EXPLANATORY STATEMENT

Issued by the Authority of the Minister for Health

Health Insurance Act 1973

Health Insurance Legislation Amendment (2019 Measures No. 1) Regulations 2019

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.

Part II of the Act provides for the payment of Medicare benefits for professional services rendered to eligible persons. Section 9 of the Act provides that Medicare benefits be calculated by reference to the fees for medical services set out in prescribed tables.

Subsections 4(1) and 4AA(1) of the Act provides that regulations may prescribe tables of medical and diagnostic imaging services which set out items of services, the fees applicable for each item, and rules for interpreting the tables. The *Health Insurance (General Medical Services Table) Regulations 2019* (GMST) and the *Health Insurance (Diagnostic Imaging Services Table) Regulations 2019* (DIST) currently prescribe such tables.

Paragraph 10(2)(aa) of the Act provides that Medicare benefits are payable in respect of a service at an amount equal to 100% of the schedule fee if prescribed in regulations. Section 28 of the *Health Insurance Regulations 2018* (HIR) specifies such a table of services.

Purpose

The purpose of the *Health Insurance Legislation Amendment (2019 Measures No. 1) Regulations 2019* (the Regulations) is to amend the GMST, DIST and the HIR from 1 November 2019. Further amendments are made to the GMST from 1 January 2020.

Schedule 1 of the Regulations implement decisions of Government taken in the 2017-18 Budget, 2018-19 Mid-Year Economic and Fiscal Outlook (MYEFO) and the 2019-20 Budget. These changes were recommended by the Medical Services Advisory Committee (MSAC) and the clinician-led Medicare Benefits Schedule Review Taskforce (the Taskforce).

MSAC reviews new medical services or technology and the circumstances under which public funding should be supported by Medicare. The Taskforce is a clinician-led review of all Medicare services to ensure that they reflect current best clinical practice, align with the latest evidence and promote the provision of health services that improve health outcomes.

Schedule 1 of the Regulations will amend the GMST and the DIST to implement the following changes from 1 November 2019:

- Two new positron emission tomography services as recommended by MSAC. These services are for the staging of locally advanced breast cancer, and for the evaluation of suspected local or regional occurrence of breast cancer or suspected metastatic breast cancer.
- Four new interim magnetic resonance imaging services to support future consideration by MSAC. These services are for the diagnosis of breast cancer where other diagnostic imaging

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has proven inconclusive, and for treatment planning where an earlier diagnostic imaging result is inconsistent with the clinical assessment.

- A rule which increases the benefit payable for the first scan on a patient in a residential aged care facility to encourage diagnostic imaging providers to visit such patients to provide mobile skeletal, chest and abdominal x-ray services, as recommended by MSAC.
- Amending existing colonoscopy services to distinguish eligible patient cohorts by appropriate interval screenings, as recommended by the Taskforce.
- Amending the existing regional nerve block and anaesthesia services to reflect contemporary clinical practice and to improve quality of care, as recommended by the Taskforce.

Schedule 1 of the Regulations will also make other policy and consequential changes from 1 November 2019. Part 1 will list eight new video conferencing services for patients in rural and remote areas (as defined by Modified Monash areas 6 to 7) to assist with access to a medical practitioner, as announced by Government in the 2018-19 MYEFO measure *Guaranteeing Medicare — strengthening primary care.* Parts 6 and 7 will implement consequential amendments and clarify policy by making changes to the DIST, GMST and the HIR from 1 November 2019.

Schedule 2 of the Regulations amends the GMST to implement the following changes from 1 January 2020:

- A schedule fee reduction for the urgent after-hours service rendered by other medical practitioners, as announced by Government in the 2017-18 MYEFO under the *Guaranteeing Medicare — Medicare Benefits Schedule Review — response to Taskforce recommendations* measure. This change was recommended by the Taskforce to incentivise after hours providers in metropolitan areas to employ vocationally registered general practitioners.
- Amending the geographic eligibility for MBS items 10991, 64991 and 74991 so that incentives are targeted to current rural and remote areas. This change was announced by Government in the 2018-19 Budget as part of the *A Stronger Rural Health Strategy* measure. In the 2019-20 Budget, the Government announced the change would commence on 1 January 2020 under the *Guaranteeing Medicare — strengthening primary care* measure.

Consultation

The MBS Review is conducted by expert committees and working groups focusing on specific areas of the MBS. The clinical committee reports were released for public consultation to inform the final Taskforce reports and recommendations to Government. The after-hours, anaesthesia and colonoscopy recommendations were informed through public consultation on the reports of the After-Hours Working Group, the Anaesthesia Clinical Committee and the Gastroenterology Clinical Committee.

As part of the MSAC process, consultation was undertaken with professional bodies, consumer groups, the public and clinical experts for applications put forward for consideration.

Implementation Liaison Groups involving professional bodies and clinical experts have also been consulted to inform development of the Regulations.

The Department consulted with stakeholders on key elements and principles of the *A Stronger Rural Health Strategy* measure. This included stakeholders representing general practice

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including the Australian Medical Association, Royal Australian College of General Practitioners and the Australian College of Rural and Remote Medicine.

Details of the Regulations are set out in the Attachment.

The Act specifies no conditions which need to be met before the power to make the Regulations may be exercised.

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

The Regulations will commence the day after this instrument is registered. Schedule 1 of the Regulations commences on 1 November 2019 and Schedule 2 commences on 1 January 2020.

Authority: Subsection 133(1) of the *Health Insurance Act 1973*

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ATTACHMENT

Details of the *Health Insurance Legislation Amendment (2019 Measures No. 1) Regulations 2019*

Section 1 – Name

This section provides that the instrument is the *Health Insurance Legislation Amendment (2019 Measures No. 1) Regulations 2019.*

Section 2 – Commencement

This section provides that sections 1 to 4 commence the day after registration, that Schedule 1 commences on 1 November 2019, and that Schedule 2 commences on 1 January 2020.

Section 3 – Authority

This section provides that the instrument is made under the *Health Insurance Act 1973*.

Section 4 – Schedules

This section provides that each instrument that is specified in a Schedule to this instrument is amended or repealed as set out in the applicable items in the Schedule concerned, and any other item in a Schedule to this instrument has effect according to its terms.

Schedule 1 – Amendments commencing 1 November 2019

- **PART 1 – MEDICAL PRACTITIONER VIDEO CONFERENCING CONSULTATIONS**

This part introduces eight new services (items 2461, 2463, 2464, 2465, 2471, 2472, 2475 and 2478) into the GMST for general practice consultation services provided via video conferencing to patients in rural and remote areas (Modified Monash 6 to 7).

Item [1] – Amendment to subclause 1.2.5(1)
This amends subclause 1.2.5(1) by substituting item 2220 with new item 2478, to include the eight new services (refer to Item [5]). Clause 1.2.5 provides that medical practitioners must personally attend the service which must be performed on a single occasion.

Item [2] – Amendment to paragraph 1.2.5(3)(c)
This amends paragraph 1.2.5(3)(c) to insert the eight new services (refer to Item [5]) after item 2220. Paragraph 1.2.5(3)(c) provides that a personal attendance by a medical practitioner includes a video conferencing consultation.

Item [3] – Amendment to paragraph 1.2.6(4)(c)
This amends subclause 1.2.6(4)(c) by inserting the eight new services after item 2220. Clause 1.2.6 provides that medical practitioners must personally attend the service. This applies regardless if the medical practitioner, or a person on behalf of the medical practitioner, performs the service. Paragraph 1.2.6(4)(c) provides that a personal attendance by a medical practitioner includes a video conferencing consultation.

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Item [4] – New clause 2.20.5
This inserts a new clause 2.20.5 that applies limitations on the eight new services (items 2461, 2463, 2464, 2465, 2471, 2472, 2475 and 2478). Services provided under these items will only apply if the patient is not an admitted patient and if the patient is located within a Modified Monash 6 area or a Modified Monash 7 area.

At the time of the video conferencing attendance, both the patient and the medical practitioner will need to be located at least 15km by road from each other. The patient or the medical practitioner cannot travel to a place to satisfy this requirement. These requirements are consistent with other video conferencing services listed in the GMST.

The patient will also need to have received at least three face-to-face attendances from the medical practitioner providing the video conferencing service in the preceding 12 months. This confirms that the video conferencing attendance services can only be rendered by a medical practitioner with an existing clinical relationship with the patient.

Item [5] – Addition to Group A30 table
This will insert the eight new services (items 2461, 2463, 2464, 2465, 2471, 2472, 2475 and 2478) for the video conferencing services into two new subgroups under Group A30 which is for medical practitioner (including a general practitioner, specialist or consultant physician) telehealth attendances.

Four services (items 2461, 2463, 2464 and 2465) are for services provided by general practitioners. These are inserted into a new subgroup 5, *General practitioner video conferencing consultation attendance for patients in rural and remote areas*.

Four services (items 2471, 2472, 2475 and 2478) are for services provided by medical practitioners who are not general practitioners. These are inserted into new subgroup 6, *Other non-referred video conferencing consultation attendance for patients in rural and remote areas*.

The eight new services have the same clinical requirements, including time, as the equivalent face-to-face attendance services for general practitioners (items 3, 23, 36 and 44) and for medical practitioners who are not general practitioners (items 52, 53, 54 and 57). As with the equivalent face-to-face services, the schedule fee for the four general practitioners services (items 2461, 2463, 2464 and 2465) will continue to be higher than the medical practitioner services (items 2471, 2472, 2475 and 2478).

- **PART 2 – BREAST CANCER SERVICES**

This part introduces two new fluorodeoxyglucose positron emission tomography (FDG PET) services and four new magnetic resonance imaging (MRI) services into the DIST. These services are for the diagnosis and management of patients with breast cancer. This part includes additional minor amendments to other MRI services.

Item [6] – New items 61524 and 61525
This introduces two new services (items 61524 and 61525) for FDG PET for two cohorts of patients who are likely to be candidates for active cancer treatment.

Item 61524 provides support for patients who have locally advanced (Stage III) breast cancer.

Item 61525 provides support for patients who are suspected of having local or regional recurrence or a metastatic spread of the carcinoma.

Both of these services can only be requested by a specialist or consultant physician, and will be subject to the PET requirements set out in Division 2.4 of the DIST.

Item [7] – Amendment to items 63487 to 63490 and new items 63531 to 63534
This item amends four MRI services (items 63487 to 63490) and introduces four new MRI services (items 63531 to 63534).

Items 63487 and 63488 are amended to clarify that the services are for a MRI scan of both breasts.

Items 63487 to 63490 are amended to align the service descriptor with other MRI service descriptors by removing the specification that the services need to be performed under the supervision of an eligible provider at an eligible location, and that the patient is to be referred by a specialist or consultant physicians. These requirements are provided in Division 2.5.1 of the DIST and do not need to be specified in the service descriptor for these items.

The four new services (items 63531, 63532, 63533 and 63534) are for breast MRI services for two patient cohorts.

Items 63531 (K) and 63532 (NK) will provide a MRI service for patients with suspected breast cancer who have had inconclusive results from conventional imaging and are unable to have a biopsy.

Item 63533 (K) and 63534 (NK) will provide a MRI service for patients with breast cancer who have a discrepancy between the clinical examination of the extent of the cancer and the results of the conventional imaging. These patients will be able to access the new MRI services where the use of the MRI may alter treatment planning.

The four MRI services will only be able to be requested by a specialist or consultant physician, and will be subject to the usual MRI requirements set out in Division 2.5 of the DIST. The services will be able to be performed with contrast item 63491 and with anaesthesia.

All services listed in the DIST, excluding Positron Emission Tomography services, have two different Schedule Fee levels: ‘K’ items (100% of the Schedule Fee) and ‘NK’ items (50% of the Schedule Fee). The benefit amount is determined by the age of the equipment used to provide the service and is known as capital sensitivity. Capital sensitivity encourages service providers to upgrade and replace (as appropriate) old equipment with the aim of improving the delivery of quality of diagnostic imaging services. Clause 1.2.1 of the DIST sets out the application of (K) and (NK) items.

- **PART 3 – RADIOLOGY SERVICES FOR PATIENTS IN RESIDENTIAL AGED CARE FACILITIES**

This part implements a schedule fee increase into the DIST to encourage diagnostic imaging providers to perform certain mobile x-ray scans for patients in residential aged care facilities.

Item [8] – New clause 2.3.2A

This introduces a new clause 2.3.2A *Increased fee for service rendered using first eligible X-ray procedure carried out during attendance at residential aged care facility*. This provides that an eligible skeletal, chest or abdominal X-ray service will have its schedule fee increased by $73.65 in addition to the schedule fee amount listed in the relevant service, if a person provides a diagnostic imaging procedure (a scan) for one or more patients who are care recipients in a residential aged care facility. The service fee will only be applicable for the first patient who is seen at the residential aged care facility during the attendance. Clause 2.3.1 specifies who will be able to provide this service.

Item [9] – New definitions
This inserts three new definitions to *Clause 3.1 – Dictionary* of the DIST to provide the meaning of *care recipient, eligible X-ray procedure* and *residential aged care facility*.

The meaning of *care recipient* is the same as in the GMST, which is a person receiving residential care under section 21-2 of the *Aged Care Act 1997* (ACA). Under the ACA, a person is eligible to receive residential care if they have physical, medical, social or psychological needs that require the provision of care which can be appropriately met through residential care services, and if the person meets relevant criteria specified in the Approval of Care Recipients Principles.

The meaning of an *eligible X-ray procedure* will be a diagnostic imaging procedure used in rendering a service to which at least one of the following specific items applies:

- A service provided under X-ray items 57509, 57515, 57521, 57527, 57530, 57533, 57539, 57703, 57705, 57709, 57711, 57712, 57714, 57715, 57717, 58521, 58523, 58524, 58526, 58527, 58529 or 57536. A service under these items would generally relate to a patient who has experienced a fall.
- A service provided under X-ray items 58503 or 58505 if pneumonia or heart failure is suspected.
- A service provided under X-ray items 58903 or 58905 if acute abdomen or bowel obstruction is suspected.

The meaning of *residential aged care facility* is the same as in the GMST, which is a facility where residential care, as defined in section 41- 3 of the ACA, is provided. Under the ACA, residential care is personal care or nursing care (or both) that is provided to a person who resides in a residential facility with appropriate staffing, meals and cleaning services, and furnishings, furniture and equipment for the provision of care and accommodation. Any other requirements specified in the Subsidy Principles are also to be met. Residential care does not include care provided in the person's private home, in a hospital or psychiatric facility, or in a facility that primarily provides care to people who are not frail or aged.

- **PART 4 – COLONSCOPY SERVICES**

This part implements changes to the GMST for colonoscopy services to distinguish the eligible patient cohorts by the appropriate interval screening.

Item [10] and Item [11] - Clause 2.46.14
These make consequential amendments to the heading of clause 2.46.14 and to the clause itself by omitting reference to items 32090 and 32093. Items 32090 and 32093 will be repealed and will no longer apply to the clause (refer to Item [13]).

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Clause 2.46.14 provides that a second service can be claimed under the specified item if it is provided under a second episode of anaesthesia or other sedation.

Item [12] – Amend items 32084 and 32087
This makes a consequential amendment to the descriptors of items 32084 and 32087 by omitting reference to items 32090 or 32093, and including reference to new items 32222 to 32228. This change will provide that new items 32222 to 32228 cannot be claimed with a service associated with items 32084 or 32087. Items 32090 and 32093 will be repealed and will no longer be applicable (refer to Item [13]).

Item [13] – Repeal items 32088, 32089, 32090 and 32093
This repeals four colonoscopy services (items 32088, 32089, 32090 and 32093) which are being replaced with eight new services (items 32222 to 32229 – refer to item [14]).

Item [14] – New services (items 32222, 32223, 32224, 32225, 32226, 32227, 32228 and 32229)
This will introduce eight new colonoscopy services (items 32222, 32223, 32224, 32225, 32226, 32227, 32228 and 32229). The new services replace four existing colonoscopy services (items 32088, 32089, 32090 and 32093 – refer to item [13]) to better distinguish eligible patient cohorts and appropriate screening intervals.

Items 32222, 32223, 32224, 32225, 32226, and 32228 are diagnostic items. Item 32229 can be performed in conjunction with the diagnostic items if one or more polyps are removed as part of the colonoscopy. Item 32227 is a distinct therapeutic colonoscopy service for the treatment of bleeding or for the treatment of colonic strictures with balloon dilatation.

- **PART 5 – ANAESTHESIA SERVICES**

This part implements changes to the GMST for anaesthesia services to better reflect modern clinical practice.

Item [15] – Amendment to item 11507
This makes a consequential amendment to the descriptor of items 11507 by removing reference to item 22018. Item 22018 will be repealed and will no longer apply (refer to Item [45]).

Item [16] – Amendment to item 11508
This makes a consequential amendment to the descriptor of items 11508 by substituting “peri-operative” with “perioperative” which better reflects Australian medical terminology.

Item [17] – Amendment to item 11512
This makes a consequential amendment to the descriptor of items 11512 by removing reference to item 22018. Item 22018 will be repealed and will no longer apply (refer to Item [45]).

Item [18] – Amendments to items 18216, 18219, 18226 and 18227
This amends items 18216, 18219, 18226 and 18227 respectively by inserting “combined spinal epidural” after “Intrathecal”. This change will enable these services to be performed by the combined spinal epidural (CSE) technique, which is the intentional injection of drug into the subarachnoid space and the placement of a catheter into the epidural space as part of the same procedure. The advantage of the CSE is that neuraxial block can be achieved rapidly using the spinal component while the epidural catheter can be used to prolong or modify the block. The benefits of using CSE to provide analgesia in labour include the rapid onset of pain relief

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compared with a conventional epidural technique (particularly in late labour) and maintenance of the ability to ambulate.

Item [19] – New item 18297
This introduces a new service (item 18297) for assistance at the administration of an epidural blood patch. Currently, epidural blood patch is provided for under item 18233. Item 18297 will allow for the assistance by another medical practitioner.

Items [20], [21], [22] and [23] – Amendments to clauses 2.45.1 and 2.45.2
These make consequential amendments to subclauses 2.45.1(1), 2.45.1(2), 2.45.1(3) and clause 2.45.2 by replacing item 22001 with item 22002. Item 22001 will be removed (refer to item [42]) and will no longer apply. Item 22002 will be amended (refer to item [43]).
Subclause 2.45.1(1) sets the schedule fee for item 25025. Subclause 2.45.1(2) sets the schedule fee for item 25030. Subclause 2.45.1(3) sets the fee for item 25050. Clause 2.45.2 sets the schedule fee for items 25200 and 25205.

Item [24] – Amendment to item 20142
This reduces the schedule fee for item 20142 from $120.60 to $100.50. This reduces the relative value units from six units to five units in recognition that cataract surgery is less complex than when this item was introduced in 2001.

Item [25] – Amendment to items 20144 and 20145
This reduces the schedule fee for items 20144 and 20145 from $160.80 to $140.70. This reduces the relative value units from eight units to seven units in recognition that both corneal transplants (item 20144) and vitrectomy (item 20145) are less complex than when these items were introduced in 2001.

Item [26] – Amendment to item 20160
This amends the descriptor of item 20160 to clarify that it is for intranasal procedures. The service provided under this item is for the management of anaesthesia for procedures on the nose or accessory sinuses.

Item [27] – Amendment to item 20162
This amends the descriptor of item 20162 to clarify that the service is for intranasal surgery for malignancy or ablation. The service provided under this item is for the management of anaesthesia intranasal surgery for malignancy or ablation, as opposed to the management of anaesthesia for radical surgery on the nose and accessory sinuses.

Item [28] – Amendment to item 20410
This reduces the schedule fee for item 20410 from $100.50 to $80.40. This reduces the relative value units from five units to four units in recognition that electrical conversion of arrhythmias should be about the same unit value as for electroconvulsive therapy.

Item [29] – Repeal item 20705
This repeals item 20705. Item 20705 provided for initiation of anaesthesia for diagnostic laparoscopy procedures in the upper abdomen. It is no longer required as the initiation of anaesthesia for diagnostic laparoscopy procedures in the upper abdomen can be performed under item 20706.

Item [30] – Amendment to item 20706

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This amends the descriptor of item 20706 to include laparoscopic cholecystectomy as a technique for laparoscopic procedures in the upper abdomen. A laparoscopic cholecystectomy is surgery during which the gallbladder is removed.

Item [31] – Amendment to items 20745 and 20750
This amends items 20745 and 20750.

Item 20745 will be amended to include endoscopic retrograde cholangiopancreatography. This is an endoscopic procedure that allows for examination of the pancreatic and bile ducts. The fee will increase from $120.60 to $140.70 to account for the inclusion of this procedure.

Item 20750 will be amended to specify that the item is for hernia repair(s) to the upper abdominal wall. The fee for the item will increase from $80.40 to $100.50.

Item [32] – Amendment to item 20790
This amends item 20790 to clarify that the service is also for open cholecystectomy or laparoscopic assisted nephrectomy. The service provided under this item is for the management of anaesthesia for procedures within the peritoneal cavity in upper abdomen.

Item [33] – Repeal item 20805
This repeals item 20805. Item 20805 provided for initiation of anaesthesia for diagnostic laparoscopy procedures of the lower abdomen. It is no longer required as the initiation of anaesthesia for diagnostic laparoscopy procedures in the lower abdomen can be performed under item 20806.

Item [34] – Amendment to item 20840
This amends the descriptor of item 20840 to specify that this item is for open procedures in the peritoneal cavity in the lower abdomen.

Item [35] – Amendment to item 20902
This amends the descriptor of item 20902 to specify that the item should be used for procedures involving surgical haemorrhoidectomy, but not for the banding of haemorrhoids.

Item [36] – Repeal item 20953
This repeals item 20953. Item 20953 provided for initiation of anaesthesia for endometrial ablation or resection in association with hysteroscopy and is no longer required as the service is covered by other anaesthetic services.

Item [37] – Amendment to item 21922
This reduces the schedule fee for item 21922 from $140.70 to $120.60. This reduces the relative value units from seven units to six units in recognition that anaesthesia for scanning is less complex now than when the item was introduced in 2001.

Item [38] – Amendment to item 21926
This reduces the schedule fee for item 21926 from $100.50 to $80.40. This reduces the relative value units from five units to four units in recognition that anaesthesia for fluoroscopy is less complex now than when the item was introduced in 2001.

Item [39] – Repeal item 21927

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This repeals item 21927. Item 21927 is for anaesthesia for barium enema or other opaque study of the small bowel and is no longer required as the service is covered by other anaesthetic services.

Item [40] – Amendment to item 21936
This reduces the schedule fee for item 20193 from $120.60 to $100.50. This reduces the relative value units from six units to five units in recognition that anaesthesia for two dimensional real time transoesophageal examination is less complex now than when the item was introduced in 2001.

Item [41] – Amendment to item 21952
This amends the descriptor of item 21952 to specify that the item should be used for procedures involving diagnostic muscle biopsy to assess for malignant hyperpyrexia.

The schedule fee for the item will also be amended from $201.00 to $80.40. This reduces the relative value units from ten units to four units in recognition that the modern surgical and anaesthesia approach to this service has made it much less complex, justifying a reduction to four units.

Item [42] – Repeal item 22001
This repeals item 22001. Item 22001 is for collecting the patient's own blood and re-injecting it later, during and after surgery, including when the patient is under anaesthesia. This service is no longer required as blood transfusion is covered under item 22002.

Item [43] – Amendment to item 22002
This amends the descriptor of item 22002 to restrict the administration of blood or bone marrow to homologous transfusions only.

Item [44] – Amendment to items 22012 and 22014
This amends items 22012 and 22014 to specify that these items can only be claimed for patients deemed to be high risk.

A service under item 22012 will be able to be performed on a patient who is categorised as having a high risk of complications, or who develops a high risk of complications during the procedure in association with the administration of anaesthesia.

A service under item 22014 will be able to be performed on a patient who is categorised as having a high risk of complications or develops a high risk of complications during the current procedure, and who has already undergone on the day, another procedure in association with which monitoring of that type of blood pressure to which item 22012 applies was performed.

Item [45] – Repeal item 22018
This repeals item 22018. Measurement of the mechanical or gas exchange function of the respiratory system is something that is incorporated into all modern anaesthesia machines and forms the basis of daily practice in anaesthesia therefore an additional item for this is unnecessary in contemporary practice. Arterial blood gas analysis for assessment of metabolic and respiratory function is commonly used in conjunction with arterial cannulation (item 22025) so is not necessary to be included here.

Item [46] – Amendment to item 22025

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This amends item 22025 to specify that the service can only be claimed for patients deemed to be high risk.

A service under item 22025 will be able to be performed on a patient who is categorised as having a high risk of complications or develops a high risk of complications during the procedure where anaesthesia is administered.

Item [47] – Amendment to items 22031 and 22036
This amends items 22031 and 22036 to update the descriptor to substitute "post operative" with "post-operative" to align with the definition within the Act.

Item [48] – Repeal items 22040, 22045 and 22050 and introduce items 22041 and 22042
This repeals items 22040, 22045 and 22050 and substitutes with new items 22041 and 22042.

The service under item 22041 is for the introduction of a plexus or new block that is proximal to the lower leg or forearm, for post-operative pain management. New item 22041 will consolidate services which are currently available under items 22040, 22045 and 22050.

New item 22042 is for the introduction of a regional or field nerve block performed via retrobulbar, peribulbar or sub-Tenon's block injection of an anaesthetic agent, or other complex eye block, when administered by an anaesthetist perioperatively.

Item [49] – Repeal item 22070
This repeals item 22070. Item 22070 is for cardioplegia and in modern anaesthesia practice there is no requirement for this to be a separate service.

Item [50] – Repeal items 23021 to 23083 and introduce new items 23025 to 23085
This repeals 21 anaesthesia items 23021 to 23083 and replaces them with seven new items (23025, 23035, 23045, 23055, 23065, 23075 and 23085). This changes the time component from a five minute to a fifteen minute block but does not affect the schedule fee.

Item [51] – Amendment to item 25015
This amends the descriptor item 25015 by changing the age parameters from patients who are less than 12 months or 70 years and older, to patients who are aged 3 years or less or at least 75 years old. This change will better reflect the anaesthesia complexities of these patients. Modifying items allow anaesthetists to claim items that reflect the patient's physical status and the resulting increase in complexity of the anaesthesia. This includes patients who meet specific age requirements, have complex systemic disease or who "require immediate treatment without which there would be significant threat to life or a body".

Items [52] and [53] – Amendment to items 33845 and 50330
This amends items 33845 and 50330 to update their descriptors to substitute "post operative" with "post-operative" to align with the terminology within the Act.

- **PART 6 – ADMINISTRATIVE REVIEW**

Subsection 4AA(1) of the Act provides that regulations may prescribe a table of diagnostic imaging services which sets out items of diagnostic imaging services, the fees applicable for each item, and rules for interpreting the table. Subdivision A of the DIST sets out the capital sensitivity arrangements to encourage service providers to upgrade and replace old diagnostic imaging equipment with the aim of improving the quality of diagnostic imaging services.

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Clause 1.2.1 establishes that a service which is rendered on equipment beyond the *new effective life age* or *maximum extended life age* (if the equipment has been upgraded) applies to an (NK) item. These services are given a reduced benefit in comparison to an equivalent service done on newer equipment (a service to which a 'K' item applies).

Clause 1.2.3 provides exemptions from the capital sensitivity provisions. Subclause 1.2.3(4) provides that the Secretary may grant exemptions in respect of diagnostic imaging equipment in inner regional areas, where the equipment is operated on a rare and sporadic basis, and provides crucial patient access to diagnostic imaging services. The decision under subclause 1.2.3(4) is a discretionary decision and is reviewable by the Secretary or her delegate who is an SES employee or an acting SES employee. In circumstances where the Secretary refuses to grant an exemption from the capital sensitivity provisions, clause 1.2.4 allows a proprietor to seek a reconsideration of the decision.

Part 6 of the Regulations amends the capital sensitivity exemption provisions from 1 November 2019 to allow an external merits review by the Administrative Appeal Tribunal (AAT). Where an applicant has sought reconsideration of a decision not to grant an exemption under subclause 1.2.3(4), and the Secretary has subsequently upheld the original decision under clause 1.2.4 on or after 1 November 2019, an application may be made to the AAT for a review of the decision. The AAT application may be made by, or on behalf of, a person whose interests are affected by the decision.

As Part 6 complements and is ancillary to Subdivision A of the DIST, the amendments in Part 6 are supported by the necessary or convenient regulation making power under subsection 133(1) of the Act for carrying out or giving effect to section 4AA of the Act.

Item [54] – Amendment to subclause 1.2.3(3)
This amends subclause 1.2.3(3) of the DIST to clarify that an (NK) item does not apply to a service until:

- after the time to apply to the AAT for review has expired; or
- if the matter is under review by the AAT, once the applicant is notified of the AAT decision.

A note is inserted to clarify that the time for making an application for review is set out in paragraph 29(1)(d) and subsection 29(2) of the *Administrative Appeals Tribunal Act 1975*.

Item [55] – New clause 1.2.4A
This introduces a right of appeal to the AAT if the Secretary has upheld a decision, made on or after 1 November 2019, not to grant a capital sensitivity exemption on reconsideration under clause 1.2.4. The AAT application may be made by, or on behalf of, a person whose interests are affected by the decision.

- **PART 7 – MISCELLANEOUS AMENDMENTS**

This part introduces minor policy and machinery amendments to the DIST, GMST and HIR.

Item [56] – Amendment to clause 2.3.1 of the DIST
This amends clause 2.3.1 of the DIST to better reflect the intention of the clause through updated drafting.

Clause 2.3.1 was introduced on 1 November 2012 to define who must perform a diagnostic imaging procedure involved in x-ray, angiography and fluoroscopy services.

This clause sets out that only appropriately qualified health practitioners including medical practitioners, medical radiation practitioners and dental practitioners (only for certain items) will be able to perform these services in metropolitan areas and inner regional areas (other than any RRMA 4 and RRMA 5 areas of the inner regional classification). Diagnostic radiology procedures in regional, rural or remote areas must be performed by a medical practitioner; or a person, other than a medical practitioner, who provides the service under the supervision of a medical practitioner in accordance with accepted medical practice.

Item [57] – Repeal clause 2.3.1 of the GMST
Clause 2.3.1 of the GMST provides that under certain circumstances general practitioners are required to use items under Group A2 rather than items under Group A1. It commenced on 1 November 2008 in the *Health Insurance (General Medical Services Table) Regulations 2008* to create a cohort of general practitioners who, for the purpose of items in Group A2, were:

- subject to a final determination from the Professional Services Review (PSR) Determining Authority under section 106TA of the Act; and
- the determination contained a direction that the practitioner be disqualified for a specified period in respect of a service to which an item in Group A1 applies under paragraph 106U(1)(g) of the Act.

Paragraph 106U(1)(g) of the Act provides that the PSR Determining Authority may disqualify a practitioner from providing 'specified services' or 'services other than specified services'. A function of the PSR is to sanction general practitioners found to have engaged in inappropriate practice. A possible sanction is partial disqualification from rendering certain Medicare services. Clause 2.3.1 provided that where a general practitioner was disqualified from using Group A1 Medicare items, they could use the lower Medicare benefit items in A2 items (usually reserved for medical practitioner without vocational recognition) to continue to participate in Medicare during the period of their partial disqualification.

This amendment repeals clause 2.3.1 of the GMST. This clause is no longer required due to a new definition of when a practitioner is partially disqualified, which will cover general practitioners under these circumstances (refer to items [58] and [75]).

Item [58] – Amendment to eight A2 services
This amends the descriptor of eight A2 services (items 52, 53, 54, 57, 58, 59, 60 and 65) by omitting reference to clause 2.3.1 and substituting with a reference to the new definition of 'a Group A1 disqualified practitioner', as defined in clause 3.1 of the GMST (refer to Item 75]). These are consequential changes in relation to the repeal of clause 2.3.1 (refer to Item [57]).

Item [59] – Amendment to items 90092, 90093, 90095 and 90096
This amends the descriptor of four attendance items provided by omitting the rendering cohort of doctors in paragraphs (a) and (b) and substituting with "by a medical practitioner who is not a general practitioner".

Item [60] - Amendment to item 12205
This amends sleep study item 12205 to clarify that additional patient cohorts will be able to access this service. This includes patients who have had a suboptimal response to a therapeutic

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or procedural intervention, and patients with uncertainty regarding control of sleep-related disordered breathing.

Item [61] – Amendment to item 12207
This amends sleep study item 12207 to clarify the clinical intent of the term "cardio-respiratory failure". The term 'cardio-respiratory failure' will be changed to 'respiratory failure' as this term refers to either 'cardio' or 'respiratory' failure. The word 'cardio' will be removed given patients with severe respiratory failure have at least a degree of cardiac failure, and patients with pure cardiac failure do not have an exceptional need for this investigation.

Items [62], [63], [64] and [65] – Amendment to items 30075, 30078, 30275, 30329, 30330, 35551, 35664 and 35670
These amendments update "lymph gland/s" references to "lymph node/s" in the descriptor of items 30075, 30078, 30275, 30329, 30330, 35551, 35664 and 35670. For these services, the correct anatomical term is 'lymph node/s' as 'lymph gland/s' are neither endocrine nor exocrine glands.

Item [66] – New item 41501
This introduces a new service (item number 41501) for a stroboscopy, which will better describe the procedure and ensure compliance. This service will be for the examination of glottal cycles and vibratory characteristics of the vocal folds, using videostroboscopy, for the diagnosis, or for treatment effectiveness where there is failure to progress or respond, for:

- dysphonia, if non-stroboscopic techniques of visualising the larynx have failed to identify any frank abnormality of the vocal folds; or
- benign vocal fold lesions; or
- premalignant or malignant laryngeal lesions; or
- vocal fold motion impairment or glottal insufficiency; or
- evaluation of vocal fold function after treatment or phonosurgery.

Item [67] – Repeal item 41846
This will repeal item 41846. Item 41846 is no longer required as item 41501 will cover stroboscopy services (refer to item [66]).

Item [68] – Amendment to item 45626 and new item 45627
This will allow more accurate data to be captured on trachoma-related ectropion or entropion surgery.

Existing item 45626 is amended for the correction of an ectropion or entropion condition to distinguish that the condition was not caused by trachoma.

New item 45627 is for the correction of an ectropion or entropion condition, which distinguishes that the condition was caused by trachoma.

Items [69] and [70] – Amendment to Clause 2.46.25
These make amendments to the heading of clause 2.46.25 and to the clause itself by omitting references to items 51113 and 51114.

Clause 2.46.25 restricts spinal surgery items in subgroup 17 (51011 to 51171) from being co-claimed with any other item in group T8, if the purpose of the other procedural item is to perform spinal surgery.

This amendment enables spinal surgery items 51113 and 51114 to be performed with the paediatric scoliosis item numbers (items 50600 to 50644) in appropriate circumstances. This will benefit paediatric patients with significant spine deformity who require a combination of paediatric and adult spinal surgery procedures.

Item [71] – Amendment to items 51051, 51052 and 51053
This amends spinal surgery items 51051, 51052 and 51053 to reference the correct anatomical clarification term and to enable the services to be provided appropriately.

Services provided under these items are for the performance of operations to correct certain deformities of the spine. The term 'motion segment' will be replaced with the correct clinical term 'vertebra' (plural is 'vertebrae'), which will clarify that patients with a stooped spine can access interbody fusion of the disc space proximal and distal to the osteotomy. The amendment allows interbody fusion of the disc space proximal and distal to the osteotomy (fusing adjacent vertebrae in the anterior column), where appropriate.

Item [72] – Amendment to items 51061 to 51066
This amends the descriptor of items 51061 to 51066 by replacing the term "Spine fusion" with the correct term "Spinal fusion" to more accurately define this term.

Item [73] – Amendment to item 51145
This amends item 51145 to allow a second medical practitioner to be remunerated for providing assistance at the operation. This service is for wound debridement following spinal surgery and assistance is generally required as extensive dissection is frequently required during this procedure.

Item [74] – Amendment to Item 52027
This updates the reference of "lymph gland/s" to "lymph node/s" in the descriptor of item 52027. The correct anatomical term is 'lymph node/s' as 'lymph gland/s' are neither endocrine nor exocrine glands.

Item [75] – New Dictionary Term
This inserts a definition of what a disqualified practitioner is in relation to Group A1 items in *Clause 3.1 – Dictionary* of the general medical services table. The definition is being inserted to replace the function of clause 2.3.1 which is being repealed (refer to item [57]).

Paragraph (b) of the definition continues to cover general practitioners who have been the subject of a final determination under section 106TA of the Act, and the determination contained a direction that the general practitioner be disqualified for a specified period in respect of a service to which an item in Group A1 applies under paragraph 106U(1)(g) of the Act. This is consistent with the current cohort of general practitioner in clause 2.3.1 of the GMST.

Paragraph (a) of the definition includes a new cohort of general practitioners who are partially disqualified. These general practitioners are disqualified for a specified period in respect of a service to which an item in Group A1 applies as a result of an agreement with the Director of the Professional Services Review under section 92 of the Act. From 1 November 2019, this cohort of partially disqualified practitioners will be able to render the A2 items (refer to item [58]).

This amendment ensures that general practitioners who have been partially disqualified from rendering a Group A1 service as a result of Professional Services Review process will have

access to Medicare items in Group A2 during the period of disqualification.

Item [76] – Amend non-medicare service
This amends the definition of *non-medicare service* in the GMST to include extracorporeal magnetic innervation (ExMI). ExMI is a non-surgical therapy primarily used for the treatment of incontinence. The efficacy of ExMI has yet to be assessed through a health technology assessment process for its safety, effectiveness and cost-effectiveness. This change will explicitly restrict the payment of Medicare benefits for consultation services provided with, or in connection to, ExMI.

Items [77], [78], [79], [80] and [81] – Amendment to subsection 28(1) of the HIR
Item [77] amends the note with a generic note to stipulate that some services are specified in a determination made under section 3C of the Act. This note will encapsulate all items that are specified in a determination.

Items [78] to [81] will prescribe items in section 28 of the HIR, which will enable the Medicare benefit to be set at 100% of the schedule fee for the items.

Items [78] and [79] insert heart health assessment items 177 and 699. These services are listed in the *Health Insurance (Section 3C General Medical Services – Heart Health Assessment No.2) Determination 2019*.

Item [80] inserts the eight new general practice attendance items via videoconference in rural and remote areas (2461, 2463, 2464, 2465, 2471, 2472, 2475, 2478), which are being inserted by amendment item [5] of the Regulations.

Item [80] will also prescribe four new attendance items (2480, 2481, 2482, 2483) which will provide an equivalent service for services rendered by medical practitioners in rural and remote areas. These services will commence from 1 November 2019 per the *Health Insurance (Section 3C General Medical Services – General Practice Telehealth Services) Amendment Determination (No. 2) 2019*.

Item [81] inserts 22 new eating disorders items (items 90250, 90251, 90252, 90253, 90254, 90255, 90256, 90257, 90264, 90265, 90271, 90272, 90273, 90274, 90275, 90276, 90277, 90278, 90279, 90280, 90281 and 90282). These services will commence from 1 November 2019 per the *Health Insurance (Section 3C General Medical Services – Eating Disorders Treatment Plan and Psychological Treatment Services) Determination 2019*.

Schedule 2 – Amendments commencing 1 January 2020

- **PART 1 – AFTER-HOURS SERVICES**

Item [1] reduces the schedule fee for urgent after hours item 591 in the GMST from $101.60 to $91.45. Item 591 is rendered by medical practitioners working in general practice without vocational training (known as ‘other medical practitioners’).

In the 2017-18 Mid-Year Economic and Fiscal Outlook, the Government announced changes to urgent after-hours services under the *Guaranteeing Medicare — Medicare Benefits Schedule Review — response to Taskforce recommendations* measure. In March 2018, the *Health Insurance Legislation Amendment (After Hours Services) Regulations 2018* implemented the first phase of the changes by restructuring the items to reduce the fees for urgent after-hours

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services rendered by other medical practitioners. This change will implement the second phase of this measure.

Item 591 was indexed by 1.6% on 1 July 2019 from $100.00 to $101.60. The amended fee incorporates the initial reduction of $10 from the schedule fee of item 591 prior to indexation ($100 minus $10 which equals $90), and applies indexation of 1.6% to the $90 fee. This comes to the new amended fee of $91.45. This is in line with Government's policy in relation to indexation and changes to urgent after-hours items.

- **PART 2 – BULK-BILLING**

Regulation amendments under Part 2 update the geographical eligibility criteria for general practitioner (GP) bulk billing incentive items 10991, 64991 and 74991. This change is part of the *A Stronger Rural Health Strategy* and is to ensure that bulk billing incentives are correctly targeted to rural and remote areas. The geographic eligibility criteria will be updated to Modified Monash Model remoteness classification 2 to 7.

Items [2] and [3] – Amendment to clause 2.34.1
Item [2] inserts a new definition of *designated area*. This definition is identical to the current definition of *eligible area* in the GMST, which includes regional, rural or remote areas, Tasmania, geographical areas which are included in a list of SSD spatial units, and geographical areas which are included in the SLA spatial unit of Palm Island (AC). This amendment ensures that the current eligibility criteria for item 10992 does not change (refer to item [4] of this Schedule).

Item [3] substitutes the definition of *eligible area* with a new definition that means an eligible area is a Modified Monash area 2 to 7. GP bulk billing incentive items 10991, 64991 and 74991 specify that the service is to be provided in an eligible area.

Item [4] – Amendment to item 10992
This item amends the descriptor of item 10992 by omitting "an eligible area" and substituting with "a designated area". This amendment will enable item 10992 to continue to be claimed in the existing geographical eligible criteria. Item 10992 provides a bulk billing incentive for concessional patients or patients under the age of 16 who receive an after-hours service in "a designated area".

Items [5] and [6] – Updates to clause 3.1 Dictionary of the GMST
Item [5] updates the definition of the Australian Statistical Geography Standard to reference the latest July 2016 edition. This edition will exist as at 1 January 2020 and is published on the Australian Bureau of Statistics' website.

Item [6] inserts a new definition of *designated area* in *Clause 3.1 – Dictionary*. The meaning of *designated area* is given by clause 2.34.1 in Division 2.34 (refer to item [2] of this Schedule).

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Statement of Compatibility with Human Rights

Prepared in accordance with Part 3 of the Human Rights (Parliamentary Scrutiny) Act 2011

Health Insurance Legislation Amendment (2019 Measures No. 1) Regulations 2019

This Disallowable Legislative Instrument is compatible with the human rights and freedoms recognised or declared in the international instruments listed in section 3 of the *Human Rights (Parliamentary Scrutiny) Act 2011*.

Overview of the Determination

The purpose of the *Health Insurance Legislation Amendment (2019 Measures No. 1) Regulations 2019* (the Regulations) is to implement the Government's response to recommendations from the Medical Services Advisory Committee (MSAC) and the clinician-led Medicare Benefits Schedule Review Taskforce (the Taskforce).

MSAC reviews new medical services or technology and the circumstances under which public funding should be supported by Medicare. The Taskforce is a clinician-led review of all Medicare services to ensure that they reflect current best clinical practice, align with the latest evidence and promote the provision of health services that improve health outcomes.

The Regulations will amend the GMST and DIST to implement the changes to the Medicare Benefits Schedule (MBS) from 1 November 2019 and 1 January 2020. Amendments will also be made to the HIR from 1 November 2019.

Human rights implications

The Regulations engage Articles 9 and 12 of the International Covenant on Economic Social and Cultural Rights (ICESCR), specifically the rights to health and social security.

The Right to Health

The right to the enjoyment of the highest attainable standard of physical and mental health is contained in Article 12(1) of the ICESCR. The UN Committee on Economic Social and Cultural Rights (the Committee) has stated that the right to health is not a right for each individual to be healthy, but is a right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.

The Committee reports that the *'highest attainable standard of health'* takes into account the country's available resources. This right may be understood as a right of access to a variety of public health and health care facilities, goods, services, programs, and conditions necessary for the realisation of the highest attainable standard of health.

The Right to Social Security

The right to social security is contained in Article 9 of the ICESCR. It requires that a country must, within its maximum available resources, ensure access to a social security scheme that provides a minimum essential level of benefits to all individuals and families that will enable them to acquire at least essential health care. Countries are obliged to demonstrate that every effort has been made to use all resources that are at their disposal in an effort to satisfy, as a matter of priority, this minimum obligation.

The Committee reports that there is a strong presumption that retrogressive measures taken in relation to the right to social security are prohibited under ICESCR. In this context, a retrogressive measure would be one taken without adequate justification that had the effect of

reducing existing levels of social security benefits, or of denying benefits to persons or groups previously entitled to them. However, it is legitimate for a Government to re-direct its limited resources in ways that it considers to be more effective at meeting the general health needs of all society, particularly the needs of the more disadvantaged members of society.

Analysis

The Regulations will maintain or advance rights to health and social security by ensuring access to publicly subsidised health services which are clinically effective and cost-effective.

Conclusion

The Regulations are compatible with human rights as they maintain the right to health and the right to social security.

Greg Hunt
Minister for Health