Australian Government
Australian Institute of Health and Welfare

Use of chronic disease management and allied health Medicare services

Web report | Last updated: **15 Dec 2022** | Topic: Chronic disease

About

Medicare chronic disease management (CDM) services enable General Practitioners to plan and coordinate care for people with a chronic or terminal medical condition. These services also provide access to Medicare-subsidised individual and group allied health services for people with complex care needs to help manage their conditions. In 2019, more than 3.8 million patients had a CDM service while around 2.4 million patients received Medicare-subsidised allied health services.

Cat. no: PHC 9

- Fact sheets
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Findings from this report:

- In 2019, over 2.4 million patients claimed around 8.2 million Medicare-subsidised individual allied health services
- More than 3.8 million Australians had a Chronic Disease Management service in 2019
- In 2019, the most used Medicare-subsidised individual allied health services were podiatry, physiotherapy, and dietetics
- The use of GPMP and TCA services has increased steadily over the last decade

Summary

Chronic Disease Management (CDM) services are Medicare-subsidised services provided by General Practitioners (GPs) and are available to people with chronic or terminal medical conditions. Rather than a having a list of eligible conditions, a GP can determine whether a patient would benefit from a structured approach to care, based on their clinical judgement and accounting for the eligibility criteria and guidance contained within the Medicare Benefits Schedule (MBS) (Department of Health 2014).

The CDM services cover the coordination, creation and review of several care planning tools:

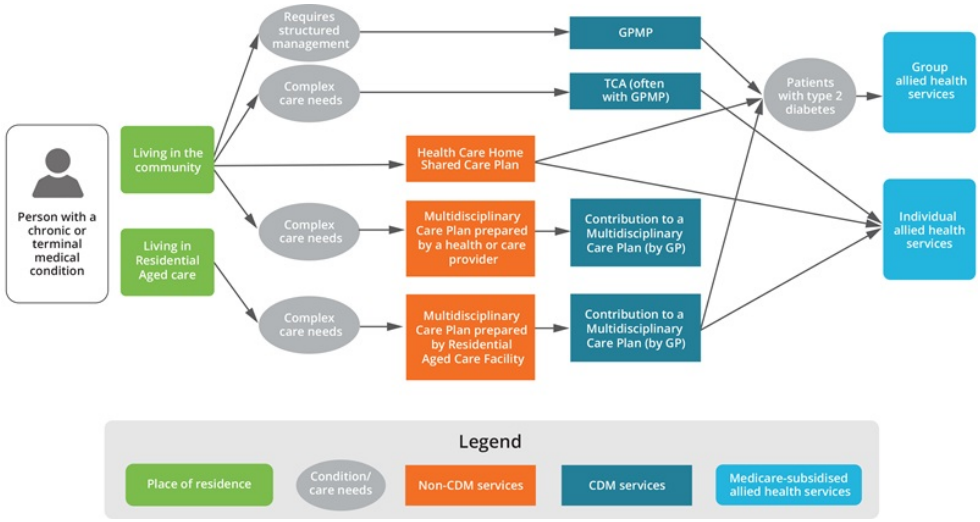
A **General Practitioner Management Plan** (GPMP), which is a plan of action agreed between a patient and their GP. The plan identifies the patient's health and care needs, sets out the services to be provided by the GP, and lists the actions the patient can take to help manage their condition.

Team Care Arrangements (TCAs), for patients with complex care needs requiring multidisciplinary care, which provide Medicare-subsidised care (5 services per calendar year) from selected allied health care providers for individual treatment services where the patient also has a GPMP.

Multidisciplinary Care Plans, are written plans that are prepared for a patient by a health or care provider often for patients in a Residential Aged Care Facility and describe the treatment and services to be provided to the patient by the collaborating providers.

It is recommended that GPMPs, TCAs and multidisciplinary care plans be regularly reviewed by the GP and the patient. Figure 1 shows patient pathways for CDM services.

Figure 1: Patient pathways to the CDM and Medicare-subsidised allied health services



Note: The Healthcare Homes trial began in October 2017 and ended on 30 June 2021. This pathway was available to patients in 2019, which is the analysis period for the bulk of this report.

This web report explores the use of CDM services and Medicare-subsidised allied health services in 2019. More than 3.8 million Australian's had a CDM service in 2019, with GPMPs and TCAs being the most used services (see Table 1). The use of GPMPs and TCAs was highest among patients aged 75–84 and varied according to remoteness and socioeconomic area (see Profile of CDM patients). The use of GPMP and TCA services has increased steadily over the last decade, with close to $1 billion paid by Medicare for CDM services in 2019 (see Trends in GPMP and TCA item use and Spending on CDM services).

In 2019, over 2.4 million patients claimed around 8.2 million Medicare-subsidised individual allied health services, with the most used services being podiatry, physiotherapy, and dietetics (see Table 4a). The use of Medicare-subsidised individual allied health services has increased steadily over the past decade (see Trends in allied health service use). Medicare paid $446 million in benefits for these services, with bulk billing rates varying considerably between the services (see Spending on allied health services). Of patients who accessed Medicare-subsidised individual allied health services in 2019, 37% used all 5 services. The number of services used decreased with increasing remoteness (See Patterns of allied health service use).

COVID-19 impact

The COVID-19 pandemic changed the way that many Australians' accessed health care. For CDM and Medicare-subsidised allied health services, a series of telehealth services were introduced to enable care to continue to be delivered. Telephone rather than videoconference was used for most CDM telehealth services in 2020. Telephone CDM services peaked in May, decreased in June/ July and rose again in August before continuing to decrease to December 2020 (See Impact of COVID-19 on CDM and Medicare-subsidised allied health services).

References

Department of Health (2014) *Questions and Answers on the Chronic Disease Management (CDM) items*, Department of Health website, accessed 24 March 2021.

Overview of chronic disease management services

Chronic disease management (CDM) services

Chronic disease management (CDM) services are GP services on the Medicare Benefits Schedule (MBS) and are available to people with a chronic or terminal medical condition. Under these services, a chronic medical condition is defined as one that has been or is likely to be present for 6 months or longer (Department of Health 2014a). This could include conditions such as asthma, cancer, cardiovascular disease, diabetes, musculoskeletal conditions or stroke. There is no list of eligible conditions for these services. Whether a patient is eligible for a CDM service or services is essentially a matter for the GP to determine, using their clinical judgement and taking into account both the eligibility criterion and the general guidance (Department of Health 2014b).

CDM services cover the coordination, creation and review of several care planning tools.

General Practitioner Management Plan (GPMP)

A GP Management Plan (GPMP; MBS items 721, 229) can help people with chronic medical conditions by providing an organised approach to care (Department of Health 2014c). A GPMP is a plan of action agreed between a patient and their GP. The plan identifies the patient's health and care needs, sets out the services to be provided by the GP, and lists the actions the patient can take to help manage their condition.

For patients with type 2 diabetes, a GPMP provides Medicare-subsidised care from selected allied health care providers for group allied health treatment services. Eligible allied health services include diabetes education services, exercise physiology and dietetics. This is in addition to individual allied health services made available through Team Care Arrangement (TCAs). See Allied health services.

Team Care Arrangements (TCAs)

Patients with complex care needs requiring multidisciplinary care are eligible for Team Care Arrangements (MBS items 723, 230). These will help coordinate more effectively the care needed from a patient's GP and other health or care providers. TCAs require a GP to collaborate with at least two other health or care providers who will give ongoing treatment or services.

TCAs provide access to Medicare-subsidised care from selected allied health care providers for individual treatment services. Eligible allied health services include Aboriginal and Torres Strait Islander health services, diabetes education services, audiology, exercise physiology, dietetics, mental health services, occupational therapy, physiotherapy, podiatry, chiropractic services, osteopathy, psychology and speech pathology. See Allied health services.

Review of GPMPs and TCAs

It is recommended that plans be regularly reviewed by the GP and patient (MBS items 732, 233). A review involves checking that a patient's goals are being met through the plan and provides an opportunity to make any adjustments needed.

Multidisciplinary care plan

These services allow primary care medical practitioners to contribute to a multidisciplinary care plan prepared by another health or care provider for a person with a chronic or terminal medical condition and complex care needs (MBS items 729, 231, 731, 232).

It is important to note that items 229, 230, 231, 232 and 233 were not available until 1 July 2018.

Care for people with chronic conditions in Australia

In Australia, most care for people with chronic conditions is provided in the primary health care setting (AIHW 2020a). Primary health care encompasses a range of services delivered outside the hospital and represents the front line of Australia's health care system (AIHW 2020b). While GPs are the cornerstone of primary health care in Australia, care can also be provided through nurses, allied health professionals, pharmacists, dentists and Aboriginal and Torres Strait Islander health workers and practitioners (Department of Health 2018). Effective primary health care supports people to manage complex and chronic conditions, thereby improving their health and wellbeing and reducing the need for specialist services and hospitalisations.

The CDM services profiled in this report are one option available to manage chronic conditions in primary care. In 2019, there were 161 million GP attendances claimed through Medicare (including CDM services) (Department of Health 2019). Outside of the CDM services, people may manage their chronic conditions with their GP through standard consultations, or through other specialised GP Medicare services. Examples of specialised GP Medicare services which may be beneficial to people with chronic conditions include:

- GP health assessments: an assessment of a patient's health and physical, psychological and social function to identify opportunities for early intervention and care, for target population groups
- GP Mental Health services: assessments, care planning and treatment for patients with mental health conditions
- Diabetes cycles of care: services including specific checks and measures to encourage effective management of diabetes mellitus
- Asthma cycles of care: services including specific checks and measures to encourage effective management of moderate to severe asthma (AIHW 2020c).

Since 2007, some private health insurers have also provided chronic disease management programs (CDMPs) as part of their Broader Health Cover services for members. The aim of these CDMPs has been to prevent or substitute for hospitalisation or help patients with chronic disease better manage and reduce the effects of that disease (Biggs 2013). A detailed analysis of the role of CDMPs is beyond the scope of this report. For more information, please see *chronic disease management: the role of private health insurance*.

Overview of CDM item use

The public health measures introduced during 2020 to help control the spread of COVID-19 led to substantial changes in the way Australian's were provided with and accessed health services. To account for the impact of COVID-19, this report separates the use of CDM services prior to 2020 and during 2020. Most results cover the period January—December 2019. For services used during 2020, see Impact of COVID-19 on CDM and Medicare-subsidised allied health services.

More than 3.8 million Australians had at least one CDM service in 2019 (Table 1). Preparation of a GP Management Plan (GPMP) was the most used item, accessed by 2.9 million patients (114 per 1,000 population), followed by the Coordination of Team Care Arrangements (TCAs) with 2.5 million patients (97 per 1,000 population). It is common for patients to have both a GPMP and TCAs, with almost 2.4 million patients having both services in 2019. This represents 83% of GPMP patients having TCAs, and 97% of TCAs patients having a GPMP.

A review of a patient's GPMP or TCA is recommended to occur every 6 months, or as clinically necessary (Department of Health 2014d). In 2019, 1.8 million patients had a review of their GPMP and/or TCAs. See Review of GPMP and TCAs for further analysis of the review service.

By comparison, the services for Contribution or Review of a Multidisciplinary Care Plan are much less frequently used, particularly for patients living in the community. Around 96,600 aged care residents had this service, representing just over half (53%) of the permanent residential aged care population at 30 June 2019 (AIHW 2021).

What are chronic disease management services?

General practitioner management plans (GPMPs; MBS items 721, 229) and Team Care Arrangements (TCAs; MBS items 723, 230) are chronic disease management (CDM) services available on the Medicare Benefits Schedule (MBS) for people with a chronic or terminal medical condition.

A GPMP is a plan of action agreed between a patient and their GP.

TCAs provide access to Medicare-subsidised care from selected allied health care providers for individual treatment services.

For more information, please see chronic disease management services.

Table 1: CDM services, number of services and patients, 2019

CDM service	Item number	Number of services	Rate of services per 1,000 population (crude)	Number of patients	Rate of patients per 1,000 population (crude)
Preparation of a GP Management Plan (GPMP)	721,229	2,896,875	114.2	2,892,090	114.0
Coordination of Team Care Arrangements (TCAs)	723,230	2,463,722	97.1	2,459,582	97.0
Review of a GP Management Plan or Coordination of a Review of Team Care Arrangements	732,233	3,951,162	155.8	1,770,147	69.8
Contribution to a Multidisciplinary Care Plan, or to a Review of a Multidisciplinary Care Plan, for a patient who is not a care recipient in a residential aged care facility	729,231	2,334	0.1	2,253	0.1
Contribution to a Multidisciplinary Care Plan, or to a review of a multidisciplinary care plan, for a resident in an aged care facility	731,232	158,996	6.3	96,607	3.8
Total CDM service		**9,473,089**	**373.5**	**3,832,164**	**151.1**

Notes

1. Rates in this web report are calculated using the Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) as at 30 June 2019, based on the data from the 2016 Census of Population and Housing.
2. Totals and subtotals of patients may be less than the sum of each service group as a patient may receive more than one type of service but will be counted only once in the relevant total.

Source: AIHW analysis of MBS data maintained by the Department of Health and Aged Care and sourced from Services Australia.

References

AIHW (Australian Institute of Health and Welfare) (2020a) *Chronic conditions and multimorbidity*, AIHW, Australian Government, accessed 5 May 2022.

AIHW (2020b) Primary health care (PDF 11.2MB), AIHW, Australian Government, accessed 30 April 2021.

AIHW (2020c) *Medicare-subsidised GP, allied health and specialist health care across local areas: 2013–14 to 2018–19*, AIHW, Australian Government, accessed 30 April 2021.

AIHW (2021) *GEN: People using aged care*, AIHW, Australian Government, accessed 3 May 2021.

Biggs A (2013) *Chronic disease management: the role of private health insurance*, Department of Parliamentary Services, Australian Government, accessed 31 August 2021.

Department of Health (2014a) *Questions and Answers on the Chronic Disease Management (CDM) items*, Department of Health, Australian Government, accessed 24 March 2021.

Department of Health (2014b) *Chronic Disease Management (formerly Enhanced Primary Care or EPC) — GP services*, Department of Health, Australian Government, accessed 24 March 2021.

Department of Health (2014c) *Questions and Answers on the Chronic Disease Management (CDM) items*, Department of Health, Australian Government, accessed 24 March 2021.

Department of Health (2014d) *Chronic Disease Management Patient Information*, Department of Health, Australian Government, accessed 24 March 2021.

Department of Health (2018) *Fact sheet: Primary Health Care*, Department of Health, Australian Government, accessed 30 April 2021.

Department of Health (2019) *Medicare Statistics: Rolling 12-month time series [Excel spreadsheet]*, Department of Health, Australian Government, accessed 30 April 2021.

Overview of chronic disease management services

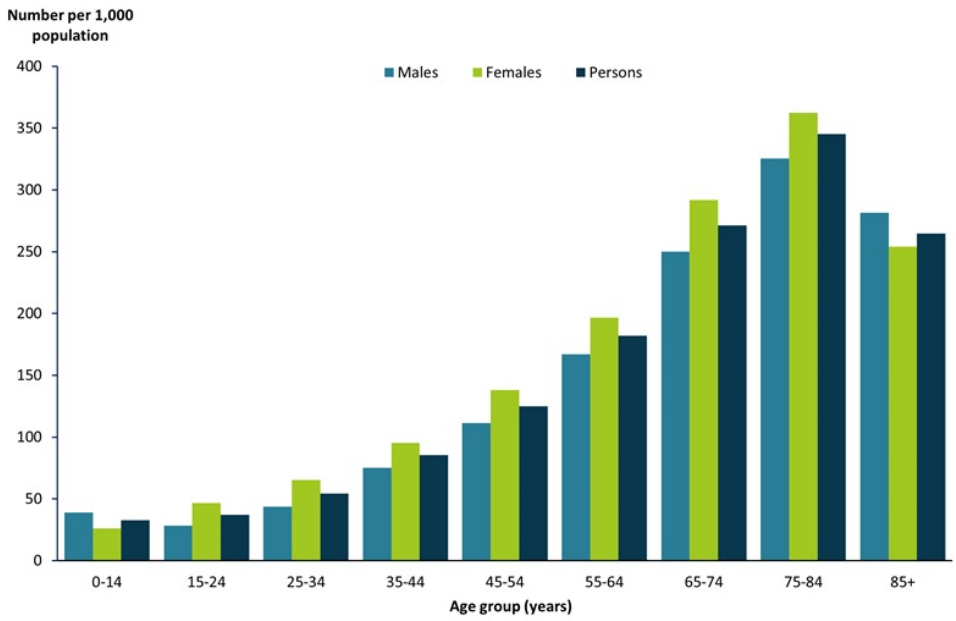
On this page:

Claiming patterns of CDM services vary by demographic characteristics, jurisdiction, remoteness and socioeconomic areas. This section focuses on patients who had a Preparation of a GPMP or a Coordination of TCA service in 2019, as the two most highly used CDM services.

Age and sex

The rate of patients claiming for both GPMP and TCAs services was higher for females than males: (GPMP: 113 vs 96 per 1,000 population, TCAs: 97 vs 80 per 1,000 population). For both services, rates were highest among patients aged 75–84. Some differences were noted by age and sex. Rates increased with age until 75–84 then dropped. For all age groups, except for boys aged 0–14 and males aged 85 years and over, rates were higher for females than males (Figures 2 and 3).

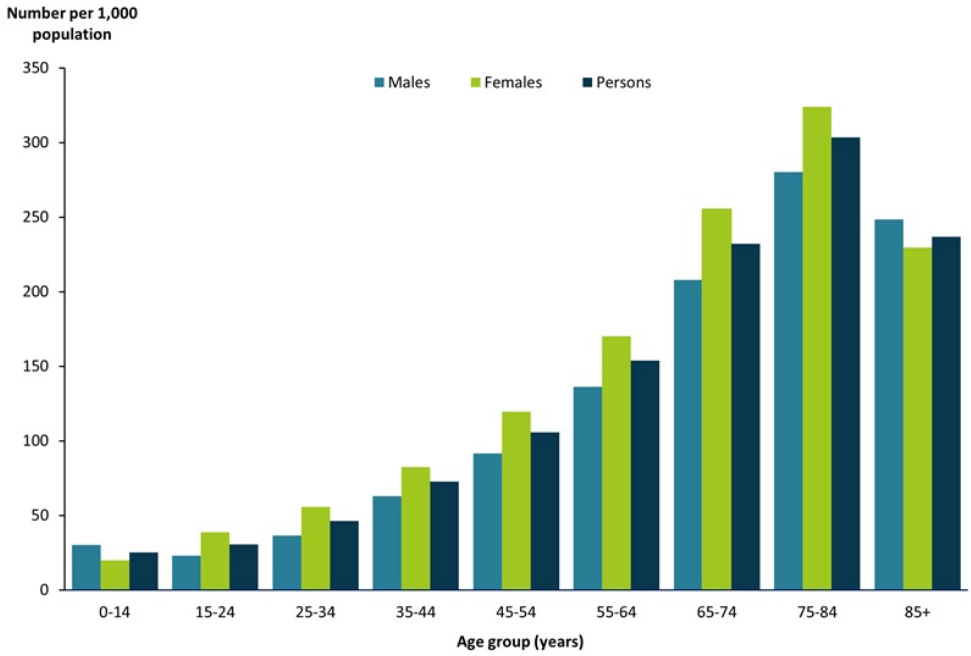
Figure 2: Patients who had a GPMP service (per 1,000 population), by age and sex, 2019



Note: Includes MBS items 721 and 229.

Source: AIHW analysis of MBS data maintained by the Department of Health and Aged Care and sourced from Services Australia (Data Table 1.1).

Figure 3: Patients who had a TCA service (per 1,000 population), by age and sex, 2019



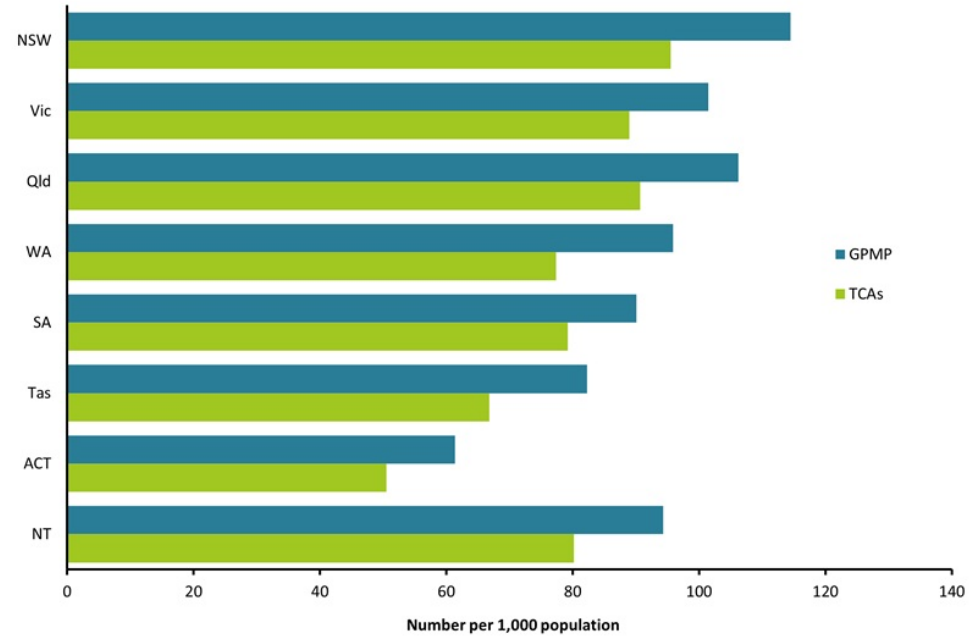
Note: Includes MBS items: 723 and 230.

Source: AIHW analysis of MBS data maintained by the Department of Health and Aged Care and sourced from Services Australia (Data Table 1.2).

State and territory

The rate of patients claiming for GPMP services was higher than TCAs in all states and territories (Figure 4). For both services, New South Wales had the highest rates (GPMP: 115 per 1,000 population, TCAs: 96 per 1,000 population) and the Australian Capital Territory the lowest (GPMP: 61 per 1,000 population, TCAs: 51 per 1,000 population), after adjusting for differences in age structure.

Figure 4: Patients who had a GPMP or TCA service (per 1,000 population), by state and territory, 2019



Notes

1. Age-standardised to the 2001 Australian standard population.
2. Includes MBS items: 721, 723, 229 and 230.

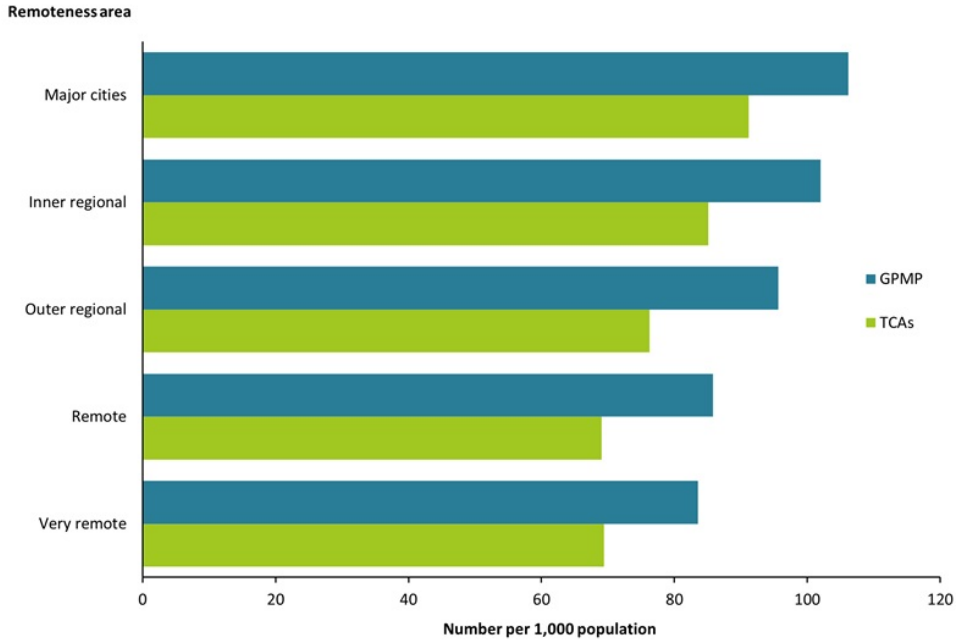
Source: AIHW analysis of MBS data maintained by the Department of Health and Aged Care and sourced from Services Australia (Data Table 1.3).

Remoteness area

For GPMP services, the rate of patients claiming was higher in *Major cities* (106 per 1,000 population), followed by *Inner regional* areas (102 per 1,000 population). Patients claiming TCAs were higher for *Major cities* (91 per 1,000 population), followed by *Inner regional* areas (85 per 1,000 population) after adjusting for differences in the age structure between remoteness areas (Figure 5).

It is important to note that along with the CDM services, Indigenous Australians have access to the Health Assessment for Aboriginal and Torres Strait Islander People (MBS Item 715, 228) and follow-up allied health services (MBS Items 81300 to 81360, also available with a Health Care Home shared plan). These services provide an alternative referral pathway for Aboriginal or Torres Strait Islander people to access allied health services.

Figure 5: Patients who had a GPMP or TCA service (per 1,000 population), by remoteness area, 2019



Notes

1. Age-standardised to the 2001 Australian standard population.
2. Includes MBS items: 721, 723, 229 and 230.
3. Remoteness is classified according to the Australian Statistical Geography Standard (ASGS) 2016 Remoteness Areas structure based on area of residence.

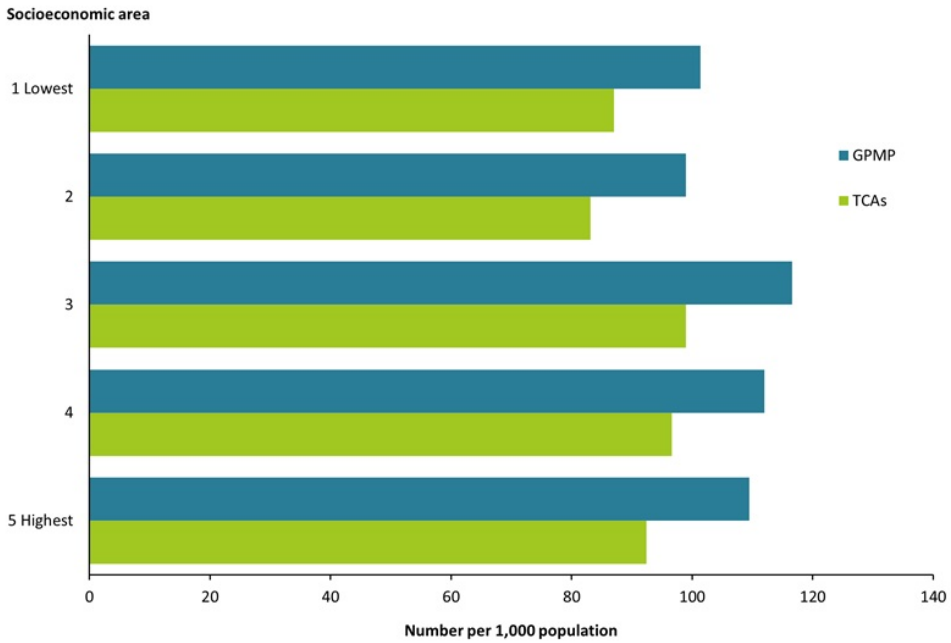
Source: AIHW analysis of MBS data maintained by the Department of Health and Aged Care and sourced from Services Australia (Data Table 1.5).

Socioeconomic area

The rate of patients claiming GPMP services was generally higher among patients living in the highest socioeconomic areas (109 per 1,000 population) compared with the lowest socioeconomic areas (101 per 1,000 population), after adjusting for age (Figure 6). A similar pattern was noted in the claiming patterns by socioeconomic areas for TCAs services (92 per 1,000 population for highest compared with 87 per 1,000 for lowest socioeconomic areas).

Chronic conditions tend to be more prevalent in areas with higher levels of disadvantage (see *National Health Survey: First results, 2017-18 financial year | Australian Bureau of Statistics*). These findings could indicate that people from different socioeconomic areas are accessing health care for chronic conditions in different ways. For example, those with greater levels of advantage may have better access to GPs, while those with greater levels of disadvantage may be seeking treatment from outpatient and community health services.

Figure 6: Patients who had a GPMP or TCA service (per 1,000 population), by socioeconomic area, 2019



Notes

1. Age-standardised to the 2001 Australian standard population.
2. Includes MBS items: 721, 723, 229 and 230.
3. Socioeconomic areas are classified according to the Index of Relative Socio-Economic Disadvantage (IRSD) based on area of residence defined by the ABS as of 30 June 2016.

Source: AIHW analysis of MBS data maintained by the Department of Health and Aged Care and sourced from Services Australia (Data Table 1.5).

Geography

After adjusting for age, variation in the use of GPMP and TCAs was found across areas when examining by Primary Health Networks (PHNs) and Statistical Area Level 3 (SA3).

Variation by Primary Health Network (PHN) areas

After adjusting for age, the 3 PHN areas with highest rates of GPMP item use were: North Coast (NSW) (145 per 1,000 population), Western Sydney (NSW) (141 per 1,000 population) and South Western Sydney (NSW) (133 per 1,000) (See Figure 7). The 3 PHN areas with the lowest rates of GPMP item use were: Country SA (SA) (80 per 1,000 population), Gippsland (Qld) (73 per 1,000 population) and Australian Capital Territory (ACT) (63 per 1,000 population) (See Data Table 1.6).

For TCAs services, the 3 PHN areas with the highest rates of item use were: North Coast (NSW) (123 per 1,000 population), Western Sydney (NSW) (119 per 1,000 population), and South Western Sydney (NSW) (115 per 1,000 population) (See Figure 7). The 3 PHN areas with the lowest rate of TCAs item use were: Tasmania (Tas) (69 per 1,000 population), Gippsland (Qld) (63 per 1,000 population), and Australian Capital Territory (ACT) (51 per 1,000 population) (See Data Table 1.6).

Variation by Statistical Area Level 3 (SA3)

After adjusting for age, the 3 SA3 areas with the highest rates of GPMP item use were: Port Macquarie (NSW) (181 per 1,000 population); Tumut – Tumbarumba (NSW) (165 per 1,000 population) and Bathurst (NSW) (163 per 1,000 population each) (See Figure 7). The 3 SA3 areas with the lowest rates of GPMP item use were: South Canberra (ACT) (36 per 1,000 population), Esperance (WA) and Manjimup (WA) (29 and 15 per 1,000 population respectively) (See Data Table 1.7).

For TCAs, the 3 SA3 areas with the highest rates of item use were: Canberra East (ACT) (521 per 1,000 population), Beaudesert (Qld) (224 per 1,000 population), and Barkly (NT) (212 per 1,000 population) (See Figure 7). The 3 SA3 areas with the lowest rates of TCA item use were: Esperance (WA) (35 per 1,000 population), Woden Valley (ACT) (34 per 1,000 population), and Manjimup (WA) (20 per 1,000 population) (See Data Table 1.7).

Figure 7: Distribution of GPMP and TCA services (per 1,000 population) by PHN and SA3, 2019 (navigation to map pages)

For the best experience to view the interactive map use Chrome, Edge or Firefox browsers. For more information on browser compatibility, see Supported browsers

Distribution of GPMP and TCA services (per 1,000 population) by PHN and SA3, 2019

(map opens in a new window)

Rates of service use may vary by geographic location for a number of reasons, such as availability of services or characteristics of the patient population within an area (for example the age and health of the population). In terms of services, while the average number of Full Time Equivalent GPs per 100,000 population nationally is 117.7, the concentration of GPs working in major cities is higher than the national average, whereas regional, rural and remote areas all have below average rates of GPs (RACGP 2020). Patient experience data also shows that there are longer waits to see a GP for patients outside major cities (RACGP 2020). Regionally, the number of GPs in Modified Monash [1] (MM) Model areas 3 to 5 (large, medium and small rural towns) and MM7 (very remote communities) decreased over the period 2019 to 2020, while GPs in MM6 areas (remote communities) have been decreasing since 2018 (Department of Health 2021).

The age of the population in geographical areas is also an important consideration, particularly when examining crude rates. Chronic conditions are associated with increasing age – 80% of Australians aged 65 and over were estimated to have one or more of the selected chronic conditions[2] in 2017–18 (ABS 2018). For information on the age distribution of the population by geography see: *Regional population by age and sex, 2020 | Australian Bureau of Statistics*.

[1] For more information on the Modified Monash Model, see *Modified Monash Model*.

[2] Selected chronic conditions include: arthritis, asthma, back pain and problems, cancer, cardiovascular diseases (selected heart, stroke and vascular diseases; excluding hypertension), chronic obstructive pulmonary disease (COPD), diabetes, chronic kidney disease, mental and behavioural conditions (including mood disorders, alcohol and drug problems and dementia), and osteoporosis.

References

ABS (Australian Bureau of Statistics) (2018) *National Health Survey: First Results, 2017–18*. ABS Cat no. 4364.0.55.001. ABS, Australian Government, accessed 16 November 2021.

Department of Health (2021) *GP Medicare billing data – what does it say about current health workforce policy?* Department of Health, Australian Government, accessed 16 November 2021.

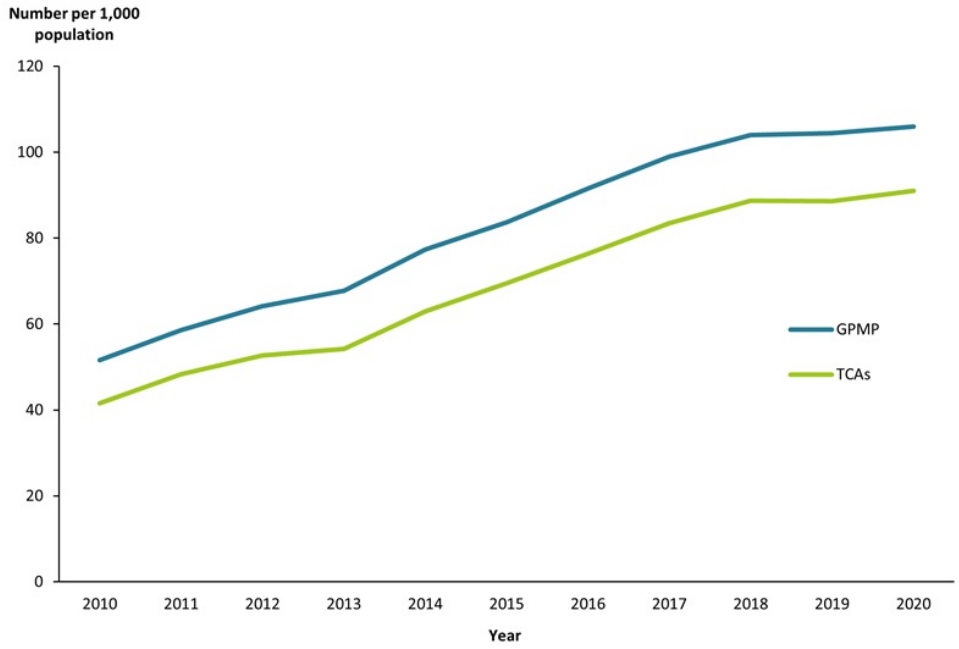
RACGP (The Royal Australian College of General Practitioners) (2020) *General Practice: Health of the Nation 2020*. RACGP, accessed 16 November 2021.

Overview of chronic disease management services

The use of GPMP and TCAs services increased steadily over the last decade[1] (Figure 8). For GPMP, the rate of patients claiming doubled from 52 per 1,000 population in 2010 to 105 per 1,000 population in 2018. The rate remained the same in 2018 and 2019 and then similar in 2020 (106 per 1,000 population). A similar claiming pattern is noted for TCAs, increasing from 2010 to 2018 (42 compared with 89 per 1,000 population), remaining the same in 2019, then similar in 2020 (91 per 1,000 population). 2020 is when telehealth services were introduced due to the COVID-19 pandemic. These have been included in the count of services in 2020 (See Data Table 1.8).

The Health Care Homes[2] trial began in October 2017, with patient enrolment extended in December 2018 up until 30 June 2019. The program ceased on 30 June 2021. Under Health Care Homes, over 10,000 patients in 10 PHNs received coordinated and innovative patient-centred care for their chronic and complex health conditions (Department of Health 2021). The Health Care Homes program may have contributed to the pattern of claiming observed between 2018 and 2019. Additional time points are needed to determine whether the pattern persists and understand what the possible reasons may be.

Figure 8: Patients who had a GPMP or TCA service (per 1,000 population), 2010 to 2020



Notes

1. Age-standardised to the 2001 Australian standard population.
2. Includes MBS items: 721, 723, 229 and 230.

Source: AIHW analysis of MBS data maintained by the Department of Health and Aged Care and Aged Care and sourced from Services Australia (Data Table 1.8).

[1] The GP Enhanced Primary Care (EPC) care planning items were removed from the MBS in 2005 and replaced by the Chronic Disease Management (CDM) items (721-731). For more information see *Department of Health and Aged Care | Removal of Enhanced Primary Care (EPC) Terminology*.

[2] A Health Care Home is a general practice or Aboriginal Community Controlled Health Services (ACCHS) that coordinates care for patients with chronic and complex conditions. For more information see *Health care homes*.

References

Department of Health (2021) *Health care homes*, Department of Health, Australian Government, accessed 16 November 2021.

Overview of chronic disease management services

The MBS outlines the fee associated with each service item. Table 2 outlines the Schedule Fee listed for each CDM item. For non-admitted patients, CDM services typically attract 100% rebate of the Schedule fee[1]. Around 99% of CDM services in 2019 were bulk billed. This is higher than the overall bulk-billing rate for non-referred GP attendances, which was 90% in 2020–21 (Department of Health 2022).

Table 2: Fee summary for Medicare CDM services, 2019

Description	Fee ($)
Preparation of a GP Management Plan (GPMP) - item 721	146.55
Preparation of a GP Management Plan (GPMP) - item 229	117.25
Coordination of Team Care Arrangements (TCAs) - item 723	116.15
Coordination of Team Care Arrangements (TCAs) - item 230	92.90
Review of a GP Management Plan or Coordination of a Review of Team Care Arrangements - item 732	73.20
Review of a GP Management Plan or Coordination of a Review of Team Care Arrangements - item 233	58.55
Contribution to a Multidisciplinary Care Plan, or to a Review of a Multidisciplinary Care Plan, for a patient who is not a care recipient in a residential aged care facility - item 729	71.55
Contribution to a Multidisciplinary Care Plan, or to a Review of a Multidisciplinary Care Plan, for a patient who is not a care recipient in a residential aged care facility - item 231	57.25
Contribution to a Multidisciplinary Care Plan, or to a review of a multidisciplinary care plan, for a resident in an aged care facility - item 731	71.55
Contribution to a Multidisciplinary Care Plan, or to a review of a multidisciplinary care plan, for a resident in an aged care facility - item 232	57.25

Note: Fees as at July 2019.

Source: AIHW analysis of MBS data maintained by the Department of Health and Aged Care and sourced from Services Australia.

[1]100% of the Schedule fee for non-referred attendances by general practitioners to non-admitted patients and services provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner on behalf of a general practitioner (MBS Online 2021).

Benefits paid

Close to $1 billion was paid by Medicare for CDM services (Table 3). This represents a rate of $39,414 per 1,000 population. Of this, GPMPs had the highest overall costs ($420 million), followed by a Review of GPMP or TCAs ($286 million) and Coordination of TCAs ($283 million).

Table 3: Medicare benefits paid for CDM services, 2019

CDM services	Item number	Total Medicare benefits paid ($)	% of total benefits paid for CDM items	Medicare benefits per 1,000 population ($)

Preparation of a GP Management Plan (GPMP)	721, 229	419,554,093	42.0	16,541.1
Coordination of Team Care Arrangements (TCAs)	723, 230	282,761,853	28.3	11,148.0
Review of a GP Management Plan or Coordination of a Review of Team Care Arrangements	732, 233	285,988,854	28.6	11,275.2
Contribution to a Multidisciplinary Care Plan, or to a Review of a Multidisciplinary Care Plan, for a patient who is not a care recipient in a residential aged care facility	729, 231	162,997	0.0	6.4
Contribution to a Multidisciplinary Care Plan, or to a review of a multidisciplinary care plan, for a resident in an aged care facility	731, 232	11,249,190	1.1	443.5
Total CDM services		**999,716,987**	**100.0**	**39,414.3**

Note: Expenditure results are not adjusted for inflation.

Source: AIHW analysis of MBS data maintained by the Department of Health and Aged Care and sourced from Services Australia.

References

Department of Health (2022) *Statistics under Medicare*, Department of Health website, viewed 5 May 2022.

Overview of Medicare-subsidised allied health services

On this page:

Allied health encompasses a range of services provided by university qualified health practitioners with specialised expertise in preventing, diagnosing and treating a range of conditions and illnesses. The practitioners have autonomy of practice, a defined scope of practice, a regulatory mechanism and a national organisation with clearly defined entrance criteria. Examples include psychologists, optometrists and physiotherapists. Patients being managed under the CDM services may be eligible for Medicare-subsidised individual or group allied health services.

Individual allied health services

Patients may be referred for Medicare-subsidised individual allied health services where the care is deemed beneficial to their condition by their GP or medical practitioner (Department of Health 2021a). There are 13 eligible individual allied health services (item numbers are provided in the Technical notes):

- Aboriginal and Torres Strait Islander health services
- diabetes education services
- audiology
- exercise physiology
- dietetics
- mental health services
- occupational therapy
- physiotherapy
- podiatry
- chiropractic services
- osteopathy
- psychology
- speech pathology.

To access these services, patients must have either:

- a GPMP and TCA
- for people living in residential aged care, a multidisciplinary care plan which their GP or medical practitioner has contributed to
- a Health Care Home shared care plan[1].

Eligible patients may access up to 5 individual health services (of any type) per calendar year. More services in a calendar year are not available under any circumstances (Department of Health 2014). Each service must run for at least 20 minutes. The allied health provider will supply a report on their treatment to the referring GP or medical practitioner after a patient's first and last service, or more often if clinically necessary (Department of Health 2014).

Group allied health services

Patients with type 2 diabetes may be referred for group allied health services: diabetes education services, exercise physiology and/or dietetics (Department of Health 2021b; item numbers are provided in the Technical notes). To be eligible for these services, patients must have either:

- a GPMP
- for people living in residential aged care, a multidisciplinary care plan that their GP or medical practitioner has contributed to
- a Health Care Home shared care plan.

Following referral from their GP, the diabetes educator, exercise physiologist or dietitian will conduct an individual assessment. This involves assessing the patient's suitability for the group services based on their medical history and care needs and preparing the patient for the group service. If suitable, the patient is eligible for up to 8 group services per calendar year. Group services are attended by between 2 and 12 patients and run for at least 60 minutes. After the last service, the allied health provider will supply a report on their treatment to the referring GP or medical practitioner. Group allied health services are available in addition to the individual allied health services.

Allied health services in Australia

In Australia, allied health services are provided in a range of settings, such as hospitals, private practice, residential aged care, community care, schools and universities (Department of Health 2021c). The allied health services accessible through CDM services and featured in this report represent one source of Medicare-subsidised allied health services available for people with chronic conditions,

and of all allied health activity in Australia. People with chronic conditions may choose to access allied health services through these other channels depending on their eligibility, availability of services or programs in their area, the recommendation of their care provider and/or personal preference. They may use these channels either in addition to, or instead of the CDM allied health services.

Other Medicare-subsidised allied health services

In addition to outpatient services provided in public hospitals, Medicare-subsidised allied health services are generally available to people with specific and complex care needs that would benefit from specialised care. Other programs and initiatives which may be accessed by people with a chronic condition include:

- The Better Access initiative: access to psychologists, appropriately trained GPs and other medical practitioners, occupational therapists and social workers for people with a diagnosed mental disorder referred by a GP, other medical practitioner, psychiatrist or paediatrician.
- Follow-up Allied Health Services for people of Aboriginal or Torres Strait Islander descent: access to Aboriginal health workers, diabetes educators, audiologists, exercise physiologists, dietitians, mental health workers, occupational therapists, physiotherapists, podiatrists, chiropractors, osteopaths, psychologists and speech pathologists for Aboriginal and Torres Strait Islander people who have had a health assessment. (Department of Health 2011)
- Better Start for Children with Disability: access to psychologists, speech pathologists, occupational therapists, audiologists, optometrists, orthoptists and physiotherapists for children with selected disabilities.
- Helping Children with Autism: access to psychologists, speech pathologists, occupational therapists, audiologists, optometrists, orthoptists or physiotherapists for children with autism or other pervasive developmental disorders (Services Australia 2020).

Medicare-subsidised optometry services are also available without referral.

Other subsidised allied health services

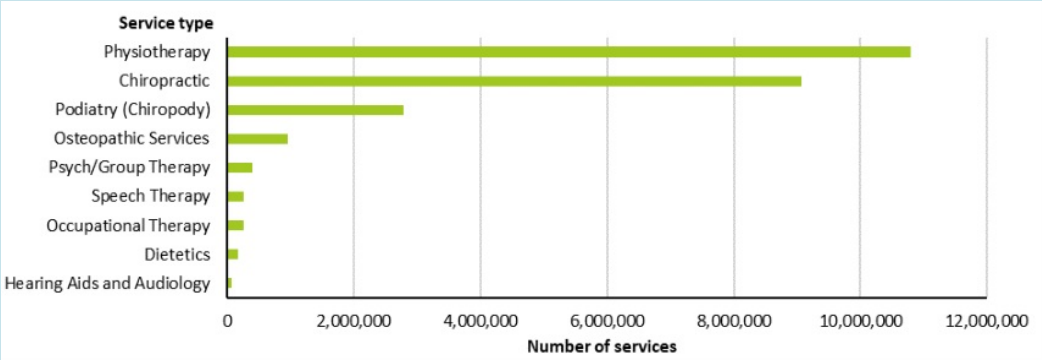
Outside of Medicare, people may access subsidised allied health services through a variety of channels, including:

- treatment in public hospitals and community health centres
- older people can receive allied health services at home or in residential aged care
- services provided by Primary Health Networks
- services provided through the Department of Veterans' Affairs
- National Disability Insurance Scheme
- services covered by third-party compensation (Department of Health 2021d).

Privately funded allied health services

People with chronic conditions can also access allied health services by paying out-of-pocket. Those with private health insurance general treatment cover (known as 'ancillary' or 'extras' cover) may have part of the cost subsidised by their insurance provider. As at 31 December 2021, 14.1 million Australians had general treatment cover, representing 55% of the population (APRA 2022a). Physiotherapy was the most claimed service in 2020 (10.8 million), followed by chiropractic (9.1 million) and podiatry (2.8 million) (APRA 2022b). With currently available data, it is not possible to determine how many CDM patients also accessed privately funded allied health services, either completely out-of-pocket or with a partial rebate through their private health insurance coverage. It is also not possible to know how many people with chronic conditions accessed allied health services outside of those provided through CDM allied health services.

Number of allied health services funded by Private Health Insurance in 2020, selected allied health services



Source: APRA 2022b.

Overview of Medicare-subsidised allied health service use associated with CDM services

In 2019, over 2.4 million patients received Medicare-subsidised allied health services associated with the CDM services, a rate of 95 patients per 1,000 Australians (Table 4a and 4b). A total of over 8.2 million individual allied health services were claimed in this period, which equates to an average of 3.4 services per patient. The top 3 most commonly used individual allied health services by number of patients were:

1. Podiatry: over 1.1 million patients received 3,520,654 services
2. Physiotherapy: 887,317 patients received 2,811,866 services
3. Dietetics: 264,016 patients received 450,270 services.

Around 17,400 patients with type 2 diabetes received 83,438 group allied health services (3.3 per 1,000 population). Exercise physiology was the most used service.

Table 4a: CDM Medicare-subsidised individual allied health services, number of services and patients, 2019

Type of individual allied health	Item number	Number of services	Rate of services per 1,000 population (crude)	Number of patients	Rate of patients per 1,000 population (crude)
Aboriginal or Torres Strait Islander health service	10950	2,674	0.1	2,029	0.1
Audiology	10952	3,527	0.1	2,900	0.1
Chiropractic service	10964	499,014	19.7	148,073	5.8
Dietetics	10954	450,270	17.8	264,016	10.4
Diabetes education	10951	96,901	3.8	61,439	2.4
Exercise physiology	10953	351,750	13.9	163,100	6.4
Mental health service	10956	8,434	0.3	3,152	0.1
Occupational therapy	10958	77,276	3.0	29,225	1.2
Osteopathy	10966	235,590	9.3	75,766	3.0
Physiotherapy	10960	2,811,866	110.9	887,317	35.0
Podiatry	10962	3,520,654	138.8	1,132,596	44.7
Psychology	10968	38,089	1.5	13,689	0.5
Speech pathology	10970	149,779	5.9	44,024	1.7
Total individual allied health service[1]		**8,245,824**	**325.1**	**2,416,511**	**95.3**
Total allied health service[1]		**8,329,262**	**328.4**	**2,418,777**	**95.4**

Note: 1. Totals and subtotals of patients may be less than the sum of each service group as a patient may receive more than one type of service but will be counted only once in the relevant total.

Source: AIHW analysis of MBS data maintained by the Department of Health and Aged Care and sourced from Services Australia.

Table 4b: CDM Medicare-subsidised group allied health services, number of services and patients, 2019

Type of group allied health	Item number	Number of services	Rate of services per 1,000 population (crude)	Number of patients	Rate of patients per 1,000 population (crude)
Diabetes education – assessment for group services	81100	2,213	0.1	2,213	0.1
Diabetes education – group service	81105	1,491	0.1	586	0.0
Dietetics – assessment for group services	81120	1,185	0.0	1,185	0.0
Dietetics – group service	81125	2,398	0.1	977	0.0
Exercise physiology – assessment for group service	81110	11,698	0.5	11,697	0.5
Exercise physiology – group service	81115	64,453	2.5	11,637	0.5
Total group allied health service[1]		**83,438**	**3.3**	**17,458**	**0.7**

Total allied health service[1]		**8,329,262**	**328.4**	**2,418,777**	**95.4**

Note: 1. Totals and subtotals of patients may be less than the sum of each service group as a patient may receive more than one type of service but will be counted only once in the relevant total.

Source: AIHW analysis of MBS data maintained by the Department of Health and Aged Care and sourced from Services Australia.

[1] The Health Care Homes trial began in October 2017, with patient enrolment extended in December 2018 up until 30 June 2019. The program ceased on 30 June 2021.

References

APRA (Australian Prudential Regulation Authority) (2022a) *Quarterly private health insurance statistics*. APRA website, accessed 28 March 2022.

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Department of Health (2021c) *How allied health professionals help people*, Department of Health, Australian Government, accessed 29 April 2021.

Department of Health (2021d) *Allied Health in Australia*, Department of Health, Australian Government, accessed 7 May 2021.

Services Australia (2020) *MBS programs and initiatives for allied health professionals*. Services Australia, Australian Government, accessed 7 May 2021.

Overview of Medicare-subsidised allied health services

Claiming patterns of the three most used Medicare-subsidised individual allied health services varied by demographic characteristics, jurisdiction, remoteness and socioeconomic areas.

Figures 9 and 10 contain demographic information for selected Medicare-subsidised individual allied health services. Key findings from the top 3 most used services include (See Data Tables 2.1, 2.2 and 2.3):

Podiatry

The rate of the patients claiming this service was:

- Higher for females than males (41 females compared with 33 males per 1,000 population), after adjusting for age.
- Higher in patients aged 65 and over. For females compared with males, the difference was greater in almost all age groups (excluding those aged 0 to 14).
- Higher in *Major cities* and *Inner regional* areas (38 per 1,000 population) compared with *Very remote* areas (8.4 per 1,000 population), after adjusting for age.
- Slightly higher in the lowest socioeconomic areas (38 per 1,000 population), compared with the highest socioeconomic areas (36 per 1,000 population), after adjusting for age.

Physiotherapy

The rate of the patients claiming this service was:

- Higher for females than males (39 females compared with 25 males per 1,000 population), after adjusting for age.
- Highest among patients aged 75–84. Some differences were noted by age and sex. Rates increased with age until 75–84 then dropped, for males and females (with the exception of females aged 75–84). Rates were highest for females aged 65–74 (108 per 1,000 population) and males aged 75–84 (75 per 1,000 population).
- Higher in *Major cities* compared with *Very remote* areas (35 compared with 6.4 per 1,000 population), after adjusting for age.
- Higher in the highest socioeconomic areas (35 per 1,000 population), compared with the lowest socioeconomic areas (30 per 1,000 population), after adjusting for age.

Dietetics

The rate of patients claiming this service was:

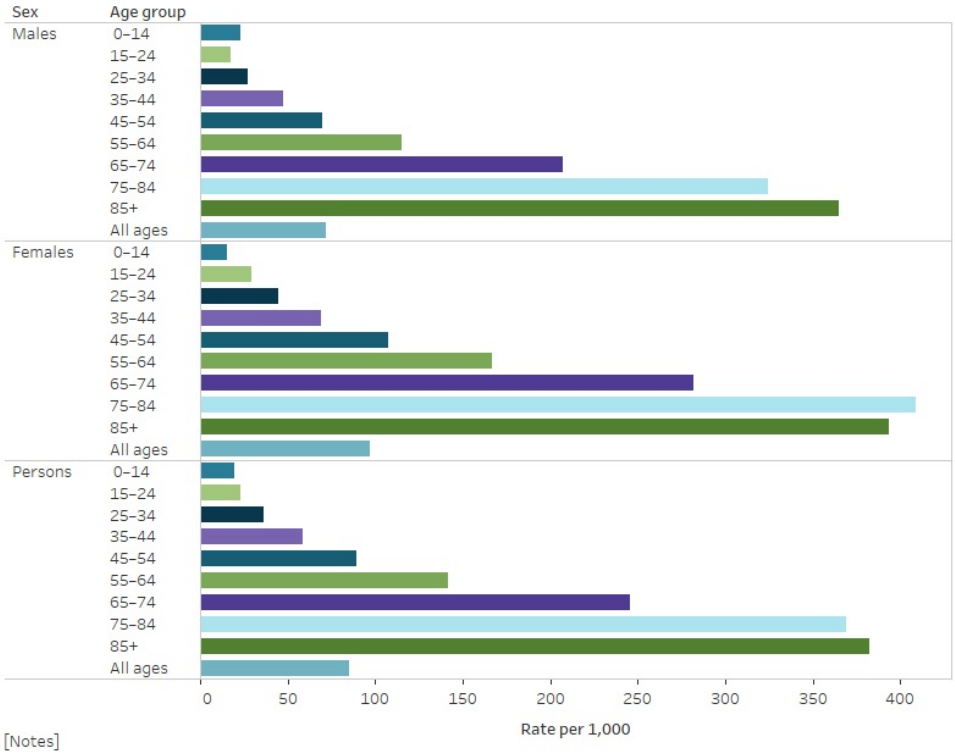
- Higher for females (12 per 1,000 population) than males (7.9 per 1,000) and was highest for people aged 65–74 (20 per 1,000 population).
- Higher in *Major cities* and *Inner regional* areas (10 per 1,000 population) compared with *Very remote* areas (2.7 per 1,000 population), after adjusting for age.
- Minimal differences were noted by socioeconomic area, after adjusting for age.

It is important to note that the variation in claiming observed for these three allied health services by remoteness area may be influenced by geographical variation in the prevalence of chronic conditions. For more information on some of these chronic conditions see: *Geographical variation in disease: diabetes, cardiovascular and chronic kidney disease, Type 2 diabetes dashboards*.

This bar chart shows how many patients, age group-wise and sex- wise, claimed selected allied health services in 2019, and is calculated as a rate per 1000 population. The graph shows that patients aged 75 years and above claim he highest individual allied health service in 2019.

Figure 9. Patients who claimed any individual allied health service in 2019 (per 1000 population), by age and sex

Select an individual allied health service from the dropdown:
Total individual allied health services



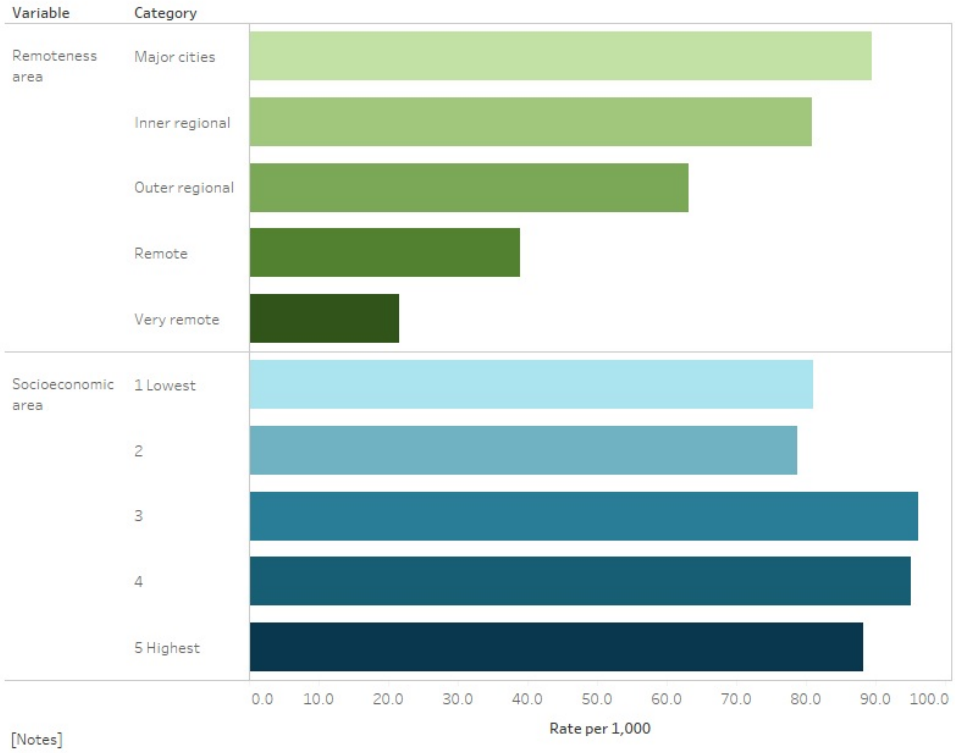
[Notes]

Source: AIHW analysis of MBS data maintained by the Department of Health and sourced from Services Australia.

This bar chart shows how many patients, demographic characteristics- wise, claimed allied health services in 2019, and is calculated as a rate per 1000 population. The graph shows that patients in major cities claim the highest individual allied health service in 2019 and patients living in relatively higher socioeconomic areas claim the highest individual allied health service in 2019.

Figure 10. Patients who claimed individual allied health service in 2019 (per 1000 population), by selected population characteristics

Select an individual allied health service from the dropdown:
Total individual allied health services



[Notes]

Source: AIHW analysis of MBS data maintained by the Department of Health and sourced from Services Australia.

Note: See Data Tables 2.1, 2.2, 2.3 for details.

Examination of all Medicare-subsidised allied health services by geographical location can be found here: *Medicare-subsidised GP, allied health and specialist health care across local areas: 2019–20 to 2020–21*.

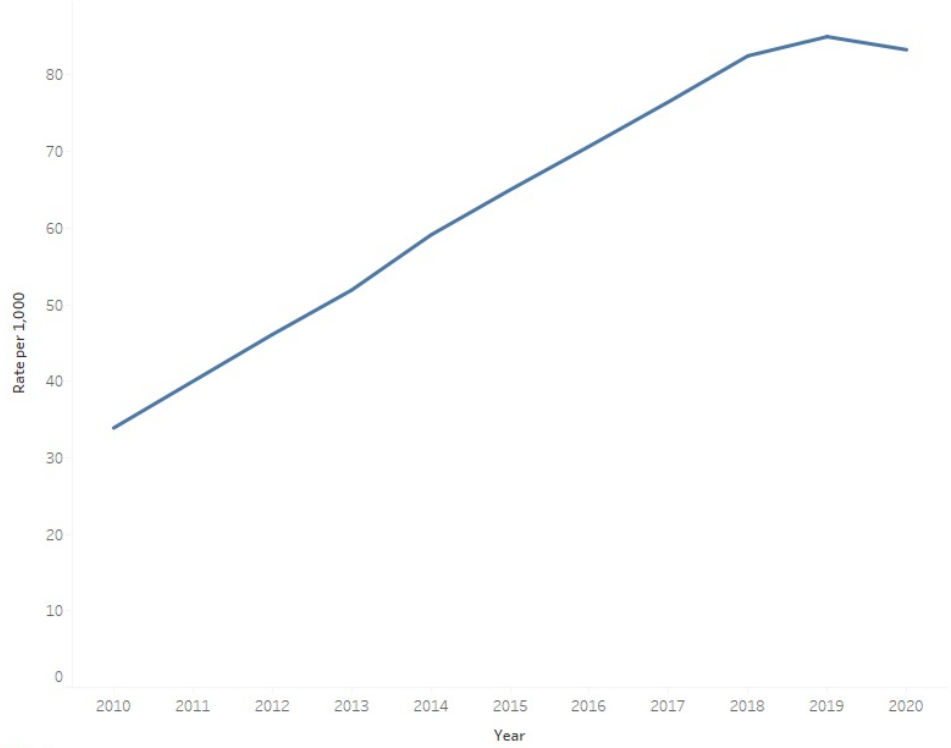
Overview of Medicare-subsidised allied health services

The use of Medicare-subsidised individual allied health services has increased steadily over the past decade (Figure 11). The rate of patients claiming these services more than doubled from 34 per 1,000 population in 2010 to 85 per 1,000 population in 2019 (See Data Table 2.4). The rate remained the stable between 2019 and 2020; see Impact of COVID-19 on CDM and allied health services for further analysis of 2020 activity.

Figure 11 also shows trends for selected Medicare-subsidised individual allied health services.
This bar chart shows how many patients, claimed allied health services from 2010 to 2020, and is calculated as a rate per 1000 population.
The graph shows a steady increase in patients till 2019 and a slight decrease in 2020.

Figure 11. Patients who claimed any individual allied health service (per 1000 population), 2010 to 2020

Select an individual allied health service from the dropdown:
Total individual allied health services

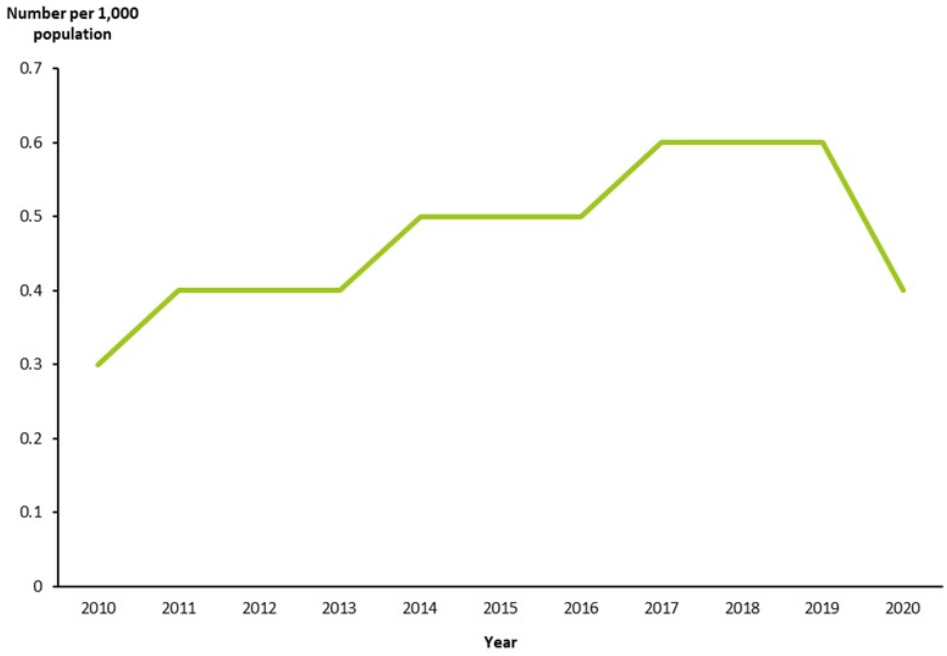


[Notes]

Source: AIHW analysis of MBS data maintained by the Department of Health and sourced from Services Australia.

The use of group allied health services has generally increased over time from 2010 to 2019, with a degree of fluctuation (Figure 12). The rate of patients using group services dropped between 2019 and 2020; see Impact of COVID-19 on CDM and allied health services for further analysis of 2020 activity.

Figure 12: Patients who claimed group allied health services (per 1,000 population), 2010 to 2020



Notes

1. Age-standardised to the 2001 Australian standard population.
2. Includes MBS items: 81100, 81105, 81110, 81115, 81120, 81125.

Source: AIHW analysis of MBS data maintained by the Department of Health and Aged Care and sourced from Services Australia (Data Table 2.5).

Overview of Medicare-subsidised allied health services

The MBS outlines the fee associated with each service item. Table 5 outlines the Schedule Fee and benefit (rebate) listed for individual and group allied health services.

Table 5: Fee summary for allied health services, 2019

Description	Item number	Fee ($)	Benefit (85% rebate) ($)
Individual items	10950, 10951, 10952, 10953, 10954, 10956, 10958, 10960, 10962, 10964, 10966, 10968, 10970	63.25	53.80
Group items - Assessment for group services	81100, 81110, 81120	81.15	69.00
Group items - Group service	81105, 81115, 81125	20.20	17.20

Note: Fees as at July 2019.

Source: AIHW analysis of MBS data maintained by the Department of Health and Aged Care and sourced from Services Australia.

Benefits paid

Medicare paid $446 million in benefits for individual allied health services in 2019, representing a rate of $17,591 per 1,000 population (Table 6). Of this, podiatry had the highest overall benefits paid ($189 million), followed by physiotherapy ($152 million) and chiropractic services ($27 million).

Table 6: Medicare benefits paid for Medicare-subsidised individual allied health services, 2019

Type of individual allied health	Item number	Total Medicare benefits paid ($)	% of total benefits paid for individual allied health items	Medicare benefits per 1,000 population ($)
Aboriginal or Torres Strait Islander health service	10950	142,631	0.0	5.6
Audiology	10952	195,497	0.0	7.7
Chiropractic service	10964	26,679,918	6.0	1,051.9
Dietetics	10954	24,369,620	5.5	960.8
Diabetes education	10951	5,212,843	1.2	205.5
Exercise physiology	10953	19,003,806	4.3	749.2
Mental health service	10956	515,543	0.1	20.3
Occupational therapy	10958	4,733,226	1.1	186.6
Osteopathy	10966	12,816,947	2.9	505.3
Physiotherapy	10960	151,785,244	34.0	5,984.2
Podiatry	10962	188,673,432	42.3	7,438.5
Psychology	10968	3,342,680	0.7	131.8
Speech pathology	10970	8,717,766	2.0	343.7
Total individual allied health items		**446,189,153**	**100.0**	**17,591.2**

Note: Expenditure results are not adjusted for inflation.

Source: AIHW analysis of MBS data maintained by the Department of Health and Aged Care and sourced from Services Australia.

The total Medicare benefits paid for group allied health services was $2.2 million in 2019 ($87 per 1,000 population) (Table 7). Of this, $1.9 million was for exercise physiology services, around $177,000 for diabetes education services, and around $122,000 for dietetics services.

Table 7: Medicare benefits paid for Medicare-subsidised group allied health services, 2019

Type of group allied health services	Item number	Total Medicare benefits paid ($)	% of total benefits paid for group allied health items	Medicare benefits per 1,000 population ($)
Diabetes education – assessment for group services	81100	151,549	6.9	6.0
Diabetes education – group service	81105	25,426	1.2	1.0
Dietetics – assessment for group services	81120	81,054	3.7	3.2
Dietetics – group service	81125	40,937	1.9	1.6
Exercise physiology – assessment for group service	81110	800,108	36.3	31.5
Exercise physiology – group service	81115	1,103,876	50.1	43.5
Total group allied health services		**2,202,950**	**100.0**	**86.9**

Note: Expenditure results are not adjusted for inflation.

Source: AIHW analysis of MBS data maintained by the Department of Health and Aged Care and sourced from Services Australia.

Bulk billing

The bulk-billing rate varied considerably between Medicare-subsidised individual allied health services (Table 8a). The highest rates of bulk billing in 2019 were found for Aboriginal or Torres Strait Islander health services (100%), followed by diabetes education services (85%). Services for speech pathology (15%) and occupational therapy (26%) were least likely to be bulk billed.

Almost all Medicare-subsidised group allied health services were bulk billed in 2019, with exercise physiology having a slightly lower bulk billing rate (92% of assessments and 91% of group services) (Table 8b).

Table 8a: Bulk-billing rates for Medicare-subsidised individual allied health services, 2019

Individual allied health services	Proportion bulk-billed (%)
Aboriginal or Torres Strait Islander health service	100.0
Audiology	68.6
Chiropractic service	74.4
Dietetics	76.9
Diabetes education	84.5
Exercise physiology	77.2
Mental health service	60.1
Occupational therapy	26.2
Osteopathy	30.5
Physiotherapy	74.4
Podiatry	75.6
Psychology	30.1
Speech pathology	15.1

Source: AIHW analysis of MBS data maintained by the Department of Health and Aged Care and sourced from Services Australia.

Table 8b: Bulk-billing rates for Medicare-subsidised group allied health services, 2019

Group allied health services	Proportion bulk-billed (%)
Diabetes education service-Assessment for group services	99.1
Diabetes education service-group service	100.0
Dietetics service-Assessment for group services	99.4
Dietetics service-group service	98.4
Exercise physiology service-Assessment for group service	91.5
Exercise physiology service-group service	90.9

Source: AIHW analysis of MBS data maintained by the Department of Health and Aged Care and sourced from Services Australia.

Use of other Medicare services

Claiming patterns and use of other Medicare-subsidised services by the CDM population

On this page:

CDM services and Medicare-subsidised allied health services support people with chronic and terminal medical conditions. However, how these services are used in practice depends on a number of factors, including the specific needs of each patient, their preferences for how they manage their condition and the clinical advice provided by their health practitioner. This section explores patterns around the claiming of CDM services and the use of other Medicare-subsidised services by the CDM population.

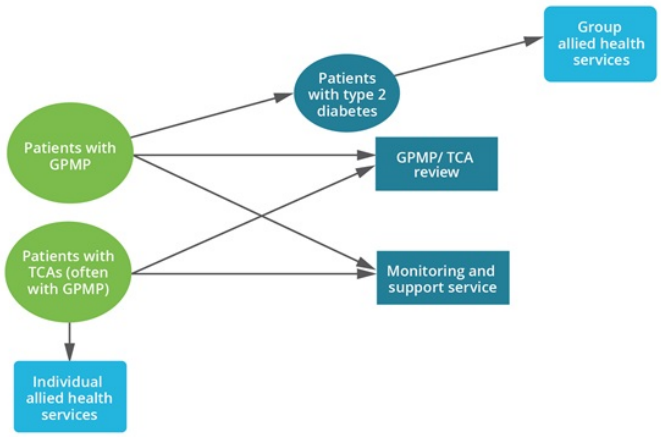
Use of review, monitoring and support services

Once a GPMP or TCA is established, it is recommended that the GP regularly review the plan with the patient to ensure it continues to meet their care needs. Other health practitioners working in the practice may also assist the GP to monitor and support a patient's care. Two specific MBS services that exist to facilitate these review processes are:

1. Review of GPMP/TCA (items 732, 233)
2. Provision of monitoring and support for a person with a chronic disease by a practice nurse or Aboriginal and Torres Strait Islander health practitioner (referred to as 'monitoring and support service'; item 10997).

This analysis follows a cohort of 813,174 patients who had a GPMP or TCA established between 1 January 2019 and 30 March 2019, and explores their use of the review and support services for the subsequent 12 months. Figure 13 shows GPMP or TCA patient flows to these services.

Figure 13: GPMP or TCA patient flow to review, monitoring and support services



Review of GPMP and TCAs

To support best practice care, it is expected and strongly encouraged that GPMP and TCAs be regularly reviewed (Department of Health 2014). The recommended period for review is every 6 months, although the minimum claiming period is every 3 months or earlier in exceptional circumstances (Department of Health 2021a). The same item is used for a review of a GPMP or a TCA. If a patient has both a GPMP and TCA, they may have a review service for each plan.

Just under half (47%) of the GPMP/TCA cohort had a review of their plan in the next 12 months. There was some variation in characteristics of patients who did and didn't have a review:

- Patients who had a review were older, with a median age of 66 compared with 57 for those without a review.
- By state and territory, the highest proportion of GPMP/TCA patients having a review service within the next 12 months was found among those living in South Australia (51%), while the lowest proportion was among those living in Victoria (44%) (See Data Table 3.1).
- The highest proportion of GPMP/TCA patients having a review service within the next 12 months was found among those living in *Remote* areas (54%), while the lowest proportion was among those living in *Major cities* (45%) (See Data Table 3.2).
- The proportion of GPMP/TCA patients having a review service was higher for those living in the lowest socioeconomic areas (49%) compared with those in the highest socioeconomic areas (42%) (See Data Table 3.3).

It is important to note that patients may receive similar care to that provided during a review through other MBS services. For example, a patient may have their plan reviewed during a standard consult with their GP, along with discussion or treatment of other issues. It is not possible to quantify how many GPMP/TCA patients have their plans reviewed outside of the specific review service.

Monitoring and support services

This item can be used to provide checks on clinical progress, monitoring medication compliance, self-management advice and/or collection of information between structured care plan reviews with the GP (Department of Health 2021b). This service is provided on behalf of and under the supervision of the patient's GP and may be claimed up to 5 times per patient per calendar year. This item is relatively well used, with 1.5 million patients claiming 2.6 million services in 2019.

Of the GPMP/TCA cohort, 38% claimed one or more monitoring and support services in the following 12 months. There was some variation in characteristics of patients who did and didn't use the monitoring and support service:

- Patients who had a monitoring and support service were older, with a median age of 67 compared with 58 for those without a service.
- Patients living in South Australia were the most likely to have a monitoring and support service (61% of the GPMP/TCA cohort), while patients living in the Australian Capital Territory and New South Wales were the least likely (26% and 29% respectively) (See Data Table 3.4).
- A higher proportion of GPMP/TCA patients living in *Very remote* areas had a monitoring and support service (46%), compared with those living in *Major cities* (35%) (See Data Table 3.5).
- The proportion of GPMP/TCA patients having a monitoring and support service was higher for those living in the lowest socioeconomic areas (40%) compared with those in the highest socioeconomic areas (31%) (See Data Table 3.6).

Patterns of allied health service use

Patients with a GPMP and TCA are eligible to access up to 5 Medicare-subsidised individual allied health services per calendar year to support the treatment and management of their chronic condition[1]. However, not all patients with a GPMP and TCA will need five allied health services. The patient should be referred for the number of services that will help in the treatment of their condition, up to five will be MBS-subsidised. Of patients who had a Coordination of TCAs service in 2019 (N = 870,333), 35% did not claim any of the Medicare-subsidised individual allied health services. This may be driven by a number of factors, including the patient not requiring allied health services, patient preferences, patient recovery, adherence to GP recommendations or barriers to accessing allied health services.

While the data in this section provides a snapshot of how many people have used Medicare-subsidised individual allied health services in the 2019 calendar year, care should be taken in using these numbers to draw additional inferences about the individuals accessing these services. Because an individual may, for example, have been referred for TCAs towards the end of the year, they may only have had a very limited timeframe to use allied health services in 2019. They may have used 1 individual allied health service in 2019 and then use the remaining 4 services in 2020. These 4 services will count towards the 5 services available in the 2020 calendar year, and patients would need to obtain another referral to access additional individual allied health services. Thus, while these data provide a good overall snapshot, the number of individual allied health services used by an individual may not necessarily be a good representation of the health needs for that particular individual.

Further cohort analysis is required in order to better understand the health circumstances of individuals accessing the Medicare-subsidised individual allied health services.

For more information on Medicare-subsidised allied health services see: *Department of Health | Questions and Answers on the Chronic Disease Management (CDM) items*.

Some variation was observed between TCA patients who did and did not use individual allied health services.

The proportion of TCA patients who did not use Medicare-subsidised individual allied health services:

- decreased with age: 48% of patients aged 0–14 compared with 23% of patients aged 85 and over (Figure 14)
- varied by state and territory: 64% of TCA patients living in the Northern Territory compared with 26% of patients living in South Australia
- increased with remoteness area: 34% of TCA patients living in *Major cities*, compared with 81% of TCA patients living in *Very remote* areas
- was similar across socioeconomic areas.

As previously mentioned, Indigenous Australians have access to the Health Assessment for Aboriginal and Torres Strait Islander People (MBS Item 715, 228) and follow-up allied health services (MBS Items 81300 to 81360). These items provide an alternative referral pathway for Aboriginal or Torres Strait Islander people to access allied health services.

Note: See Data tables 3.7, 3.8, 3.9, 3.10.

It is important to note that the above analysis investigated Medicare-subsidised individual allied health services use in those who had TCAs in the 2019 calendar year. However, patients continue to be eligible for rebates for allied health services while they are being managed under a GPMP and TCAs as long as the need for services continues to be recommended in their plan – they do not need a new GPMP and TCA each calendar year. Therefore, this analysis does not represent all eligible patients who did not claim any Medicare-subsidised individual allied health services in the 2019 year.

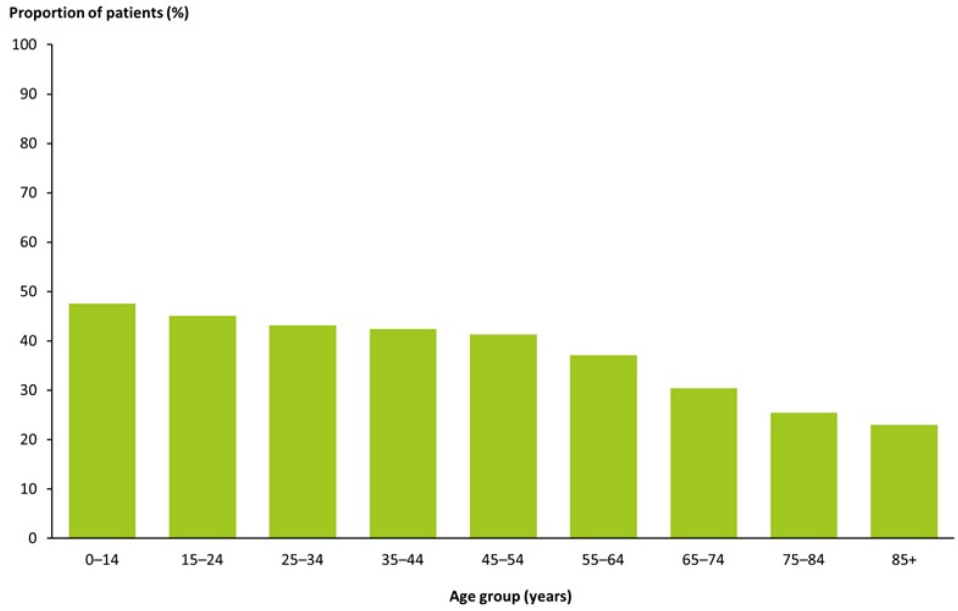
Other considerations include:

- It is not possible to identify patients who had been referred for individual allied health services previously but no longer need them.
- It is not possible to identify when a new referral for allied health services is given because these referrals can be provided during a review of a GPMP and TCAs or during a standard GP consultation.
- There is no identifiable end date for a GPMP and TCAs.

Cohort analysis identifying when patients first received a GPMP and TCAs is required to gain a holistic view of those who did and did not claim allied health services.

For more information on Medicare-subsidised allied health services see: *Department of Health | Questions and Answers on the Chronic Disease Management (CDM) items*.

Figure 14: Proportion of TCA patients who did not claim any Medicare-subsidised individual allied health services, by age group, 2019

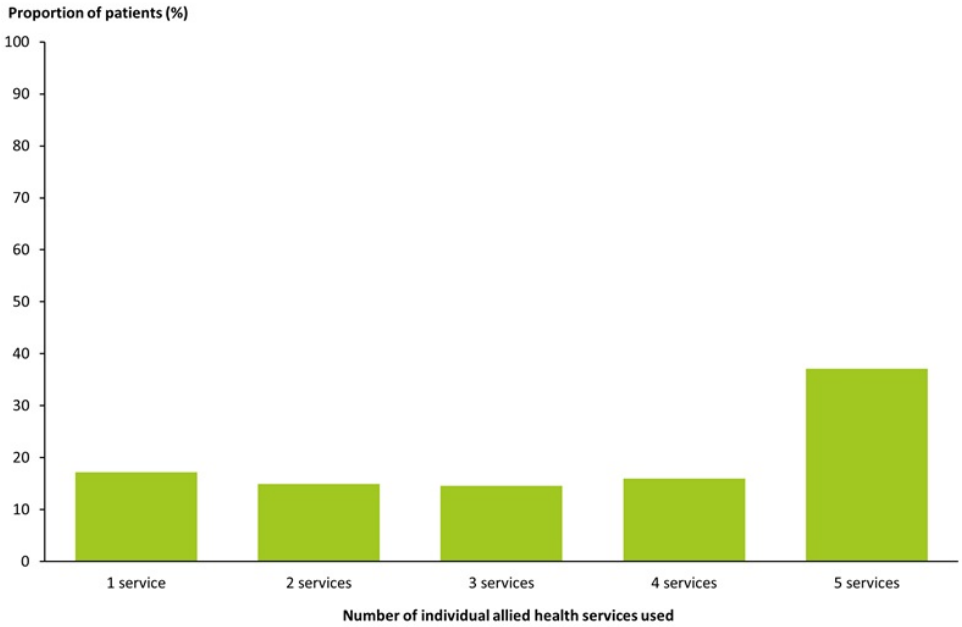


Note: Includes MBS items: 723 & 230.

Source: AIHW analysis of MBS data maintained by the Department of Health and Aged Care and sourced from Services Australia (Data Table 3.7).

Of patients who did use Medicare-subsidised individual allied health services in 2019 (N = 2,412,608), 37% claimed all 5 available services (Figure 15) (See Data table 3.12). Depending on their care needs, some patients may not have been referred for 5 allied health services. It is not possible to identify how many services a GP has recommended for a patient from the Medicare-subsidised data. Some patients may have been referred for more services than they used but did not access their full entitlement of services. This may be due to similar factors mentioned above: patient preferences, adherence to GP recommendations or barriers to accessing allied health services.

Figure 15: Utilisation of Medicare-subsidised individual allied health services among allied health patients, 2019

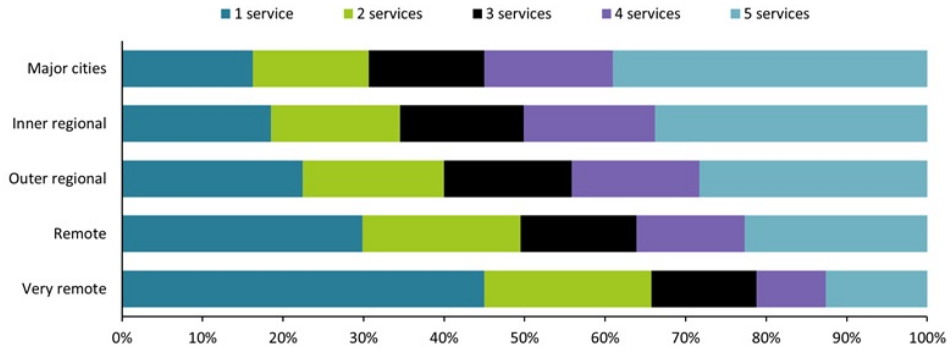


Note: Includes MBS items: 10950, 10951, 10952, 10953, 10954, 10956, 10958, 10960, 10962, 10964, 10966, 10968, 10970.
Source: AIHW analysis of MBS data maintained by the Department of Health and Aged Care and sourced from Services Australia (Data Table 3.12).

Some variation was observed between patients using Medicare-subsidised individual allied health services who used their full entitlement of services and those who did not:

- Using more services is generally associated with increasing age. Those aged 75–84 had the highest proportion of patients using 5 services (46%), followed by patients aged 85 and over (45%) (See Data Table 3.11).
- However, use of all 5 services was also somewhat common in the youngest age group: 32% of patients aged 0–14 years compared with 24% of patients aged 15–24.
- The number of services used decreased with increasing remoteness (Figure 16) (See Data Table 3.13).
- The number of services used did not vary by socioeconomic area (See Data Table 3.14).

Figure 16: Utilisation of Medicare-subsidised individual allied health services among allied health patients, by remoteness area, 2019



Note: Includes MBS items: 10950, 10951, 10952, 10953, 10954, 10956, 10958, 10960, 10962, 10964, 10966, 10968, 10970.

Source: AIHW analysis of MBS data maintained by the Department of Health and Aged Care and sourced from Services Australia (Data Table 3.13).

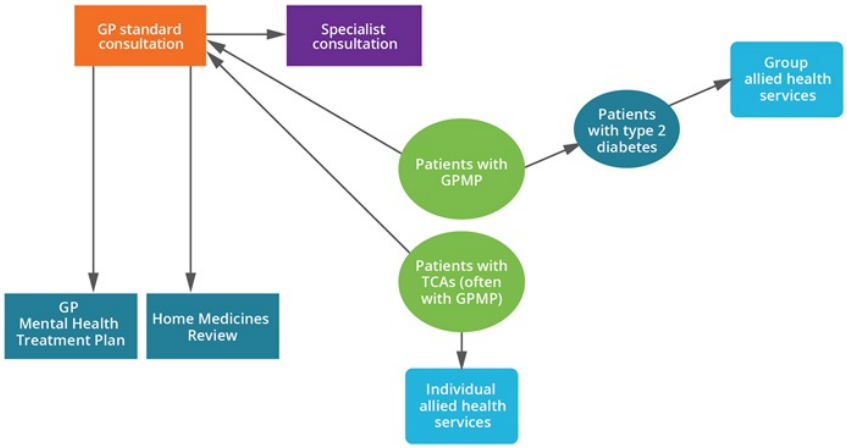
The observed variation in the use of all 5 individual allied health services according to remoteness area may indicate that there is a lack of access to these services in outer regional and remote communities. There is a higher prevalence of allied health professions in major cities compared to remote and very remote areas (National Rural Health Alliance 2019). When examining the allied health workforce by Modified Monash (MM) Model areas, the highest rate of full-time equivalent physiotherapists, psychologists, occupational therapists and optometrists per 100,000 population are located in the major cities, with this number decreasing as remoteness increases (Department of Health 2021c).

The variation may also be linked to affordability. In 2019–20, those living in greater capital city areas had higher median weekly income compared with the rest of the state ($1,001 compared with $881, respectively) and a higher median net household worth ($613,000 compared with $523,000, respectively) (ABS 2022). The Medicare rebate freeze on allied health services[1], lifted on 1 July 2019, may have also had an impact on affordability of allied health services in rural and remote areas.

Use of other MBS services

People with chronic conditions are likely to use a greater number of health services than those without. This analysis explores selected other MBS services used in 2019 by patients who had a Preparation of GPMP or Coordination of TCAs service in the same year (N = 2,891,201 and N = 2,458,750, respectively). Figure 17 shows potential GPMP or TCA patient flows to other MBS services.

Figure 17: GPMP or TCA patient flow to other MBS services



Almost all (98%) GPMP/TCA patients had a standard GP consultation in 2019. The proportion of patients visiting a specialist was slightly higher for the TCA cohort (61%) compared with patients in the GPMP cohort (59%). For both cohorts, the most common specialist visit was for anaesthesia, followed by cardiology, ophthalmology and general surgery (Table 9). A small proportion of patients accessed other specialised GP services, including the GP Mental Health Treatment Plan, Diabetes cycle of care, Asthma cycle of care and Home Medicine Review.

Table 9: Use of other Medicare-subsidised services, GPMP and TCA patients, 2019[1]

MBS service type	Number of GPMP patients	Proportion of GPMP patients (%)	Number of TCA patients	Proportion of TCAs patients (%)
GP standard consultation	2,817,902	97.5	2,401,406	97.7
Specialist	1,705,607	59.0	1,489,648	60.6
- *Anaesthesia*	437,255	25.6	384,495	25.8
- *Cardiology*	409,811	24.0	359,791	24.2
- *Ophthalmology*	377,025	22.1	333,147	22.4
- *General surgery*	256,474	15.0	224,143	15.0
GP Mental Health Treatment Plan	249,533	8.6	221,561	9.0
Asthma cycle of care	19,862	0.7	14,479	0.6
Diabetes cycle of care	151,214	5.2	139,024	5.7
Home Medicines Review[2]	49,848	1.7	46,568	1.9
- *DMMR*	43,897	88.1	40,981	88.0
- *RMMR*	5,951	11.9	5,587	12.0

Notes

1. Data are reported by the time period in which the service was provided. Includes services with a date of service between 1 January and 31 December 2019.
2. DMMR: Domiciliary Medication Management Review (items: 245, 900); RMMR: Residential Medication Management Review (items: 249, 903)

Source: AIHW analysis of MBS data maintained by the Department of Health and Aged Care and sourced from Services Australia.

While one-third (34%) of GPMP/TCA patients had at least 1 GP standard consultation during 2019, a further third (34–35%) had more than 3 consultations in the year. More than two-thirds (68%) of patients in both cohorts visited a specialist once in 2019, with frequent specialist visits less common than GP consultations (Table 10).

Table 10: Number of times patients visited a GP or specialist, GPMP and TCA patients, 2019

Speciality type	1 visit (%)	2 visits (%)	3 visits (%)	More than 3 visits (%)
GPMP patients - GP standard consultation	34.3	19.2	12.4	34.2
GPMP patients - Specialist	68.4	18.5	6.2	6.9
TCA patients - GP standard consultation	33.9	19.0	12.3	34.8
TCA patients - Specialist	68.1	18.6	6.3	7.0

Note: Data are reported by the time period in which the service was provided. Includes services with a date of service between 1 January and 31 December 2019.

Source: AIHW analysis of MBS data maintained by the Department of Health and Aged Care and sourced from Services Australia.

[1] A medicare rebate is available for a maximum of five individual allied health services per patient per calendar year. More services in a calendar year are not available under any circumstances.

References

ABS (Australian Bureau of Statistics) (2022) *Household income and wealth, Australia*, ABS website, accessed 9 May 2022.

Department of Health (2014) *Questions and Answers on the Chronic Disease Management (CDM) items*, Department of Health, Australian Government, accessed 24 March 2021.

Department of Health (2021a) *Medicare Benefits Schedule - Note AN.0.47*, Department of Health, Australian Government, accessed 5 May 2021.

Department of Health (2021b) *Medicare Benefits Schedule - Note MN.12.4*, Department of Health, Australian Government, accessed 5 May 2021.

Department of Health (2021c) *Allied health in Australia*. Department of Health, Australian Government, accessed 16 November 2021.

National Rural Health Alliance (2019) *Fact Sheet: Allied health workforce in rural, regional and remote Australia*, National Rural Health Alliance, accessed 16 November 2021.

Impact of COVID-19

Impact of COVID-19 on CDM and Medicare-subsidised allied health services

In 2020, the COVID-19 pandemic challenged health systems around the world. The first case in Australia was recorded on 25 January 2020, and new infections around the country have continued to be recorded since that time (AIHW 2020). There have been four waves of COVID-19 in Australia since the start of the pandemic, with two waves occurring in 2020. The first wave occurred from March to April 2020, with cases in all states and territories. The second wave began in the winter of 2020, with most cases in Victoria (AIHW 2022). COVID-19 variants are continuing to emerge, with variants of concern identified by the World Health Organisation as Alpha, Beta, Delta, Gamma and Omicron (Department of Health 2021).

The pandemic has posed a particular challenge for Australians with chronic conditions, who have an increased risk of experiencing severe disease due to their underlying conditions (Department of Health 2020). Public health measures such as staged lockdowns initiated for the protection of the Australian community also indirectly impacted those with chronic conditions, as accessibility and operation of health services underwent significant changes. Even when available, people may have been less inclined to access services due to the perceived risk of COVID-19.

Recognising these direct and indirect impacts, several new or additional services were made available through changes to health service delivery models, policies and programs.

For CDM and Medicare-subsidised allied health services, a series of telehealth services were introduced on the MBS to enable care to continue to be delivered. The telehealth services included options for services to be delivered via telephone or videoconference. These services were introduced from March 2020 and were scheduled to be available until the end of 2021 (Hunt 2021). However, the Department of Health and Aged Care announced that from 1 January 2022 patient access to telehealth services will be supported by ongoing arrangements. The ongoing arrangements build on the temporary telehealth services introduced as part of the Government's response to the COVID-19 pandemic and will continue to enable all Medicare eligible Australians to access telehealth (video and phone) services for a range of (out of hospital) consultations that can also be provided in person (Department of Health 2022)[1].

A full list of item numbers relevant to CDM and Medicare-subsidised allied health services can be found in the Technical notes.

For more information on the COVID-19 pandemic see *Australia's health 2022: data insights*.

What are Chronic Disease Management services?

General Practitioner Management Plans (GPMPs) and Team Care Arrangements (TCAs) are Chronic Disease Management (CDM) services available on the Medicare Benefits Schedule (MBS) for people with a chronic or terminal medical condition(s).

A GPMP is a plan of action agreed between a patient and their GP.

TCAs provide Medicare-subsidised care from selected allied health care providers for individual treatment services.

For more information, please see Chronic Disease Management Items.

Given the impact of COVID-19 on health services, data for 2020 are presented separately here.

CDM and Medicare-subsidised allied health telehealth services in 2020

During the COVID-19 pandemic, many medical and allied health practitioners opted to conduct their CDM consultations via telehealth following the introduction of these services in the MBS from March 2020.

Similar to in-person consultations, the Preparation of a GPMP and Coordination of TCAs were the most commonly used CDM telehealth services. From the introduction of the telehealth services on 30 March 2020 to the end of the year, 573,638 patients had a GPMP service and 487,733 patients had a TCA service via telehealth (Table 11a). The Review of GPMP or TCA service was also commonly used, with 427,020 patients accessing 802,521 of these services via telehealth.

A single telehealth item was introduced for the Medicare-subsidised individual allied health services, meaning it is not possible to identify which allied health services were being accessed. From 30 March 2020 to the end of the year, 96,097 patients accessed 149,163 Medicare-subsidised individual allied health services via telehealth. For Medicare-subsidised group allied health services, telehealth services were only introduced for dietetics services (excluding telephone for the group service), with very low use.

Table 11a: CDM telehealth services, number of services and patients, 2020

CDM telehealth services	Type	Item numbers	Number of services	Number of patients

Preparation of a GP Management Plan (GPMP)	Telehealth services (videoconference)	92024, 92055	16,744	16,697
Preparation of a GP Management Plan (GPMP)	Telephone services	92068, 92099	558,437	556,941
Total GPMP telehealth			**575,181**	**573,638**
Coordination of Team Care Arrangements (TCAs)	Telehealth services (videoconference)	92025, 92056	13,632	13,592
Coordination of Team Care Arrangements (TCAs)	Telephone services	92069, 92100	475,278	474,141
Total TCAs telehealth			**488,910**	**487,733**
Review of a GP Management Plan or Coordination of a Review of Team Care Arrangements	Telehealth services (videoconference)	92028, 92059	19,959	11,871
Review of a GP Management Plan or Coordination of a Review of Team Care Arrangements	Telephone services	92072, 92103	782,562	415,149
Total review of GPMP & TCAs telehealth			**802,521**	**427,020**
Contribution to a Multidisciplinary Care Plan, or to a Review of a Multidisciplinary Care Plan, for a patient who is not a care recipient in a residential aged care facility	Telehealth services (videoconference)	92026, 92057	357	309
Contribution to a Multidisciplinary Care Plan, or to a Review of a Multidisciplinary Care Plan, for a patient who is not a care recipient in a residential aged care facility	Telephone services	92070, 92101	4,335	3,258
Total for non-residential aged care telehealth			**4,692**	**3,567**
Contribution to a Multidisciplinary Care Plan, or to a review of a multidisciplinary care plan, for a resident in an aged care facility	Telehealth services (videoconference)	92027, 92058	3,828	3,020
Contribution to a Multidisciplinary Care Plan, or to a review of a multidisciplinary care plan, for a resident in an aged care facility	Telephone services	92071, 92102	7,654	6,390
Total for aged care facility telehealth			**11,482**	**9,410**

Note: Totals and subtotals of patients may be less than the sum of each service group as a patient may receive more than one type of service but will be counted only once in the relevant total.

Source: AIHW analysis of MBS data maintained by the Department of Health and Aged Care and sourced from Services Australia.

Table 11b: Medicare-subsidised allied health telehealth services[1], number of services and patients, 2020

Medicare-subsidised allied health telehealth services	Type	Item numbers	Number of services	Number of patients
Medicare-subsidised individual allied health services	Telehealth services (videoconference)	93000	49,114	27,426
Medicare-subsidised individual allied health services	Telephone services	93013	100,049	68,671
Total Medicare-subsidised individual allied health services telehealth			**149,163**	**96,097**
Dietetic services- Assessment for group services	Telehealth services (videoconference)	93284	21	21
Dietetic services- Assessment for group services	Telephone services	93286	82	82
Total dietetic services-Assessment			**103**	**103**

Dietetics service-group services	Telehealth services (videoconference)	93285	50	36
Dietetics service-group services	Telephone services	N/A	N/A	N/A
Total dietetics service-group services			**50**	**36**

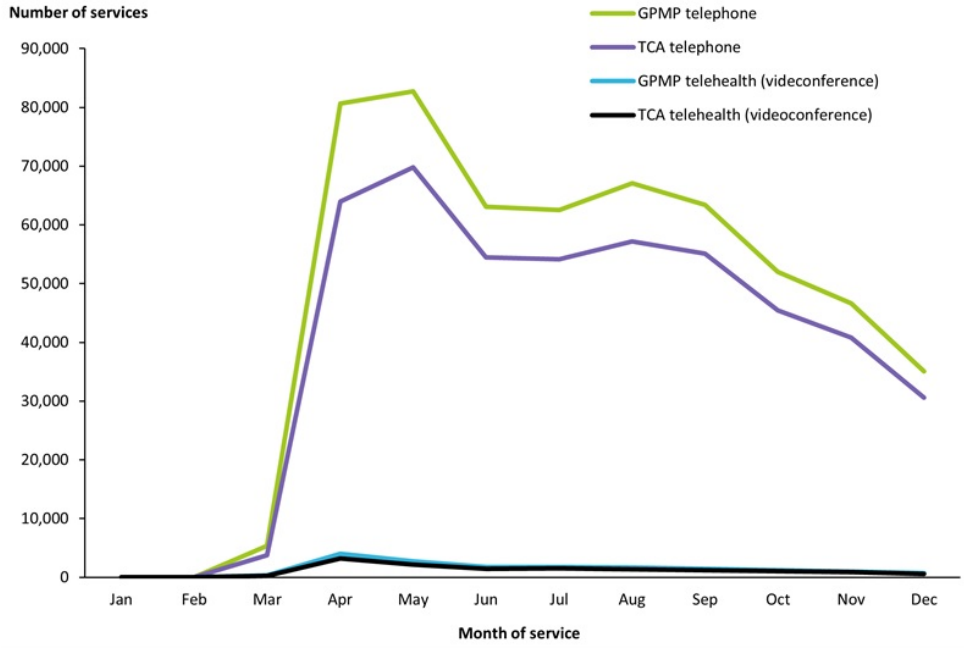
1. Services introduced on 30 March 2020.

Note: Totals and subtotals of patients may be less than the sum of each service group as a patient may receive more than one type of service but will be counted only once in the relevant total.

Source: AIHW analysis of MBS data maintained by the Department of Health and Aged Care and sourced from Services Australia.

Telephone was used for most CDM telehealth services (Figures 18–20) (See Data Tables 4.1–4.3).

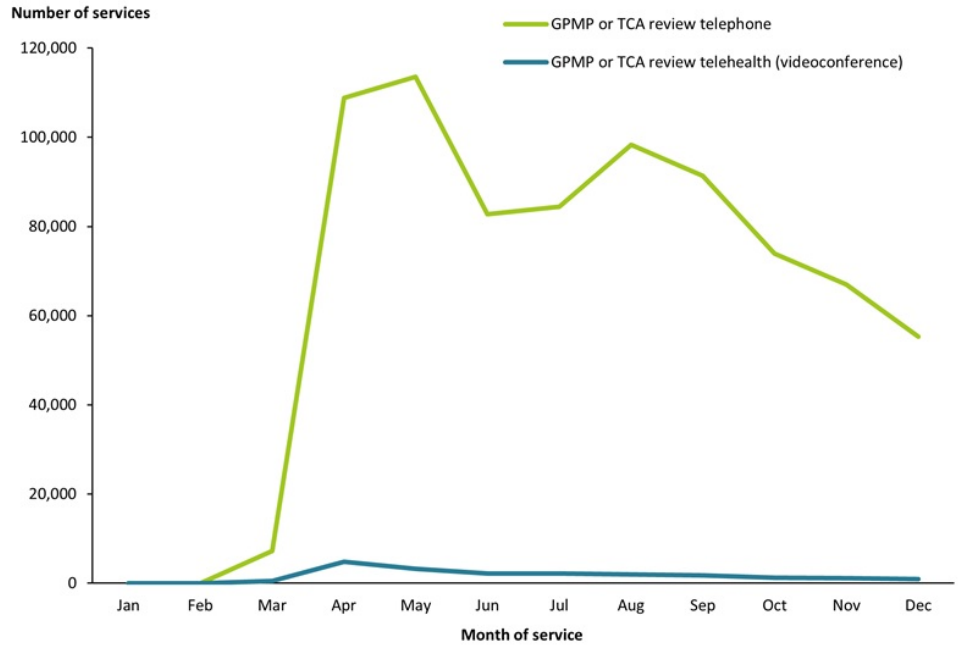
Figure 18: Month-to-month comparison of the Preparation of a GPMP and Coordination of TCA telehealth services, 2020



Note: Includes from 20 March 2020 onwards telehealth MBS items: 92024, 92025, 92055, 92056, 92068, 92069, 92099, 92100.

Source: AIHW analysis of MBS data maintained by the Department of Health and Aged Care and sourced from Services Australia (Data Table 4.1).

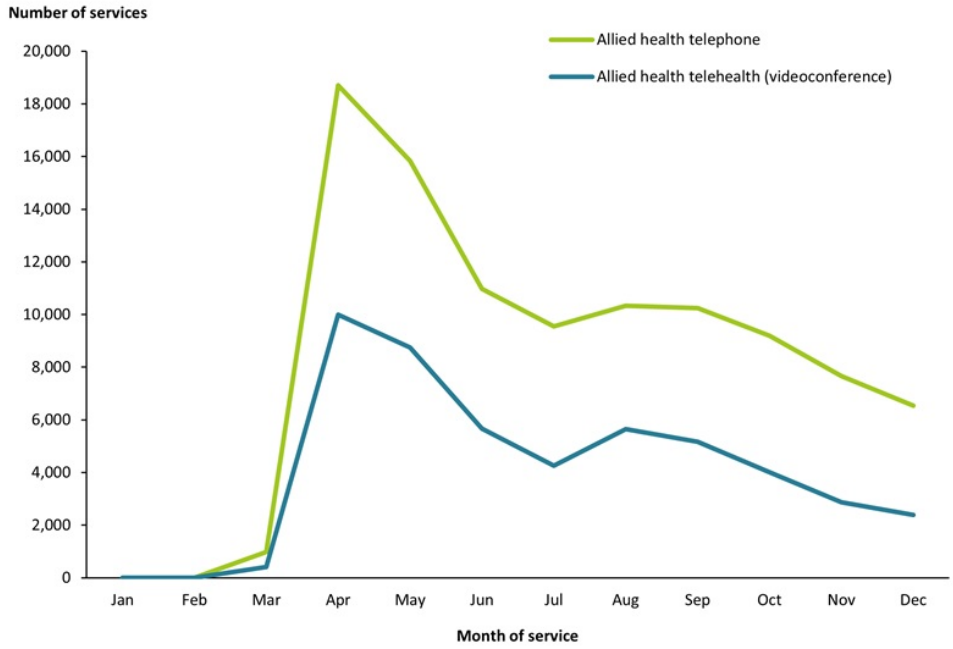
Figure 19: Month-to-month comparison of the Review of a GPMP or TCA telehealth services, 2020



Note: Includes from 20 March onwards 2020 telehealth MBS items: 92028, 92059, 92072, 92103.

Source: AIHW analysis of MBS data maintained by the Department of Health and Aged Care and sourced from Services Australia (Data Table 4.2).

Figure 20: Month-to-month comparison of telephone and videoconference Medicare-subsidised individual allied health telehealth services, 2020



Note: Includes from 20 March 2020 onwards telehealth MBS items: 93000 & 93013.

Source: AIHW analysis of MBS data maintained by the Department of Health and Aged Care and sourced from Services Australia (Data Table 4.3).

Nationally, the introduction of telehealth services had the greatest impact in the months of April and May, during the earlier phase of the national COVID-19 response. For example, they accounted for 1 in 3 GPMP and TCA consultations nationally in those months (Figures 21 and 22). In Victoria, where there was an extended lockdown during a second COVID-19 outbreak later in the year, telehealth accounted for 1 in 2 GPMP and TCA consultations during the months of August and September (See Data Tables 4.4 & 4.5).

The higher number of claims observed in 2020 in comparison to 2019 from June onwards can be attributed to the addition of the telehealth services. Potential reasons include:

- The introduction of telehealth services may have improved access to CDM services, making it easier for the GP to collaborate with other health professionals. This may also have allowed easier collaboration with specialists/other practitioners who may be more suitable for treating that patient, but who reside in other parts of the country.
- Concerns around the potential higher risk of COVID-19 disease for patients with chronic illness may have led practitioners to consider the assessment of these patients during the second half of 2020 as high priority.

Figure 21: Use of GPMP services by month and year, 2019 and 2020

Note: Includes MBS items 721 & 229, and from 30 March 2020 onwards telehealth MBS items 92024, 92055, 92068, 92099 .

Source: AIHW analysis of MBS data maintained by the Department of Health and Aged Care and sourced from Services Australia (Data Table 4.4).

Figure 22: Use of TCA services by month and year, 2019 and 2020

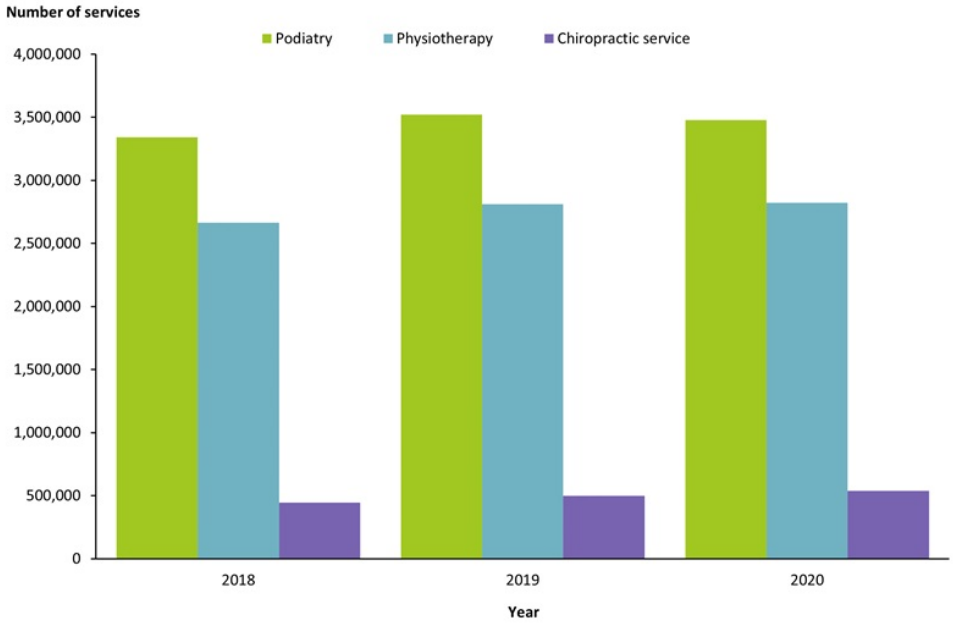
Note: Includes MBS items 723 & 230 from 30 March 2020 onwards and telehealth MBS items 92025, 92056, 92069, 92100.

Source: AIHW analysis of MBS data maintained by the Department of Health and Aged Care and sourced from Services Australia (Data Table 4.5).

Medicare-subsidised allied health services in 2020

As previously stated, all Medicare-subsidised individual allied health services had one single shared telehealth service, introduced on 30 March 2020. However, even without accounting for telehealth services, the top three Medicare-subsidised individual allied health services – podiatry, physiotherapy and chiropractic – all increased or remained stable in 2020 compared to 2019, despite the coronavirus (Figure 23) (See Data Table 4.6).

Figure 23: Use of top Medicare-subsidised individual allied health services by year, 2018 to 2020



Note: Includes MBS items 10960, 10962 and 10964.

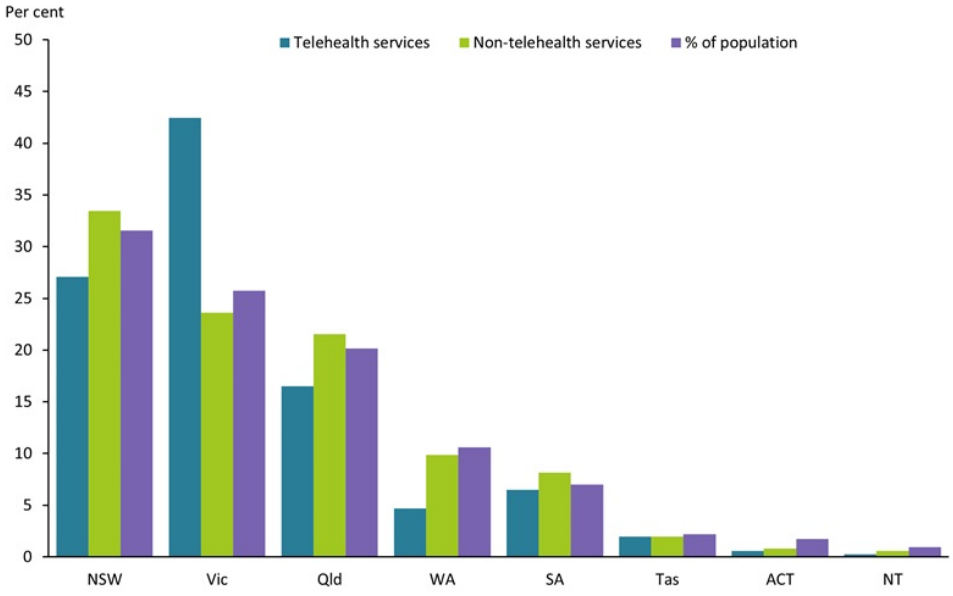
Source: AIHW analysis of MBS data maintained by the Department of Health and Aged Care and sourced from Services Australia (Data Table 4.6).

CDM and Medicare-subsidised allied health telehealth and non-telehealth services in 2020

In 2020, 60% of telehealth CDM and Medicare-subsidised allied health services were provided to females and 40% were provided to males. Non-telehealth CDM and Medicare-subsidised allied health services were split in a similar ratio, with 58% of non-telehealth services provided to females and 42% provide to males in 2020 (See Data Table 4.7).

For all CDM/Medicare-subsidised allied health telehealth services Australia-wide, Victoria accessed almost half (42%) in 2020 (Figure 24) (See Data Table 4.8), noting that Victoria was in lockdown for longer than all other states and territories in 2020. By June 2020, COVID-19 restrictions had eased for the time being for most of Australia, however, the greater region of Melbourne was forced into a strict 15-week lockdown between June to October 2020 in response to a second wave of COVID-19 infections in the city.

Figure 24: Use of CDM/Medicare-subsidised allied health telehealth services, by state and territory, 2020



Notes

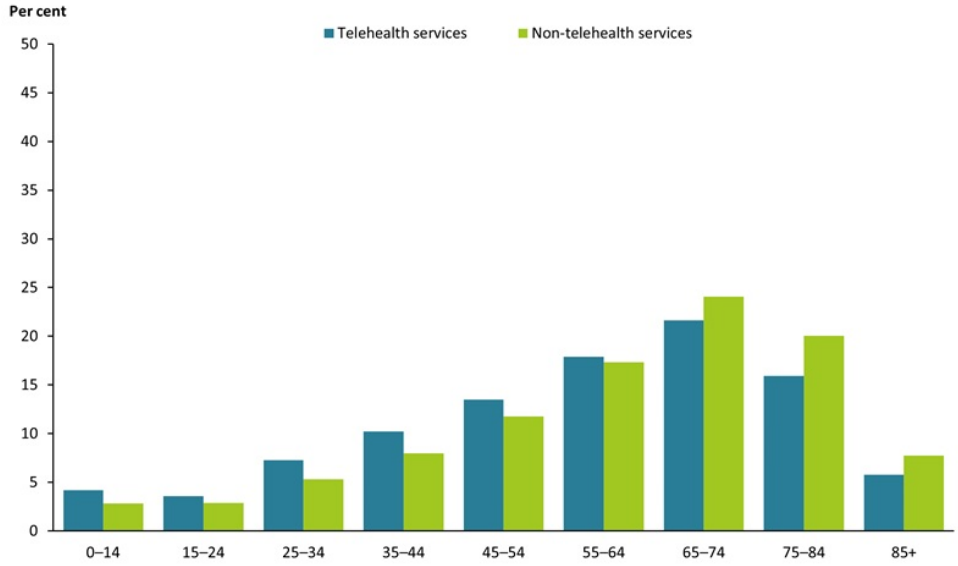
1. 1. Includes MBS items 721, 723, 732, 729, 731, 229, 230, 233, 231, 232, 10997, 10950 to 10970, 81100, 81105, 81110, 81115, 81120, 81125, and from 30 March 2020 onwards telehealth MBS items 92024, 92055, 92025, 92056, 92028, 92059, 92026, 92057, 92027, 92058, 93201, 93000, 93284, 93285, 92068, 92099, 92069, 92100, 92072, 92103, 92070, 92101, 92071, 92102, 93203, 93013, 93286.
2. 2. Proportion of the population taken from Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) as at 30 June 2020, based on the data from the 2016 Census of Population and Housing.

Source: AIHW analysis of MBS data maintained by the Department of Health and Aged Care and sourced from Services Australia (Data Table 4.8).

Fewer older people were using telehealth services, 43% of telehealth services were provided to patients aged 65 years and older as opposed

to 52% of in-person consultations (Figure 25) (See Data Table 4.9).

Figure 25: Use of CDM/Medicare-subsidised allied health telehealth services by age-group, 2020



Note: Includes MBS items 721, 723, 732, 729, 731, 229, 230, 233, 231, 232, 10997, 10950 to 10970, 81100, 81105, 81110, 81115, 81120, 81125, and from 30 March 2020 onwards telehealth MBS items 92024, 92055, 92025, 92056, 92028, 92059, 92026, 92057, 92027, 92058, 93201, 93000, 93284, 93285, 92068, 92099, 92069, 92100, 92072, 92103, 92070, 92101, 92071, 92102, 93203, 93013, 93286.

Source: AIHW analysis of MBS data maintained by the Department of Health and Aged Care and sourced from Services Australia (Data Table 4.9).

Comparison of CDM services in 2019 and 2020

A month-to-month comparison of CDM services in 2020 to 2019 (shown in Figures 21 and 22) found that services for Preparation of a GPMP and Coordination of TCAs were lower in March to May 2020 when compared to the respective months in 2019. The greatest difference was observed in March where 21,376 fewer claims for CDM services were made in 2020 compared with 2019. The number of claims was higher in 2020 for all other months when telehealth services were introduced due to the COVID-19 pandemic were included (See Data Tables 4.4 and 4.5)

The difference between the years was greatest in June 2020, where 60,000 more services for the preparation of a GPMP and 52,776 more services for the coordination of TCAs were recorded when compared to June 2019 (Figures 21 and 22). June 2020 was also when the highest number of GPMP services (282,429 services) and TCA services (240,364 services) were provided overall.

The lowest number of GPMP services was recorded in December for both 2020 (215,675 services) and 2019 (185,120 services). For TCA services, the lowest number of services were provided in April 2020 (171,401 services), and December 2019 (152,789 services). Similarly for the CDM review services, the lowest number of services were provided in April 2020 (288,617 services) and December 2019 (264,248) (See Data Table 4.10). This is consistent with seasonal annual claiming patterns, though COVID-19 lockdowns during April and May also may have influenced trends in 2020.

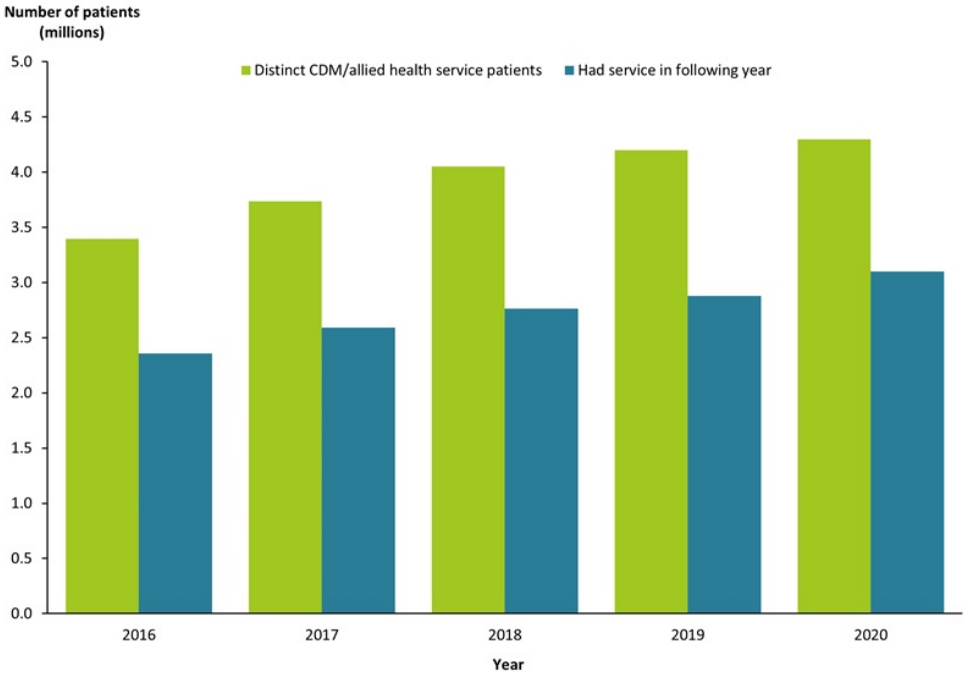
Repeat CDM and Medicare-subsidised allied health services over time

In 2019, 4.2 million patients accessed at least one CDM service or Medicare-subsidised allied health service. More than 2 in 3 (69%) of these patients also accessed at least one CDM service or Medicare-subsidised allied health service in 2020, including the telehealth equivalent services introduced in response to the COVID-19 pandemic.

This is similar to the trend in repeat usage of CDM services and Medicare-subsidised allied health services in the years prior to COVID-19 (Figure 26) (See Data Table 4.11).

There are many reasons why a patient who has previously accessed a CDM service or Medicare-subsidised allied health service may not do so again in the following year. Their condition may have improved, there may have been a disruption to service provision, for example being hospitalised or provider availability issues, or they may have died.

Figure 26: Number of CDM service or Medicare-subsidised allied health service patients who had at least one CDM or Medicare-subsidised allied health service in the following year



Note: Includes MBS items 721, 723, 732, 729, 731, 229, 230, 233, 231, 232, 10997, 10950 to 10970, 81100, 81105, 81110, 81115, 81120, 81125, and from 30 March 2020 onwards telehealth MBS items 92024, 92055, 92025, 92056, 92028, 92059, 92026, 92057, 92027, 92058, 93201, 93000, 93284, 93285, 92068, 92099, 92069, 92100, 92072, 92103, 92070, 92101, 92071, 92102, 93203, 93013, 93286.

Source: AIHW analysis of MBS data maintained by the Department of Health and Aged Care and sourced from Services Australia (Data Table 4.11).

[1] Not all CDM and Medicare-subsidised allied health telehealth were maintained from 1 January 2022, for example MBS items 92072, 92103 (Review of a GP Management Plan or Coordination of a Review of Team Care Arrangements telephone services) are no longer available.

References

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Technical notes

On this page:

Medicare Benefits Schedule claims data

Data for the report were sourced from the Medicare Benefits Schedule (MBS) claims data, which are managed by the Australian Government Department of Health and Aged Care. The claims data are derived from administrative information on services that qualify for a Medicare benefit under the Health Insurance Act 1973 and for which a claim has been processed by Services Australia.

When a health practitioner provides a clinically relevant service to a Medicare-eligible person, the practitioner or patient can make a claim with Medicare. Medicare will then provide a rebate, or benefit, to cover all or part of the cost of the service. For more detailed information on the MBS services and item types, see the Department of Health and Aged Care MBS Online website.

Scope of the MBS claims data

Under MBS arrangements, Medicare claims can be made by eligible persons, this includes Australian and New Zealand citizens and holders of permanent residence visas. Applicants for permanent residence may also be eligible depending on circumstances. In addition, persons from countries with which Australia has reciprocal health care agreements might also be entitled to benefits under MBS arrangements.

It is important to note that some Australian residents may obtain similar medical services through other arrangements. MBS claims data do not include:

- services provided to patients where no MBS benefit has been processed (even if the service is eligible for a rebate)
- services provided to public patients in hospitals
- services subsidised by the Department of Veterans' Affairs
- services delivered in public outpatient departments, or public accident and emergency departments
- services for a compensable injury or illness for which the patient's insurer or compensation agency has accepted liability
- non-hospital services subsidised by private health insurance
- services provided through other publicly funded programs including jurisdictional salaried GP services provided in remote outreach clinics
- health screening services.

The MBS claims data comprise information on services claimed and processed through Services Australia. These include patient demographics; date of service provided, service provider types; the type of services provided (MBS item number); the amount of benefit paid for that service (based on the scheduled fee); and the total amount charged for the service provided. Table 12 shows how each measure is defined.

Table 12: List of measures used in the report and their calculation

Measure	Calculation
Rate of patients who claimed the service (%)	**Numerator:** Number of patients who had at least one eligible service processed in the reporting year for the specified service type. The unique number of patients were identified through the Patient Identification Numbers in the Medicare claim records. **Denominator:** ABS ERP as at 30 June 2019. **Calculation:** (Numerator ÷ denominator) x 1,000.
Age standardised rate of patients who claimed the service (%)	**Numerator:** Number of patients who had at least one eligible service processed in the reporting year for the specified service type. The unique number of patients were identified through the Patient Identification Numbers in the Medicare claim records. **Denominator:** ABS ERP as at 30 June 2019. **Calculation:** (Numerator ÷ denominator) x 1,000; age standardised to the 2001 Australian Standard Population (see Age standardised rates for further information).

No. patients	Number of patients who had at least one eligible service processed in the reporting year for the specified service type. Totals and subtotals of patients may be less than the sum of each service group as a patient may receive more than one type of service but will be counted only once in the relevant total.
No. services	Sum of services from eligible claims for the specified service type. This does not include any bulk-billed incentive items or other top-up items.
Total Medicare benefits paid ($)	Sum of benefits paid for eligible claims for the specified service type. Results are rounded to the whole dollar. This does not include any payments associated with bulk billed incentive items or other top-up items.
Estimated Resident Population	Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) as at 30 June 2019.
Population subgroup: Remoteness	Remoteness is classified according to the Australian Statistical Geography Standard (ASGS) 2016 Remoteness Areas structure based on area of residence.
Population subgroup: Socioeconomic area	Socioeconomic areas are classified according to the Index of Relative Socio-Economic Disadvantage (IRSD) based on area of residence defined by the ABS as of 30 June 2016.
Geographical areas	Primary Health Network (PHNs) – 31 administrative health regions established to deliver access to primary care services for patients, as well as co-ordinate with local hospitals in order to improve the overall operational efficiency of the network. The 31 geographical areas covering Australia, with boundaries, are defined by the Australian Government Department of Health (2017). Statistical Areas Level 3 (SA3s) – 340 geographic areas covering Australia, with boundaries defined by the ABS. based on the Australian Statistical Geography Standard (ASGS) 2016.

Reporting year

Data are reported by the calendar year in which the service was provided for claims processed by 30 June 2021, with the exception of the *Use of review, monitoring and support services, Patterns of allied health service use* and *Use of other MBS services* sections of the web report where data are reported by calendar year in which the service was provided for claims processed by 30 June 2020.

Disaggregation by age and sex

Measures that are disaggregated by age group and sex use the patient's date of birth and sex as recorded at the last claim processed (for any MBS service) in the reporting year. Where multiple claims were processed on the last date of processing, age and sex was taken from the last date of service on that date of processing.

If a patient's age was recorded as unknown or over 116, their records were excluded from the age group results. Similarly, if a patient's sex was missing, their records were excluded from the sex group results.

Suppression of results

Consequential suppression was applied to manage confidentiality. Information about an area was suppressed (marked 'NP – not published') if any of the following conditions were met:

- there were fewer than six patients or fewer than six providers in the area (SA3)—note a patient/provider was only included if they provided or received at least one service in the area
- one provider provided more than 85% of services or two providers provided more than 90% of services
- one patient received more than 85% of services or two patients received more than 90% of services
- the number of attendances/services was greater than 0 but less than 20 for an area
- the total population of an area was fewer than 1,000
- the population of the reported age group or sex group in an area was fewer than 300.

Calculation of rates

In this publication rates are calculated using the Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) as at 30 June 2019, based on the data from the 2016 Census of Population and Housing. Issues that can arise from using the ERP to calculate rates from the MBS data include:

- This release uses the ERP at the end of the 2018–19 financial year. As the population changes, some people may be included in the numerator (MBS data), but not the denominator (ERP), for instance a person who migrated to Australia after 30 June 2019 but who claimed a service later in 2019.
- The ERP includes people who usually live in Australia, that is, people who have been residing in Australia for a period of 12 months or more over the last 16 months. Some temporary visitors who are not included in the ERP are able to claim Medicare services, for instance through reciprocal health care agreements. However, some residents who usually live in Australia (e.g. international students or those on working visas) are not eligible for Medicare.
- The ERP, the official estimate of the Australian population, is produced by the ABS using a range of data sources, including the Census of Population and Housing, and births, deaths, and migration administrative data. ERP data sources are subject to non-sampling error, which may arise from inaccuracies in collecting, recording and processing data (ABS 2019).

Age standardised rates

Age-standardisation is a method used to eliminate the effect of differences in population age structures when comparing rates for different periods of time and/or different population groups. In this report, direct age standardisation has been used. Rates for all ages are age standardised to the 2001 Australian Standard Population. Age groups used for age standardisation are as follows: 0–14, 15–24, 25–34, 35–44, 45–54, 55–64, 65–74, 75–84, 85+.

CDM and Medicare-subsidised allied health services item numbers and descriptions

Item numbers and descriptions for the CDM and Medicare-subsidised allied health services investigated in this report are provided in Tables 13 and 14 below.

Table 13: Medicare Benefits Schedule (MBS) CDM items and subsidised allied health services

Item number	Item name	Description
721	Preparing a management plan for a patient who has a chronic or terminal medical condition with or without multidisciplinary care needs	Attendance by a general practitioner for preparation of a GP management plan for a patient (other than a service associated with a service to which any of items 735 to 758 apply). See MBS online. (See para AN.0.47 of explanatory notes to this Category).
723	Coordinating the preparation of Team Care Arrangements for a patient who has a chronic or terminal medical condition and requires ongoing care from a multidisciplinary team of at least three health or care providers	Attendance by a general practitioner to coordinate the development of team care arrangements for a patient (other than a service associated with a service to which any of items 735 to 758 apply). See MBS online. (See para AN.0.47 of explanatory notes to this Category).
732	Reviewing a GP Management Plan	Attendance by a general practitioner to review or coordinate a review of: (a) a GP management plan prepared by a general practitioner (or an associated general practitioner) to which item 721 applies; or (b) team care arrangements which have been coordinated by the general practitioner (or an associated general practitioner) to which item 723 applies. See MBS online. (See para AN.0.47 of explanatory notes to this Category).
732	Coordinating a Review of Team Care Arrangements	Attendance by a general practitioner to review or coordinate a review of: (a) a GP management plan prepared by a general practitioner (or an associated general practitioner) to which item 721 applies; or (b) team care arrangements which have been coordinated by the general practitioner (or an associated general practitioner) to which item 723 applies. See MBS online. (See para AN.0.47 of explanatory notes to this Category).
729	Contributing to a multidisciplinary care plan being prepared by another health or care provider, or to a review of such a plan	Contribution by a general practitioner to a multidisciplinary care plan prepared by another provider or a review of a multidisciplinary care plan prepared by another provider (other than a service associated with a service to which any of items 735 to 758 apply). See MBS online. (See para AN.0.47 of explanatory notes to this Category).

731	Contributing to a multidisciplinary care plan being prepared for a resident of an aged care facility, or to a review of such a plan	Contribution by a general practitioner to: (a) a multidisciplinary care plan for a patient in a residential aged care facility, prepared by that facility, or to a review of such a plan prepared by such a facility; or (b) a multidisciplinary care plan prepared for a patient by another provider before the patient is discharged from a hospital, or to a review of such a plan prepared by another provider (other than a service associated with a service to which items 735 to 758 apply). See MBS online. (See para AN.0.47 of explanatory notes to this Category).
10950	Allied health service	Aboriginal and Torres Strait Islander health services
10951	Allied health service	Diabetes education services
10952	Allied health service	Audiology
10953	Allied health service	Exercise physiology
10954	Allied health service	Dietetics
10956	Allied health service	Mental health service
10958	Allied health service	Occupational therapy
10960	Allied health service	Physiotherapy
10962	Allied health service	Podiatry
10964	Allied health service	Chiropractic services
10966	Allied health service	Osteopathy
10968	Allied health service	Psychology
10970	Allied health service	Speech pathology
81100	Group allied health	Diabetes education—assessment for group services
81105	Group allied health	Diabetes education—group service
81120	Group allied health	Dietetics—assessment for group services
81125	Group allied health	Dietetics—group service
81110	Group allied health	Exercise physiology—assessment for group service
81115	Group allied health	Exercise physiology—group service

Table 14: Medicare Benefits Schedule (MBS) CDM items and subsidised allied health services telehealth items, 2020

Item name	Item numbers	Type	Description
Preparation of a GP Management Plan (GPMP)	92024, 92055	Telehealth services (videoconference)	Telehealth attendance by a general practitioner, for preparation of a GP management plan for a patient (other than a service associated with a service to which any of items 735 to 758, items 92074 to 92078 or items 92030 to 92034 apply) See MBS online. Telehealth attendance by a medical practitioner (not including a general practitioner, specialist, or consultant physician), for preparation of a GP management plan for a patient (other than a service associated with a service to which any of items 735 to 758 of the general medical services table, or items 92074 to 92078 or items 92030 to 92034 or items 235 to 240 in the Health Insurance (Section 3C General Medical Services – Other Medical Practitioner) Determination 2018 apply). See MBS online.

Preparation of a GP Management Plan (GPMP)	92068, 92099	Telephone services	Phone attendance by a general practitioner, for preparation of a GP management plan for a patient (other than a service associated with a service to which any of items 735 to 758, items 235 to 240 or items 92074 to 92078 or items 92030 to 92034 apply). Telephone attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), for preparation of a GP management plan for a patient (other than a service associated with a service to which any of items 735 to 758 of the general medical services table, or items 92074 to 92078 or items 92030 to 92034 or items 235 to 240 in the Health Insurance (Section 3C General Medical Services – Other Medical Practitioner) Determination 2018 apply). See MBS online.
Coordination of Team Care Arrangements (TCAs)	92025, 92056	Telehealth services (videoconference)	Telehealth attendance by a general practitioner, to coordinate the development of team care arrangements for a patient (other than a service associated with a service to which any of items 735 to 758, items 92074 to 92078 or items 92030 to 92034 apply). See MBS online. Telehealth attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), to coordinate the development of team care arrangements for a patient (other than a service associated with a service to which any of items 735 to 758 of the general medical services table, or items 92074 to 92078 or items 92030 to 92034, or items 235 to 240 in the Health Insurance (Section 3C General Medical Services – Other Medical Practitioner) Determination 2018 apply). See MBS online.
Coordination of Team Care Arrangements (TCAs)	92069, 92100	Telephone services	Phone attendance by a general practitioner, to coordinate the development of team care arrangements for a patient (other than a service associated with a service to which any of items 735 to 758, or items 235 to 240 or items 92074 to 92078 or items 92030 to 92034 apply). Telephone attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), to coordinate the development of team care arrangements for a patient (other than a service associated with a service to which any of items 735 to 758 of the general medical services table, or items 92074 to 92078 or items 92030 to 92034 or items 235 to 240 in the Health Insurance (Section 3C General Medical Services – Other Medical Practitioner) Determination 2018 apply). See MBS online.
Review of a GP Management Plan or Coordination of a Review of Team Care Arrangements	92028, 92059	Telehealth services (videoconference)	Telehealth attendance by a general practitioner to review or coordinate a review of: (a) a GP management plan prepared by a general practitioner (or an associated general practitioner) to which item 721 of the general medical services table, or item 229 or item 92024 or 92068 applies; or (b) team care arrangements which have been coordinated by the general practitioner (or an associated general practitioner) to which item 723 of the general medical services table, or item 230 or item 92025 or 92069 or items applies. See MBS online. Telehealth attendance by a medical practitioner (not including a general practitioner, specialist, or consultant physician), to review or coordinate a review of: (a) a GP management plan prepared by a medical practitioner (or an associated medical practitioner) to which item 229, 721 or item 229 or item 92024, 92055, 92068 or 92099 applies; or (b) team care arrangements which have been coordinated by the medical practitioner (or an associated medical practitioner) to which item 230, 723, 92025, 92056, 92069 or 92100 applies. See MBS online.

Review of a GP Management Plan or Coordination of a Review of Team Care Arrangements	92072, 92103	Telephone services	Phone attendance by a general practitioner to review or coordinate a review of: (a) a GP management plan prepared by a general practitioner (or an associated general practitioner) to which item 721 of the general medical services table or item 229 or items 92074 to 92078 or 92030 to 92034 or item 92024 or 92068 applies; or (b) team care arrangements which have been coordinated by the general practitioner (or an associated general practitioner) to which item 723 of the general medical services table or item 92025 or 92069 or items applies. Telephone attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), to review or coordinate a review of: (a) a GP management plan prepared by a medical practitioner (or an associated medical practitioner) to which item 229, 721, 92024, 92055, 92068 or 92099 applies; or (b) team care arrangements which have been coordinated by the medical practitioner (or an associated medical practitioner) to which item 230, 723, 92025, 92056, 92069 or 92100 applies. See MBS online.
Contribution to a Multidisciplinary Care Plan, or to a Review of a Multidisciplinary Care Plan, for a patient who is not a care recipient in a residential aged care facility	92026, 92057	Telehealth services (videoconference)	Telehealth contribution by a general practitioner, to a multidisciplinary care plan prepared by another provider or a review of a multidisciplinary care plan prepared by another provider (other than a service associated with a service to which any of items 735 to 758, items 92074 to 92078 or items 92030 to 92034 apply). See MBS online. Telehealth contribution by a medical practitioner (not including a general practitioner, specialist or consultant physician), to a multidisciplinary care plan prepared by another provider or a review of a multidisciplinary care plan prepared by another provider (other than a service associated with a service to which any of items 735 to 758 of the general medical services table, or items 92074 to 92078 or items 92030 to 92034 or items 235 to 240 in the Health Insurance (Section 3C General Medical Services – Other Medical Practitioner) Determination 2018 apply). See MBS online.
Contribution to a Multidisciplinary Care Plan, or to a Review of a Multidisciplinary Care Plan, for a patient who is not a care recipient in a residential aged care facility	92070, 92101	Telephone services	Phone contribution by a general practitioner, to a multidisciplinary care plan prepared by another provider or a review of a multidisciplinary care plan prepared by another provider (other than a service associated with a service to which any of items 735 to 758, or items 235 to 240, or items 92074 to 92078 or items 92030 to 92034 apply). Telephone contribution by a medical practitioner (not including a general practitioner, specialist or consultant physician), to a multidisciplinary care plan prepared by another provider or a review of a multidisciplinary care plan prepared by another provider (other than a service associated with a service to which any of items 735 to 758 of the general medical services table or items 92074 to 92078 or items 92030 to 92034 or items 235 to 240 in the Health Insurance (Section 3C General Medical Services – Other Medical Practitioner) Determination 2018 apply). See MBS online.

Contribution to a Multidisciplinary Care Plan, or to a review of a multidisciplinary care plan, for a resident in an aged care facility	92027, 92058	Telehealth services (videoconference)	Telehealth contribution by a general practitioner, to: (a) a multidisciplinary care plan for a patient in a residential aged care facility, prepared by that facility, or to a review of such a plan prepared by such a facility; or (b) a multidisciplinary care plan prepared for a patient by another provider before the patient is discharged from a hospital, or to a review of such a plan prepared by another provider (other than a service associated with a service to which items 735 to 758, items 92074 to 92078 or items 92030 to 92034 apply). See MBS online. Telehealth contribution by a medical practitioner (not including a general practitioner, specialist, or consultant physician) to: (a) a multidisciplinary care plan for a patient in a residential aged care facility, prepared by that facility, or to a review of such a plan prepared by such a facility; or (b) a multidisciplinary care plan prepared for a patient by another provider before the patient is discharged from a hospital, or to a review of such a plan prepared by another provider (other than a service associated with a service to which items 735 to 758 of the general medical services table, or items 92074 to 92078 or items 92030 to 92034 or items 235 to 240 in the Health Insurance (Section 3C General Medical Services – Other Medical Practitioner) Determination 2018 apply). See MBS online.
Contribution to a Multidisciplinary Care Plan, or to a review of a multidisciplinary care plan, for a resident in an aged care facility	92071, 92102	Telephone services	Phone contribution by a general practitioner (not including a specialist or consultant physician), to: (a) a multidisciplinary care plan for a patient in a residential aged care facility, prepared by that facility, or to a review of such a plan prepared by such a facility; or (b) a multidisciplinary care plan prepared for a patient by another provider before the patient is discharged from a hospital, or to a review of such a plan prepared by another provider (other than a service associated with a service to which items 735 to 758, items 235 to 240, or items 92074 to 92078 or 92030 to 92034 apply). Telephone contribution by a medical practitioner (not including a general practitioner, specialist, or consultant physician), to: (a) a multidisciplinary care plan for a patient in a residential aged care facility, prepared by that facility, or to a review of such a plan prepared by such a facility; or (b) a multidisciplinary care plan prepared for a patient by another provider before the patient is discharged from a hospital, or to a review of such a plan prepared by another provider (other than a service associated with a service to which items 735 to 758 of the general medical services table, or items 92074 to 92078 or items 92030 to 92034 or items 235 to 240 in the Health Insurance (Section 3C General Medical Services – Other Medical Practitioner) Determination 2018 apply). See MBS online.

Medicare-subsidised individual allied health services	93000, 93201	Telehealth services (videoconference)	Telehealth attendance by an eligible allied health practitioner if: (a) the service is provided to a person who has: (i) a chronic condition; and (ii) complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under a shared care plan or under both a GP Management Plan and Team Care Arrangements or, if the person is a resident of an aged care facility, the person's medical practitioner has contributed to a multidisciplinary care plan; and (b) the service is recommended in the person's Team Care Arrangements or multidisciplinary care plan as part of the management of the person's chronic condition and complex care needs; and (c) the person is referred to the eligible allied health practitioner by the medical practitioner using a referral form that has been issued by the Department or a referral form that contains all the components of the form issued by the Department; and (d) the service is provided to the person individually; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible allied health practitioner gives a written report to the referring medical practitioner mentioned in paragraph (c): (i) if the service is the only service under the referral—in relation to that service; or (ii) if the service is the first or last service under the referral—in relation to that service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of —in relation to those matters; to a maximum of 5 services (including any services to which this item, item 93013 or any item in Part 1 of the Schedule to the Allied Health Determination applies) in a calendar year. See MBS online. Telehealth attendance provided by a practice nurse or an Aboriginal and Torres Strait Islander health practitioner to a person with a chronic disease if: (a) the service is provided on behalf of and under the supervision of a medical practitioner; and (b) the person has a GP management plan, team care arrangements or multidisciplinary care plan in place and the service is consistent with the plan or arrangements. See MBS online.

Medicare-subsidised individual allied health services	93013, 93203	Telephone services	Phone attendance by an eligible allied health practitioner if: (a) the service is provided to a person who has: (i) a chronic condition; and (ii) complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the person is a resident of an aged care facility, the person's medical practitioner has contributed to a multidisciplinary care plan; and (b) the service is recommended in the person's Team Care Arrangements or multidisciplinary care plan as part of the management of the person's chronic condition and complex care needs; and (c) the person is referred to the eligible allied health practitioner by the medical practitioner using a referral form that has been issued by the Department or a referral form that contains all the components of the form issued by the Department; and (d) the service is provided to the person individually; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible allied health practitioner gives a written report to the referring medical practitioner mentioned in paragraph (c): (i) if the service is the only service under the referral—in relation to that service; or (ii) if the service is the first or last service under the referral—in relation to that service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of —in relation to those matters; to a maximum of 5 services (including any services to which this item, item 93000 or any item in Part 1 of the Schedule to the Allied Health Determination applies) in a calendar year. See MBS online. Phone attendance provided by a practice nurse or an Aboriginal and Torres Strait Islander health practitioner to a person with a chronic disease if: (a) the service is provided on behalf of and under the supervision of a medical practitioner; and (b) the person has a GP management plan, team care arrangements or multidisciplinary care plan in place and the service is consistent with the plan or arrangements. See MBS online.

Dietetic services-Assessment for group services	93284	Telehealth services (videoconference)	Telehealth attendance by an eligible dietitian to provide a dietetics health service to a person for assessing the person's suitability for group services for the management of type 2 diabetes, including taking a comprehensive patient history, identifying an appropriate group services program based on the patient's needs and preparing the person for the group services if: (a) the person has type 2 diabetes; and (b) the person is being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under a GP management plan or, if the person is a resident of an aged care facility, the person's medical practitioner has contributed to a multidisciplinary care plan; and (c) the person is referred to an eligible dietitian by the medical practitioner using a referral form that has been issued by the Department, or a referral form that contains all the components of the form issued by the Department; and (d) the service is provided to the person individually; and (e) the service is of at least 45 minutes duration; and (f) after the service, the eligible dietitian gives a written report to the referring medical practitioner mentioned in paragraph (c); payable once in a calendar year for this or any other assessment for group services item (including services to which this item, item 92386, or items 81100, 81110 and 81120 of the Allied Health Determination apply). See MBS online.
Dietetic services-Assessment for group services	93286	Telephone services	Phone attendance by an eligible dietitian to provide a dietetics health service to a person for assessing the person's suitability for group services for the management of type 2 diabetes, including taking a comprehensive patient history, identifying an appropriate group services program based on the patient's needs and preparing the person for the group services if: (a) the person has type 2 diabetes; and (b) the person is being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under a GP management plan or, if the person is a resident of an aged care facility, the person's medical practitioner has contributed to a multidisciplinary care plan; and (c) the person is referred to an eligible dietitian by the medical practitioner using a referral form that has been issued by the Department, or a referral form that contains all the components of the form issued by the Department; and (d) the service is provided to the person individually; and (e) the service is of at least 45 minutes duration; and (f) after the service, the eligible dietitian gives a written report to the referring medical practitioner mentioned in paragraph (c); payable once in a calendar year for this or any other assessment for group services item (including services to which this item, item 92384, or in items 81100, 81110 and 81120 of the Allied Health Determination apply). See MBS online.

Dietetics service-group service	93285	Telehealth services (videoconference)	Telehealth attendance by an eligible dietitian to provide a dietetics health service, as a group service for the management of type 2 diabetes if: (a) the person has been assessed as suitable for a type 2 diabetes group service under assessment items 81100, 81110 or 81120 of the Allied Health Determination or items 93284 or 93286; and (b) the service is provided to a person who is part of a group of between 2 and 12 patients; and (c) the service is of at least 60 minutes duration; and (d) after the last service in the group services program provided to the person under this item or items 81105, 81115 or 81125 of the Allied Health Determination, the eligible dietitian prepares, or contributes to, a written report to be provided to the referring medical practitioner; and (e) an attendance record for the group is maintained by the eligible dietitian; to a maximum of 8 group services in a calendar year (including services to which this item or items 81105, 81115 and 81125 of the Allied Health Determination apply). See MBS online.
Dietetics service-group service	N/A	Telephone services	N/A

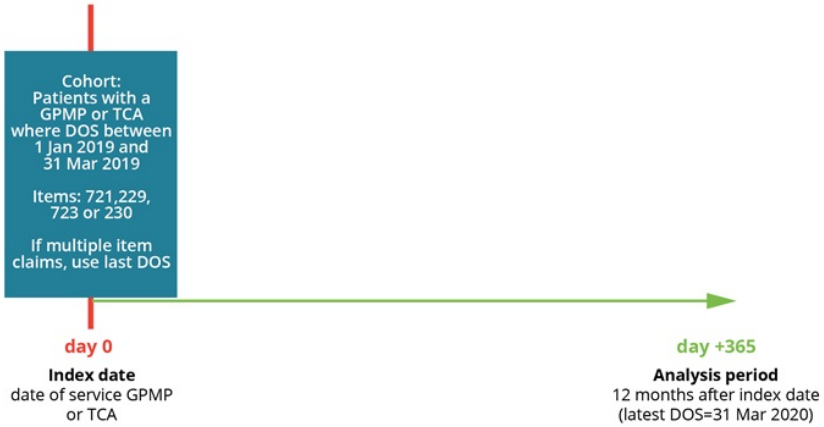
Cohorts used in this report

Several sections of this report use cohorts to address specific aspects of CDM and Medicare-subsidised individual allied health service use. These cohorts were designed as follows:

Use of review, monitoring and support services

This analysis involved a cohort of patients who had a GPMP or TCA established between 1 January 2019 and 30 March 2019 (N = 813,174) and explored their use of the review and support items for the subsequent 12 months (see Figure 27).

Figure 27: Cohort design for use of review, monitoring and support services analysis

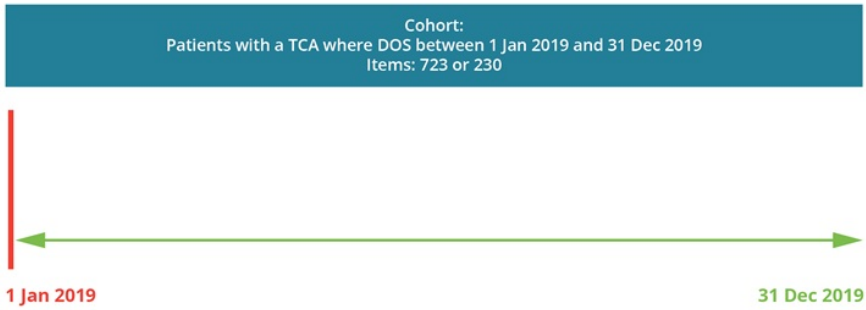


Note: DOS refers to date of service.

Patterns of allied health service use: patients who did not use any allied health services

This analysis involved patients who had TCAs coordinated in the 12-month period between 1 January 2019 and 31 December 2019 (N = 870,333) and explored the number of patients who did not claim any Medicare-subsidised individual allied health services (See Figure 28).

Figure 28: Cohort design for patterns of allied health service use: patients who did not use any allied health services analysis



Note: DOS refers to date of service.

Patterns of allied health service use: number of allied health services used by patients

This analysis involved patients who had claimed at least one Medicare-subsidised individual allied health service in the 12-month period between 1 January 2019 and 31 December 2019 (N = 2,412,608) and explored the number of allied health services used by these patients (See Figure 29).

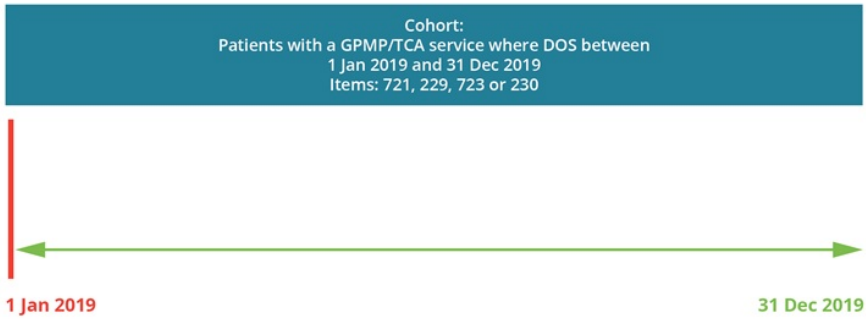
Figure 29: Cohort design for patterns of allied health service use: number of allied health services used by patients' analysis

Note: DOS refers to date of service.

Use of other MBS services

This analysis involved patients who had claimed a GPMP or TCAs in the 12-month period between 1 January 2019 and 31 December 2019 (N = 2,891,201 and N = 2,458,750, respectively) and explored their use of other MBS services, including GP attendance, specialist attendance, GP mental health treatment plans, asthma cycles of care, diabetes cycles of care and home medicines reviews (See Figure 30).

Figure 30: Cohort design for use of other MBS services analysis



Note: DOS refers to date of service.

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Data

Related material

Resources

Related topics

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