NDIS Pricing Arrangements and Price Limits and can be accessed flexibly from the Capacity Building budget. The exception is where your Capacity Building budget consists of stated supports for another service, which locks that funding to the named service. Check the wording of your plan with your plan manager or support coordinator.

Which category does it come from, Improved Daily Living or Improved Health and Wellbeing?

Both are used. Improved Daily Living is the more common pathway, since it covers building functional capacity and independence in daily activities. Improved Health and Wellbeing covers services supporting physical and mental health. Which one your provider claims against should be confirmed at the start, along with what the expected outcomes are and how progress will be measured.

Will the NDIS pay for my gym membership?

No. Gym memberships and general gym access without a direct disability-related therapeutic purpose are not funded. Exercise physiology delivered in a gym can be a funded support where it meets the reasonable and necessary criteria, but the membership or facility hire itself is a separate question. Ask how any facility cost is handled before you begin.

My physiotherapy after surgery was covered by the hospital. Can the NDIS pick it up?

Not automatically. Recovery from an acute event is generally a mainstream health responsibility rather than an NDIS one. The part that may be NDIS funded is ongoing disability-related functional support, where it meets the criteria. If you are unsure which side of the line you sit on, describe the situation to your support coordinator or the NDIA rather than assuming either way.

What should I ask for at my first appointment?

Ask what baseline measures are being taken, ask for them in writing, and ask which of your plan goals each one connects to. That single conversation at the start is what makes your report at reassessment worth something.

What makes a strong report for plan reassessment?

One that explains the therapy approach and evidences outcomes and progress against goals. Concretely: your goals and the day-to-day functional impact of your disability, what was assessed and what it means functionally, what has been tried and what worked, measurable outcomes with baselines and targets, and the recommended frequency and focus of continued support linked to your goals.

How long before my reassessment should I ask for a report?

Earlier than feels necessary. Report writing takes clinician time that is drawn from your plan, and information sometimes has to be gathered from other professionals. Ask for an expected date when you request it.

Can I use exercise physiology for mental health goals?

AEPs are trained to support people living with conditions including depression, anxiety and post-traumatic stress disorder through clinical exercise prescription, and exercise can be part of a broader plan supporting routine, motivation, sleep and confidence. For NDIS funding, the support still has to be disability-related and tied to your goals, and it works best coordinated with psychology or counselling rather than instead of it.

What is the difference between an exercise physiologist and a personal trainer?

Qualification and scope. AEPs hold university degrees plus graduate clinical qualifications, accredited through Exercise and Sports Science Australia with over 500 hours of supervised clinical practice, and they work as allied health professionals alongside GPs and other clinicians. Personal trainers hold certificate-level fitness qualifications and are not part of the clinical care team. For complex or higher-risk needs, that difference is a safety one.

Can sessions be done by telehealth?

Yes. Telehealth is used for coaching, review and program updates, and is particularly useful for people in rural and remote areas or with mobility barriers. Some assessment work benefits from being done in person, so most programs use a mix.

How often will I be seen?

That depends on your goals, your capacity, the funding available and what else is in your week. There is no standard schedule, and a provider quoting one before assessing you is guessing. Frequency is set with you and your support coordinator.

I am over 65. Does any of this apply to me?

The NDIS rules on this page do not. Under aged care, exercise physiology sits in Clinical Supports under Support at Home and is fully funded by the government, with access through an aged care assessment arranged by My Aged Care on 1800 200 422. Alternatively, a GP chronic condition management plan through Medicare is another pathway. Call 1300 771 465 and say which situation applies to you.

Do I need exercise physiology written into my plan as a line item?

Generally no. Exercise physiology is recognised in the NDIS Pricing Arrangements and Price Limits and can be accessed flexibly from the Capacity Building budget. The exception is where your Capacity Building budget consists of stated supports for another service, which locks that funding to the named service. Check the wording of your plan with your plan manager or support coordinator.

Which category does it come from, Improved Daily Living or Improved Health and Wellbeing?

Both are used. Improved Daily Living is the more common pathway, since it covers building functional capacity and independence in daily activities. Improved Health and Wellbeing covers services supporting physical and mental health. Which one your provider claims against should be confirmed at the start, along with what the expected outcomes are and how progress will be measured.

Will the NDIS pay for my gym membership?

No. Gym memberships and general gym access without a direct disability-related therapeutic purpose are not funded. Exercise physiology delivered in a gym can be a funded support where it meets the reasonable and necessary criteria, but the membership or facility hire itself is a separate question. Ask how any facility cost is handled before you begin.

My physiotherapy after surgery was covered by the hospital. Can the NDIS pick it up?

Not automatically. Recovery from an acute event is generally a mainstream health responsibility rather than an NDIS one. The part that may be NDIS funded is ongoing disability-related functional support, where it meets the criteria. If you are unsure which side of the line you sit on, describe the situation to your support coordinator or the NDIA rather than assuming either way.

What should I ask for at my first appointment?

Ask what baseline measures are being taken, ask for them in writing, and ask which of your plan goals each one connects to. That single conversation at the start is what makes your report at reassessment worth something.

What makes a strong report for plan reassessment?

One that explains the therapy approach and evidences outcomes and progress against goals. Concretely: your goals and the day-to-day functional impact of your disability, what was assessed and what it means functionally, what has been tried and what worked, measurable outcomes with baselines and targets, and the recommended frequency and focus of continued support linked to your goals.

How long before my reassessment should I ask for a report?

Earlier than feels necessary. Report writing takes clinician time that is drawn from your plan, and information sometimes has to be gathered from other professionals. Ask for an expected date when you request it.

Can I use exercise physiology for mental health goals?

AEPs are trained to support people living with conditions including depression, anxiety and post-traumatic stress disorder through clinical exercise prescription, and exercise can be part of a broader plan supporting routine, motivation, sleep and confidence.

What is the difference between an exercise physiologist and a personal trainer?

Qualification and scope. AEPs hold university degrees plus graduate clinical qualifications, accredited through Exercise and Sports Science Australia with over 500 hours of supervised clinical practice, and they work as allied health professionals alongside GPs and other clinicians. Personal trainers hold certificate-level fitness qualifications and are not part of the clinical care team.

Can sessions be done by telehealth?

Yes. Telehealth is used for coaching, review and program updates, and is particularly useful for people in rural and remote areas or with mobility barriers. Some assessment work benefits from being done in person, so most programs use a mix.

How often will I be seen?

That depends on your goals, your capacity, the funding available and what else is in your week. There is no standard schedule, and a provider quoting one before assessing you is guessing. Frequency is set with you and your support coordinator.

I am over 65. Does any of this apply to me?

The NDIS rules on this page do not. Under aged care, exercise physiology sits in Clinical Supports under Support at Home and is fully funded by the government, with access through an aged care assessment arranged by My Aged Care on 1800 200 422. Alternatively, a GP-initiated chronic disease management plan through Medicare is another pathway. Call 1300 771 465 and say which situation applies to you.