EXPLANATORY STATEMENT

Select Legislative Instrument 2005 No. 238

Issued by the Authority of the Minister for Health and Ageing

Health Insurance Act 1973

Health Insurance (General Medical Services Table) Regulations 2005

Subsection 133(1) of the *Health Insurance Act 1973* (the Act) provides that the Governor-General may make regulations, not inconsistent with the Act, prescribing all matters required or permitted by the Act to be prescribed, or necessary or convenient to be prescribed for carrying out or giving effect to the Act.

The Act provides, in part, for payments of Medicare benefits in respect of professional services rendered to eligible persons. Section 9 of the Act provides that Medicare benefits shall be calculated by reference to the fees for medical services set out in prescribed tables.

Subsection 4(1) of the Act provides that the regulations may prescribe a table of medical services (other than diagnostic imaging services and pathology services) that sets out items of medical services, the amount of fees applicable in respect of each item, and rules for interpretation of the table. Subsection 4(2) of the Act provides that, unless sooner repealed, regulations made under section 4 cease to be in force and are taken to have been repealed on the day after the 15th sitting day of the House of Representatives after the end of a period of 12 months beginning on the day on which the regulations are registered on the Federal Register of Legislative Instruments (formally the *Gazette*).

A table of general medical services is currently prescribed by the *Health Insurance (General Medical Services Table) Regulations 2004* (the 2004 Regulations). The table was amended by the *Health Insurance (General Medical Services Table) Amendment Regulations 2004 (No.8), (No. 9), (No. 10)* and *(No.11)*, and the *Health Insurance (General Medical Services Table) Amendment Regulations 2005 (No.1), (No.2)* and *(No.3)*. The 2004 Regulations were notified in the *Gazette* on 29 October 2004 and commenced on 1 November 2004.

The purpose of the Regulations is to repeal the 2004 Regulations and the amending regulations, and to prescribe a new table of general medical services for the 12 month period commencing on 1 November 2005. The new table effectively reproduces the table contained in the 2004 Regulations, with some amendments to the rules of interpretation and the schedule of services and fees. The new table sets out the items of general medical services which are eligible for Medicare benefits, the amount of fees applicable in respect of each item and rules for interpretation of the table.

Details of the Regulations are set out in the Attachment.

The Act specified no conditions to be met before the power to make the Regulations was exercised.

The Regulations are a legislative instrument for the purposes of the *Legislative Instruments Act 2003*.

The Regulations commenced on 1 November 2005.

ATTACHMENT

DETAILS OF THE *HEALTH INSURANCE (GENERAL MEDICAL SERVICES TABLE) REGULATIONS 2005*

Regulation 1 – Name of Regulations

This Regulation provided that the title of the Regulations is the *Health Insurance (General Medical Services Table) Regulations 2005*.

Regulation 2 - Commencement

This Regulation provided for the Regulations to commence on 1 November 2005.

Regulation 3 – Repeals

This Regulation provides that the *Health Insurance (General Medical Services Table) Regulations 2004* is repealed.

Regulation 4 - Definition

This Regulation defined, for the purpose of the proposed Regulations, **Act** to mean the *Health Insurance Act 1973* and **this table** to mean the table of general medical services as set out in Schedule 1.

Regulation 5 - Schedule 1

This Regulation provided that the new table of general medical services and rules of interpretation is set out in Schedule 1.

Schedule 1 – Table of general medical services amendments

In addition to re-making the *Health Insurance (General Medical Services Table) Regulations 2004*, the proposed General Medical Services Table 2005:

- provide for a 2.0% annual indexation of the fees paid for all items in the table, excluding item 173 (acupuncture performed by a medical practitioner) and items in Group A2 which relate to other medical practitioners (with the exception of emergency attendance after hours items);
- insert 67 new items;
- amend the descriptions of 71 items to accurately reflect current clinical practice;
- remove 44 items which are no longer current;
- insert Unit Values into Anaesthetic items to provide for appropriate time billing; and
- insert six items from 3C Determinations into the General Medical Services Table.

Part 1 – Prescription of Table

Part 1 of the Regulations prescribe a table of medical services which sets out the rules for interpretations of the table, the items of medical services and the amount of fees applicable for each item.

Part 2 – Rules of Interpretation amendments

Rule 3
Subrule 3(1) has been amended to define the intention of the term **2004 GMST** as being the Health Insurance (General Medical Services Table) Regulations 2004 in force immediately before 1 November 2005.

Rule 11
Subrule 11(2) has been amended to delete items 700 to 903 from the list of items to be provided in the course of a personal attendance by a single medical practitioner on a single patient on a single occasion.

Subrule 11(4) has been created for a new category of items which are able to be provided by a single medical practitioner on a single patient without reference to the number of occasions in the course of which the items can be provided. This new category of items includes items 700 to 727, 900 and 903.

Rule 12
Subrule 12(3) has been amended to remove items 729 to 866 from the list of items requiring a personal attendance by the medical practitioner.

Rule 12A
Rule 12A is a new rule which allows for items 729 to 866 to be provided by medical practitioners in the circumstances outlined in rule 12 in relation to employment by the proprietor of a hospital but without the need for a personal attendance.

Rule 15
Rule 15 has been amended to extend the coverage range from 10941 to 10943 to reflect new items (10942 and 10943) that have been introduced.

Rule 45
Subrule 45(1) has been amended to delete superseded multidisciplinary care planning items 720, 724 and 726 from the list of Group A15 items as being available to patients other than in-patients of a hospital, approved day hospital facility or care recipients in a residential aged care facility.

Subrule 45(2) has been amended to delete superseded multidisciplinary care planning items 722 and 728 from the list of Group A15 items as being available to in-patients of a hospital or approved day hospital facility other than care recipients in a residential aged care facility.

Subrule 45(3) has been amended to delete superseded multidisciplinary care planning item 730 from the list of Group A15 items as being available to care recipients in a residential aged care facility who are not in-patients of a hospital or approved day hospital facility.

Rule 45A
Subparagraph 45A (1)(a)(i) has been amended to delete the Team Care Arrangements item 723 from the list of Group A15 items as precluding the provision of item 721, within 3 months of the provision of the specified items, in ordinary circumstances.

Subparagraph 45A (1)(a)(ii) has been amended to insert the words “of the 2004 General Medical Services Table” after the reference to item 720 in order to enable this superseded item to still be

specified as one whose provision in the previous twelve months precludes, in ordinary circumstances, the provision of item 721.

Subparagraph 45A (2)(a)(ii) has been amended to insert the words “of the 2004 General Medical Services Table” after the reference to item 720 in order to enable this superseded item to still be specified as one whose provision in the previous twelve months precludes, in ordinary circumstances, the provision of item 723.

Subparagraph 45A (5)(a)(ii) has been inserted to enable the superseded items 726 and 728 to still be specified as ones whose provision in the previous three months precludes, in ordinary circumstances, the provision of item 729.

Subparagraph 45A (6)(a)(ii) has been inserted to enable superseded item 730 to still be specified as one whose provision in the previous three months precludes, in ordinary circumstances, the provision of item 731.

Rule 49
Rule 49 which defined the meaning of the term *multidisciplinary care plan* for the purpose of the superseded multidisciplinary care planning items (720, 722, 724, 726, 728 and 730) has been deleted.

Rule 50
Rule 50 which defined the meaning of the term *multidisciplinary care plan team* for the purpose of the superseded multidisciplinary care planning items has been deleted.

Rule 51
Rule 51 has been amended to substitute the reference to superseded multidisciplinary care planning items 722 and 728 with a reference to new items 725 and 727 in this explanation of the term *multidisciplinary discharge care plan.*

Rule 52
Rule 52 which defined the meaning of the term *review* of a multidisciplinary care plan team for the purpose of the superseded multidisciplinary care planning review item, item 724 has been deleted.

Rule 52A
Rule 52A has been inserted to add the words “of the 2004 General Medical Services Table” after the words “in subrule 49 (1)”, so as to include, as applicable, in the matters to be reviewed for the purpose of item 725 those matters which were described under the definition of multidisciplinary care plan for the purpose of the superseded items.

Rule 53
Rule 53 which defined the meaning of *contribution* to a plan for the purpose of superseded items 726, 728 and 730 has been deleted.

Rule 53A
Paragraph 53A (1)(a) has been inserted to add the words “of the General Medical Services Table” after the words “in subrule 49 (1)”, so as to include, as applicable, in the matters to be reviewed for the purpose of item 727 those matters which were to be described under the definition of multidisciplinary care plan for the purpose of the superseded items.

Rule 60
Paragraph 60(2)(b) has been amended to remove the word "initiate" to remove the confusion about who can initiate a review. Since its introduction on 1 November 2004 it was unclear that Pharmacists as well as General Practitioners were authorised to initiate a RMMR.

Rule 77
Paragraph 77(1)(a) has been amended to reflect the administrative changes of Medicare Australia

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Rule 81
Subrule 81(2) has been inserted to clarify that if the cost of the toxin supplied during the service is not subsidised by the Commonwealth or State, the services is taken not to include the supply of that toxin.

Rule 88
Rule 88 has been inserted to place limits on items 291, 293, 10943, 45019, 10942, 10921 10922, 10923, 10924, 10925, 10926, 10927, 10928, 10929 and 13104.

Rule 89
Rule 89 has been inserted to clarify that items 30440, 30451, 30492 or 30495 do not include imaging.

Rule 90
Rule 90 has been inserted to clarify the application of items 10900, 10940 and 10941.

Rule 91
Rule 91 has been inserted to clarify the application of items 10931, 10932 and 10933.

Rule 92
Rule 92 has been inserted to introduce a limitation on new items 10943, 16590, 18360, 18364, and 50303 (see Part 3 below, below). With item 10943 the service does not apply to a service used to assess learning difficulties or learning disabilities.

Rule 93
Rule 93 has been inserted to define that items 30299 and 30300 only apply where pre-operative lymphoscinitigraphy is used because the patient is allergic to lymphotropic dye.

Part 3 – Services and fees amendments

Enhanced Primary Care
Items 720, 722, 724, 726, 728 and 730 have been superseded and therefore omitted.

Items 725 and 727 have been amended to insert the words "of the 2004 GMST" after "item 720" and after "item 722" in (b) of column 2.

Items 729 and 731 have been amended to substitute the word "Contribution" for the word "Attendance" at the beginning of column 2 and delete the words "to contribute" later in column 2, consequent upon the proposed change to subrule 12(3).

Item 734 has been amended to substitute the reference to superseded item "730" in column 2 with a reference to item "731".

Item 736 has been amended to substitute the reference to superseded item "730" in column 3 with a reference to item "731".

Item 738 has been amended to substitute the reference to superseded item "730' in column 2 with a reference to the replacement item "731".

Item 740, 742, 744, 746, 749, 757, 759, 762, 765, 768, 771 and 773 have been amended to substitute the reference to superseded items "720 to 730" in column 2 with a reference to items "721 to 731".

Items 775, 778 and 779 have been amended to substitute the reference to superseded item "730" in column 2 with a reference to item "731".

Ophthalmology
Minor changes have been made to a number of existing Ophthalmology items to better define the original intent of the items and to reflect current clinical practice. Three new items (42744, 42805 and 42811) have also been introduced to allow benefits for bleb needling, insertion of tantalum markers and transpupillary thermotherapy.

Optometry
A new optometry item (10943) has been introduced for additional testing of children aged three to fourteen to confirm diagnosis or establish a treatment regime for a number of significant binocular or accommodative dysfunctions. The descriptor of item 10942 has also been amended to clarify that visual acuity must be worse than or equal to the measurement given.

Three new items (10931, 10932 and 10932) have been introduced to provide for a loading in recompense for travel costs and packing/unpacking of equipment where an optometrist travels to a patient's home because the patient is unable to travel to the optometrist's practice.

The item descriptors for 10916, 10940 and 10941 have been amended to include a reference to the new items. Item 10918 has been amended for consistency of expression with item 10916.

Anaesthesia
A number of anaesthetic items have been amended, introduced or deleted to ensure that the Schedule reflects current clinical practice. The amendments include the reduction in the 15 minute time unit for services two hours or longer to 10 minutes so that remuneration is more appropriate.

Home dialysis
A new item (13104) has been introduced to allow for the payment of benefits for the planning, management and supervision of patients on home dialysis by consultant physicians. This item is designed to cover one hour of physician time per month, to a maximum of 12 claims per year.

Intensive care
As the insertion and management components of intra-aortic balloons are often provided by different practitioners the items (13845 and 13847) have been amended so that claiming is appropriate. In line with these amendments item 13845 has been deleted.

The item descriptors for 13857, 13879 and 13881, which cover intubation/ventilation, have been amended to clarify that the service includes initiation of the airway access and to separate the process of initiation from the management component, as these can be done by different practitioners. In line with these amendments item 13879 has been deleted.

The items in subgroup 10 (with the exception of item 13881) have been amended to clarify that these services are to be provided by specialists or consultant physicians who are "immediately available and exclusively rostered for intensive care".

Prostate brachytherapy
Following changes in the tumor classification introduced by the American Joint Committee on Cancer in 2002, and items 15338 and 37720 have been amended to clarify the tumour stages.

Cardiothoracic surgery
The cardiothoracic section has been restructured to align the Schedule with current clinical practice and to group similar services together. This required the renumbering of 24 items which then necessitated the deletion of the current items and the creation of new numbers in their place.

The references in three items (15360, 15363 and 15541) have been amended to reflect the new item numbers. One item (38390) required amendment to reflect that current clinical practice now involves more than one defibrillation electrode.

A further three items (38450, 38452 and 38473) have been amended to reflect that the procedure is performed via an open surgical approach thus preventing the possibility of the item being claimed when performed via other approaches.

Obstetrics
A new item (16590) has been introduced for the planning and management of a pregnancy that has progressed beyond 20 weeks and would be billed once after 20 weeks and before delivery. The service was originally introduced under a Section 3C Determination of the Health Insurance Act 1973, Ministerial Determination to the GMST as item 15999 but as it is now included in the GMST it has required renumbering to keep the obstetrics section sequential.

Botulinum toxin
Items 18360 to 18368 have been moved into the GMST from a Section 3C Determination. These items were introduced following a review of generic botulinum toxin items in 2002 which identified that claims were being made for indications which had not been approved by the Therapeutic Goods Administration (TGA) and/or were not subsidised under the Pharmaceutical Benefits Scheme (PBS).

Now that TGA approvals have been obtained for all the 3C item indications, the items have been moved into the GMST with restrictions to prevent the extended Medicare safety net operating to subsidise the cost of the drug for these items which is not PBS subsidised.

Two new items (18351 and 18371) have been introduced to cover the treatment of blepharospasm and hemifacial spasm by Dysport. These indications recently received TGA approval and are expected to gain PBS approval in the future.

Sentinel node biopsy
Four new items (30299, 30300, 30302 and 30303) have been introduced for sentinel lymph node

biopsy, which is a new and less invasive technique for staging the metastatic status of the axillary lymph nodes in primary operable breast cancer and avoids the morbidities associated with complete axillary clearance.

General Surgery
Item 30024 has been introduced to cover claims for extensively infected post-surgical incisions and Fournier's Gangere. These items have previously been incorrectly claimed under item 30023 which was originally introduced to cover traumatic wound debridement rather than debridement of infected surgical wounds.

Items 31205 through 31403 have been revised to reflect current clinical practice. Item 31340 has been amended to include cross references to all items in the range of 31255 to 31355 which will correct an oversight from their introduction in the May 2005 supplement. The descriptors of items 31350 and 31355 have been amended to define the term soft tissue. The descriptors of items 31205 to 31330 and 31345, 31346, 31400 and 31403 have been amended to better define the size of lesions being removed.

Sacral nerve stimulation
A number of items (32213, 32214, 32215, 32216, 32217 and 32218) have been introduced to cover the stages within a new therapeutic procedure -sacral nerve stimulation for faecal incontinence. The procedure is contraindicated in all patients under 18 years of age; and in patients 18 years of age or older, who:

- are medically unfit for surgery;
- are pregnant or planning pregnancy;
- have irritable bowel syndrome;
- have congenital anorectal malformations;
- have active anal abscesses or fistulas;
- have anorectal organic bowel disease – including cancer;
- have functional effects of previous pelvic irradiation;
- have congenital or acquired malformations of the sacrum; or
- have had rectal or anal surgery within the previous 12 months.

Accordingly, benefits would not be payable for the treatment of these patients.

Carotid stenting
A new item (35307) has been introduced to allow benefits for carotid percutaneous transluminal angioplasty with stenting. The patient group is defined as those who:

- meet the criteria for CEA (>50% stenosis of carotid artery associated with stroke or transient ischaemic attack or >80% asymptomatic carotid stenosis); and,
- have significant coronary artery disease, severe heart failure, severe pulmonary disease, age greater than 80 years, recurrent stenosis post CEA, high cervical internal carotid lesion (above C2), low common carotid lesion below the clavicle, contralateral carotid occlusion, contralateral laryngeal nerve palsy, tracheostomy, prior radiation therapy of the neck, or radical neck dissection.

Peripheral nerve placement
The item descriptor of item 39138 has been amended to allow the payment of benefits for the placement of up to four peripheral nerve leads. The previous descriptor only allowed for the placement of one lead but supporting evidence by the profession and the device manufacturer demonstrated that there are conditions in which more than one lead is placed on the peripheral nerve.

Plastic and reconstructive surgery
The descriptor for item 45533 has been amended to remove superfluous wording and better reflect current practice.

Paediatric orthopaedic surgery
A number of orthopaedic items have been amended to reflect current clinical practice. The amendment to item 50303 clarifies that payment is once per limb. The amendment to item 50306 allows for procedures where the limb lengthening is greater than 5cm. A fee increase had been applied to items 50349 and 50351 to acknowledge the relative complexity of these items. Item 50350 has been deleted as the procedure is covered by item 50351.

Transvenous Pacing Leads
A new item, 38358 has been introduced for the extraction of chronically implanted transvenous pacing or defibrillator lead or leads. The performance of this procedure is restricted to cardiologists and cardiothoracic surgeons who have undergone specialist training and are willing to participate in an audit program administered by the Cardiac Society of Australia and New Zealand to achieve accreditation for the procedure.

Orthopaedic operations
The descriptors for items 47684, 47687, 47690 and 47693 for treatment of the spine have been amended to remove any confusion that immobilisation must be by callipers for benefits to be payable.