EXPLANATORY STATEMENT

Health Insurance Act 1973

Health Insurance Legislation Amendment (2020 Measures No. 3) Regulations 2020

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

Subsection 4(1) of the Act provides that regulations may prescribe a table of general medical services which sets out items of general medical services, the fees applicable for each item, and rules for interpreting the table. The table made under this subsection is referred to as the general medical services table (GMST). The most recent version of the regulations is the *Health Insurance (General Medical Services Table) Regulations (No. 2) 2020.*

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. The table made under this subsection is referred to as the diagnostic imaging services table (DIST). The most recent version of the regulations is the *Health Insurance (Diagnostic Imaging Services Table) Regulations (No. 2) 2020.*

Subsection 4A(1) of the Act provides that regulations may prescribe a table of pathology services which set out items of pathology services, the fees applicable for each item, and rules for interpreting the table. The table made under this subsection is referred to as the pathology services table (PST). The most recent version of the regulations is the *Health Insurance (Pathology Services Table) Regulations 2020*.

For the purposes of paragraph 10(2)(aa) of the Act, section 28 of the *Health Insurance Regulations 2018* (HIR) provides the items that have a benefit equal to 100% of the fee in respect of the service.

Purpose

The purpose of the *Health Insurance Legislation Amendment (2020 Measures No. 3) Regulations 2020* (the Regulations) is to amend the GMST, DIST, PST and HIR from 1 March 2021, and to amend the GMST at the same time as Schedule 1 of the *Health Insurance Amendment (General Practitioners and Quality Assurance) Act 2020* (the GPQA Act) commences.

The Regulations will implement some minor policy changes from the 2020-21 Budget under the *Guaranteeing Medicare – Medicare Benefits Schedule review* measure. The Regulations will also implement minor policy changes which were recommended by the clinician-led Medicare Benefits Schedule (MBS) Review Taskforce (the MBS

Review Taskforce) or the Medical Services Advisory Committee (MSAC). The Regulations will clarify the policy intent of three neurological services to enable assistance to be claimed through Medicare.

The Regulations will also implement several editorial and drafting improvements to better reflect the original policy, which also includes incorporating items from eight legislative instruments which are made under subsection 3C(1) of the Act. Consequential amendments will also be implemented to align with the GPQA Act.

Consultation

A variety of stakeholders were consulted on the proposed changes in the Regulations. Consultation on the changes to the colonoscopy items 32223, 32224 and 32226 was undertaken with the Gastroenterology Society of Australia, the Colorectal Surgical Society of Australia and New Zealand, the Royal Australian College of Surgeons and the Australian Medical Association. This change was announced in the 2020-21 Budget under the *Guaranteeing Medicare – Medicare Benefits Schedule review* measure.

Consultation on the changes to the medical perfusion item 22060 was undertaken with the Australian Medical Association, Australasian Society of Medical Perfusion, Australian Society of Anaesthetists, Private Healthcare Australia, Australian and New Zealand College of Anaesthetists and the Australian College of Rural and Remote Medicine. This change was announced in the 2020-21 Budget under the *Guaranteeing Medicare – Medicare Benefits Schedule review* measure.

Consultation on the changes to the dermatology items 30196 and 30202 was undertaken with the Dermatology and Skin Advisory Group. Consultation on the changes to ophthalmology item 42739 was undertaken with the Royal Australian and New Zealand College of Ophthalmologists.

Consultation on the relocation of eight existing cardiothoracic items for diagnostic and therapeutic procedures was undertaken with the Thoracic Society of Australia and New Zealand and the Australian Society of Otolaryngology, Head and Neck Surgery.

Consultation on the correction of congenital ear deformity item 45658 was undertaken with the Australian Society of Plastic Surgeons.

Consultation on the changes to neurosurgical items 39018, 39109 and 39113 was undertaken with the Neurosurgical Society of Australasia.

Consultation was not undertaken on the incorporation of the legislative instruments which are made under subsection 3C(1) of the Act into the Regulations. However, consultation was undertaken with interested stakeholders at the time the legislative instruments were developed and introduced. No consultation was undertaken on the other amendments, as they are consequential or administrative in nature.

Details of the Regulations are set out in the Attachment.

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

Section 1 to 4 of the Regulations will commence the day after the instrument is registered. Schedule 1, Parts 1 to 9 will commence on 1 March 2021, Schedule 1, Part 10 will commence on 1 January 2021, Schedule 1, Part 11 will commence immediately after the provisions covered by table item 2, and Schedule 1, Part 12 will commence at the same time as Schedule 1 to the *Health Insurance Amendment (General Practitioners and Quality Assurance) Act 2020*.

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

ATTACHMENT

Details of the *Health Insurance Legislation Amendment (2020 Measures No. 3) Regulations 2020*

Section 1 – Name

This section provides for the Regulations to be referred to as the *Health Insurance Legislation Amendment (2020 Measures No. 3) Regulations 2020.*

Section 2 – Commencement

This section provides for Sections 1 to 4 of the Regulations to commence immediately after the instrument is registered, for Schedule 1, Parts 1 to 9 to commence on 1 March 2021, for Schedule 1, Part 10 to commence on 1 January 2021, for Schedule 1, Part 11 to commence immediately after the provisions covered by table item 2, and for Schedule 1, Part 12 to commence at the same time as Schedule 1 to the *Health Insurance Amendment (General Practitioners and Quality Assurance) Act 2020*.

Section 3 – Authority

This section provides that the Regulations are 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

- Part 1 – Colonoscopy services

Part 1 makes minor amendments to the current colonoscopy items 32223, 32224 and 32226 in the GMST to reflect the patient's clinical indications better and to ensure that patients with serrated polyps can access these services at appropriate service intervals. This change was announced by Government in the 2020-21 Budget under the *Guaranteeing Medicare – Medicare Benefits Schedule review* measure.

Item 1 amends the item for an endoscopic examination of the colon to the caecum by colonoscopy (item 32223) to clarify that this service can also be provided for a patient who has had a colonoscopy that revealed 1 or 2 serrated lesions, each of which was less than 10 mm in diameter, and without dysplasia.

Item 2 repeals and replaces the item for endoscopic examination of the colon to the caecum by colonoscopy for a patient who has a moderate risk of colorectal cancer due to a history of adenomas (item 32224). The amended item descriptor removes the history of an advanced serrated adenoma.

The amended item descriptor also includes that the patient has had a previous colonoscopy which revealed one of the following additional indications:

- 1 or 2 sessile serrated lesions, each of which was 10 mm or greater in diameter or with dysplasia; or
- a hyperplastic polyp that was 10 mm or greater in diameter; or
- 3 or more sessile serrated lesions, each of which was less than 10 mm in diameter and without dysplasia; or
- 1 or 2 traditional serrated adenomas, of any size.

Item 3 amends the item for an endoscopic examination of the colon to the caecum by colonoscopy for a patient who has a high risk of colorectal cancer (item 32226) to clarify that this service can also be provided for a patient who has had a previous colonoscopy that revealed:

- 5 or more sessile serrated lesions, each of which was less than 10 mm in diameter and without dysplasia; or
- 3 or more sessile serrated lesions, 1 or more of which was 10 mm or greater in diameter or with dysplasia; or
- 3 or more traditional serrated adenomas, of any size.

- Part 2 – Cardiothoracic procedures

Part 2 makes minor amendments to the GMST to relocate eight existing items for diagnostic and therapeutic procedures of the lung, trachea and bronchus to a different subgroup. This change in subgroup will better reflect the type and nature of these services.

The following item numbers will be repealed and replaced with new item numbers, under *Subgroup 6 – Cardio-thoracic*:

- Item 30696 will become item 38416
- Item 30710 will become item 38417
- Item 41889 will become item 38419
- Item 41892 will become item 38420
- Item 41895 will become item 38422
- Item 41898 will become item 38423
- Item 41901 will become item 38425
- Item 41905 will become item 38426

Item 4 repeals items 30696 and 30710.

Item 5 inserts items 38416 (previously 30696) and 38417 (previously item 30710). This change is administrative in nature and does not change the existing items. Consequential amendments have also been made to the item descriptors to reference the updated item numbers and to clarify that these services cannot be provided with an item in Subgroup 1.

Item 6 inserts items 38419 (previously item 41889) and 38420 (previously item 41892). This change is administrative in nature and does not change the existing items.

Item 7 inserts items 38422 (previously item 41895) and 38423 (previously item 41898). This change is administrative in nature and does not change the existing items.

Item 8 inserts items 38425 (previously item 41901) and 38426 (previously item 41905). This change is administrative in nature and does not change the existing items.

Item 9 repeals items 41889, 41892, 41895, 41898, 41901 and 41905.

- Part 3 – Cardiac services

Part 3 inserts 24 cardiac items (55126, 55127, 55128, 55129, 55132, 55133, 55134, 55137, 55141, 55143, 55145, 55146, 61321, 61324, 61325, 61329, 61345, 61349, 61357, 61394, 61398, 61406, 61410 and 61414) from the *Health Insurance (Section 3C Diagnostic Imaging Services – Cardiac Services) Determination* 2020 into the DIST (refer to items 10 to 24 in the Regulations).

Part 3 also inserts 11 cardiac items (11704, 11705, 11707, 11714, 11716, 11717, 11723, 11729, 11730, 11731 and 11735) from the *Health Insurance (Section 3C General Medical Services – Cardiac Services) Determination 2020* into the GMST (refer to items 25 to 34 in the Regulations).

Items 10 and 11 amend subclause 1.2.21(6) and 1.2.21(8) of the DIST to apply the multiple services rule to echocardiogram services. Clause 1.2.21 applies the multiple services rule which specifies the fee applicable if two or more diagnostic imaging services are rendered on the same patient on the same day.

Item 12 inserts a new subdivision in relation to items that provide transthoracic and stress echocardiogram services.

Clause 2.1.11 provides a list of assessments that services under items 55126, 55127, 55128, 55129, 55133, 55134, 55132 and 55137 must include, to the extent that is possible.

Clause 2.1.12 provides that item 55126, which is for a baseline initial echocardiogram examination, cannot be provided if in the previous 24 months, the patient has a service provided under items 55127, 55128, 55129, 55132, 55133 or 55134.

Clause 2.1.13 outlines provisions that must apply to a service performed under stress echocardiography items 55141, 55143, 55145 and 55146. To ensure these services are provided appropriately, a service under these items cannot be provided if stress echocardiography would not provide adequate information about the patient because of the patient's body habitus, or other physical conditions (including heart rhythm disturbance), or the patient's inability to exercise to the required extent, or if the results of a previous imaging service indicate that a stress echocardiogram service would not provide adequate information.

Clause 2.1.14 provides that a service provided under stress echocardiography items 55141, 55143, 55145 or 55146 can only be provided if the patient displays one or

more symptoms of typical or atypical angina, or one or more indications in relation to suggested cardiac ischemia or valvular pathology, or for patients at intermediate to high cardiovascular risk undergoing pre-operative assessment for high-risk surgery. This provision will ensure that stress echocardiography services are based on the clinical risk of the patient, and that the services are not provided inappropriately.

Clause 2.1.15 provides requirements for the provision of stress echocardiography items. Subclauses 2.1.15(1) to 2.1.15(4) provides that items 55141, 55143, 55145 or 55146 can only be provided if the diagnostic imaging procedure is performed by a person trained in exercise testing and cardiopulmonary resuscitation who is in personal attendance during the procedure, and if a second person who is also trained in exercise testing and cardiopulmonary resuscitation, is located at the diagnostic imaging premise where the procedure is performed and is immediately available to respond at the time the exercise test is performed on the patient.

At least one of these people must be a medical practitioner, and the diagnostic imaging procedure can only be performed on premises equipped with resuscitation equipment, which includes a defibrillator. This will ensure patient safety during a test that can present significant risk and will maximise the results obtained for the purpose of reporting and subsequent treatment.

Subclause 2.1.15(5) provides requirements that an exercise stress echocardiogram and a pharmacological stress echocardiogram must include.

Clause 2.1.16 provides limitations on the provision of items 55141, 55145 and 55146. Item 55141 cannot be provided if in the previous 24 months, the patient had a service under item 55143, 55145 or 55146. Item 55145 cannot be provided if in the previous 24 months, the patient had a service under item 55141, 55143 or 55146. Item 55146 cannot be provided if in the previous 24 months, the patient had a service under item 55143 or 55145.

Clause 2.1.17 provides that if an echocardiographic examination service provided under item 55126, 55127, 55128, 55129, 55132, 55133, 55134 or 55137 or a stress echocardiographic service provided under 55141, 55143, 55145 or 55146 is performed on the same patient on the same day by the same medical practitioner, then the item with the lesser fee will be reduced by 40 per cent of the fee. The reduced fee will be taken to the nearest amount of 5 cents.

Clause 2.1.18 inserts 12 existing stress echocardiography items. This includes eight ultrasound items for an echocardiographic examination of the heart (55126, 55127, 55128, 55129, 55132, 55133, 55134 and 55137) and four ultrasound items that will provide stress echocardiography testing services (55141, 55143, 55145 and 55146).

Item 13 amends clause 2.4.1 in the DIST to reference the subgroups that apply to this clause, as opposed to the item range. Clause 2.4.1 is for the application of nuclear imaging services, other than positron emission tomography (PET) services. This is an administrative change. Clause 2.4.1 is further amended under items 71 and 72 of the Regulations.

Item 14 inserts new clauses in relation to myocardial perfusion study items (61321, 61324, 61325, 61329, 61345, 61349 and 61357) after clause 2.4.1 in the DIST.

Clauses 2.4.1A and 2.4.1B apply to the application of myocardial perfusion study items 61324, 61329, 61345, 61349, 61357, 61394, 61398, 61406, 61410 and 61414. These services can only be provided if the patient displays one or more symptoms of typical or atypical angina, or one or more indications in relation to suggested cardiac ischemia or valvular pathology, or for patients at intermediate to high cardiovascular risk undergoing pre-operative assessment for high-risk surgery. This will ensure that the provision of the stress echocardiography services are based on the clinical risk of the patient, and that the services are not provided inappropriately. The request for a service under these items must identify any symptoms or clinical indications.

Clause 2.4.1C provides that items 61324, 61329, 61345, 61349, 61357, 61394, 61398, 61406, 61410 and 61414 can only be provided if the myocardial perfusion study is performed by a person trained in exercise testing and cardiopulmonary resuscitation who is in personal attendance during the procedure, and if a second person who is also trained in exercise testing and cardiopulmonary resuscitation, is located at the diagnostic imaging premise where the procedure is performed and is immediately available to respond at the time the exercise test is performed on the patient.

At least one of these people must be a medical practitioner, and the myocardial perfusion study can only be performed on premises equipped with resuscitation equipment, which includes a defibrillator. This will ensure patient safety during a test that can present significant risk and will maximise the results obtained for the purpose of reporting and subsequent treatment.

Clause 2.4.1D provides that for patients who are 17 years old or older, items 61321, 61324, 61329, 61345, 61357, 61394, 61398, 61406 or 61414 cannot be provided more than once in 24 months, and item 61325 cannot be provided more than twice in 24 months.

Items 15 to 24 insert 12 existing myocardial perfusion study items (61321, 61324, 61325, 61329, 61345, 61349, 61357, 61394, 61398, 61406, 61410 and 61414).

Item 25 inserts items 11705 and 11731 into subclause 1.2.6(1) of the GMST. Clause 1.2.6 provides that the item applies to a service provided in the course of a personal attendance by a single medical practitioner on a single patient on a single occasion.

Item 26 inserts items 11705 and 11731 into subclause 1.2.7(1) of the GMST. Clause 1.2.7 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.

Item 27 inserts items 11704, 11707, 11714, 11716, 11717, 11723, 11729, 11730 and 11735 into subclause 1.2.11(1) of the GMST. Clause 1.2.11 prescribes a list of items that can be performed on behalf of a medical practitioner by a non-medical

practitioner, providing they are employed by the medical practitioner or perform the service under the supervision of a medical practitioner in accordance with accepted medical practice.

Item 28 inserts new clauses to provide restrictions on the provision of attendance items, which are in Part 2 of the GMST, on the same day as certain cardiac services are performed.

Clause 1.2.13 provides that an attendance service cannot be provided by a specialist or consultant physician on the same day if an ambulatory electrocardiogram service under item 11716, 11717, 11723, 11729 or 11735 is provided. The exception to this is if the patient is referred to the specialist or physician, or if the patient is being provided with ongoing care by the specialist or physician, or if the electrocardiogram service was requested and if the attendance service is provided at the same time as, or after, the ambulatory electrocardiogram service, and the attendance service is required because there is an urgent clinical need to make decisions about the patient's care as a result of the electrocardiogram service:

a) If the attendance service is provided at the same time as, or after, the ambulatory electrocardiogram service, and the attendance service is required because there is an urgent clinical need to make decisions about the patient's care as a result of the electrocardiogram service.

Clause 1.2.14 provides that an attendance service cannot be provided with an echocardiogram service (items 55126, 55127, 55128, 55129, 55132, 55133, 55134, 55137, 55141, 55143, 55145 or 55146), or with a myocardial perfusion study service (items 61321, 61324, 61325, 61329, 61345, 61349, 61357, 61394, 61398, 61406, 61410 or 61414) to the same patient on the same day.

The exception to this is if the attendance service is provided after another service and clinical management decisions are made about the patient during the other service, or if the decision to perform the echocardiogram service or myocardial perfusion study service on the same day is made as a result of a clinical assessment of the patient during the attendance service.

Item 29 inserts new clauses that outline requirements for the provision of certain cardiac services.

Clause 4.1.3A outlines requirements for the provision of a formal report for items 11704, 11705 and 11723. This includes that the formal report must be in writing and must include an interpretation of the trace, comments on the significance of the trace findings, and if appropriate, a copy of the trace and any measurements taken or automatically generated.

Clause 4.1.3B outlines the requirements for the inclusion of written clinical notes for item 11714. Clinical notes must include comments on the significance of the trace findings and of their relationship to clinical decision making for the patient in the clinical context of the findings, and interpretation that is not based solely on

measurements or diagnoses automatically generated from the trace. If appropriate, a copy of the note is also to be provided to the requesting practitioner.

Clause 4.1.3C limits the rendering specialist or consultant physician and the requesting practitioner from having a financial relationship for services provided under items 11704 and 11705.

Clause 4.1.3D provides that services provided under items 11729 and 11730 can only be performed if the patient is suitable for exercise or pharmacological induced stress testing. A service under item 11729 cannot be performed if the patient is asymptomatic and has a normal cardiac examination, or if the service is used to monitor known cardiac disease, or if the patient has an abnormal resting electrocardiography result which would prevent the interpretation of results. A service under item 11730 cannot be performed for monitoring purposes of a known cardiac disease.

Clause 4.1.3E provides that a service under items 11729 and 11730 can only be provided if a person trained in exercise testing and cardiopulmonary resuscitation is in continuous attendance during the monitoring and recording of the patient, and if a second person who is trained in cardiopulmonary resuscitation, is located at the premise where the testing is performed and is immediately available to respond at the time the exercise test is performed on the patient.

At least one of these people must be a medical practitioner, and the service can only be performed on premises equipped with resuscitation equipment, which includes a defibrillator. This will ensure patient safety during a test that can present significant risk and will maximise the results obtained for the purpose of reporting and subsequent treatment.

Clause 4.1.3F provides that a service under items 11704, 11707, 11714, 11716, 11717, 11723 and 11735 cannot be provided as part of an episode of hospital treatment or as part of hospital-substitute treatment where a benefit is paid from a private health insurer.

Clause 4.1.3G provides co-claiming restrictions for the provision of services under items 11704 and 11705 with an attendance item, which is an item under Part 2 of the GMST. Item 11704 cannot be performed if the rendering specialist or consultant physician has performed an attendance on the same patient on the same day. Item 11705 is generally limited from being co-claimed with an attendance, but in exceptional clinical circumstances an attendance can be performed.

Items 30 to 34 insert 11 existing items for cardiac investigation services (11704, 11705, 11707, 11714, 11716, 11717, 11723, 11729, 11730, 11731 and 11735).

Items 35 to 39 amend sleep study items 12203, 12204, 12205, 12207 and 12208 to provide that these services cannot be provided in association with cardiac items 11704, 11705, 11707, 11713, 11714, 11716, 11717, 11723 and 11735. This is an

administrative change which will align these items with other sleep study and cardiac items in the GMST.

Items 40 to 43 amend sleep study items 12210, 12213, 12215 and 12217 to provide that these services cannot be provided in association with cardiac items 11704, 11705, 11707, 11714, 11716, 11717, 11723 and 11735. This is an administrative change which will align these items with other sleep study and cardiac items in the GMST.

Item 44 amends sleep study item 12250 to provide that this service cannot be provided in association with cardiac items 11704, 11705, 11707, 11714, 11716, 11717, 11723 and 11735. This is an administrative change which will align this item with other sleep study and cardiac items in the GMST.

- Part 4 – Eating disorders

Part 4 inserts 30 items (90250, 90251, 90252, 90253, 90254, 90255, 90256, 90257, 90260, 90261, 90262, 90263, 90264, 90265, 90266, 90267, 90268, 90269, 90271, 90272, 90273, 90274, 90275, 90276, 90277, 90278, 90279, 90280, 90281 and 90282) from the *Health Insurance (Section 3C General Medical Services – Eating Disorders Treatment Plan and Psychological Treatment Services) Determination 2019* into the GMST. These items are for treatment and management services for patients with an eating disorder.

Item 45 inserts items 90260, 90261, 90262, 90263, 90266, 90267, 90268 and 90269 into subclause 1.2.2(1) of the GMST. Subclause 1.2.2(1) provides that a specified service does not apply if the patient does not have a referral within the period of validity.

Item 46 inserts items 90250 to 90269 into subclause 1.2.5(1) of the GMST. Subclause 1.2.5(1) specifies the requirements of a professional attendance service including what types of professional attendance are not included.

Item 47 inserts items 90250 to 90282 into subclause 1.2.6(1) of the GMST. Clause 1.2.6 provides that the item applies to a service provided in the course of a personal attendance by a single medical practitioner on a single patient on a single occasion.

Item 48 inserts items 90262, 90263, 90268, 90269, 90279, 90280, 90281 and 90282 into subclause 1.2.6(3) of the GMST. Subclause 1.2.6(3) specifies attendances included as a personal attendance by a medical practitioner, including via video conference.

Item 49 inserts items 90250 to 90282 into subclause 1.2.7(1) of the GMST. Clause 1.2.7 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.

Item 50 inserts items 90262, 90263, 90268, 90269, 90279, 90280, 90281 and 90282 into subclause 1.2.7(4) of the GMST. Subclause 1.2.7(4) specifies attendances

included as a personal attendance by a medical practitioner, including via video conference.

Item 51 inserts items 90250 to 90282 into clause 1.2.8 of the GMST. Clause 1.2.8 provides circumstances when a service would not apply.

Item 52 inserts four new rows in the table under clause 2.1.1 of the GMST to provide the fee amounts for items 90272, 90274, 90276 and 90278. This includes the base fee, the fee if the practitioner attends not more than 6 patients in a single attendance, and the fee if the practitioner attends more than 6 patients in a single attendance.

Items 53 and 54 amend subclause 2.20.6(8) to remove the reference that the general practitioner is accredited by the General Practice Mental Health Standards Collaboration, and to remove the note that specifies that the General Practice Mental Health Standards Collaboration operates under the auspices of the Royal Australian College of General Practitioners. This is a consequential amendment as the definition of mental health skills training is to be added to Part 7 – Dictionary of the GMST (refer to item 56 in the Regulations).

Item 55 inserts new Division 2.31 in relation to eating disorder services under Group A36 at the end of Part 2 of Schedule 1 of the GMST.

Clause 2.31.1 under Division 2.31 provides for the application of eating disorder items in Group A36. This includes requirements for:

- the preparation of eating disorder treatment and management plans for eating disorder items listed in Subgroup 1 and Subgroup 2;
- the review of eating disorder treatment and management plans for eating disorder items listed in Subgroup 3; and
- providing treatments under eating disorder treatment and management plans for items listed in Subgroup 4.

Clause 2.31.2 defines the group of patients who can access the eating disorder services. There are two cohorts of patients. The first cohort are patients who have been clinically diagnosed as having anorexia nervosa. The second cohort are patients who have been clinically diagnosed as having a feeding or eating disorder other than anorexia nervosa, and who meet defined ‘eligibility criteria’ prescribed in subclause 2.31.2(2). Other specified eating feeding or eating disorders are formally recognised disorders for a person who may present with many of the symptoms of other eating disorders such as anorexia nervosa, bulimia nervosa or binge eating disorder, but do not meet the full criteria for diagnosis of these disorders. This clause will target services to patients with eating disorders who have complex needs and who are assessed as being at high-risk of repeat hospitalisation and serious medical and psychological complications.

Clause 2.31.3 provides requirements for the preparation of eating disorder treatment and management plans. This includes that the plan must be in writing, and must include specific conditions, outlined in paragraph 2.31.3(b).

Clause 2.31.4 provides requirements for the review of eating disorder treatment and management plans. A review must include a review of the treatment efficacy of

treatments provided under the plan. As appropriate, the reviewing practitioner must also initiate the referral for the review, or modify the plan to include treatment option recommendations or revised treatment options.

Clause 2.31.5 provides that an item in Subgroup 4 only applies if the medical practitioner is registered with the Chief Executive Medicare to render the service. Section 33 of the *Human Services (Medicare) Regulations 2017* prescribes it is a function of the Chief Executive Medicare to establish and maintain a Register of medical practitioners who may provide focused psychological strategies under the initiative known as Better Access. Medical practitioners who meet the training and skills requirements as determined by the General Practice Mental Health Standards Collaboration, and are entered on the Register as being eligible to render a focussed psychological strategy service, can render an eating disorders psychological treatment service in Subgroup 4.

Clause 2.31.6 provides eligible mental health care management strategies. Eating disorder items in Subgroup 4, which are for eating disorders psychological treatment services, must involve the provision of at least one mental health care management strategy, as defined in the clause.

Clause 2.31.7 provides for restrictions on the application of eating disorder items. This clause specifies that eating disorder services cannot be provided if the patient is an admitted patient of a hospital. Clause 2.31.7 also specifies the limit on the number of plans that can be prepared for a patient each year, and items which can be provided in association with the eating disorder items.

Clause 2.31.8 provides for restrictions on the application of eating disorder items which are provided by video conference. Services provided under items 90262, 90263, 90268 and 90269 apply if the patient is located within a 'telehealth eligible area' per the meaning in the GMST. These services may also apply if the patient is a care recipient in a residential care service, or if the person is a patient of an Aboriginal Medical Service or Aboriginal Community Controlled Health Service which renders Medicare-eligible services.

Services provided under items 90279, 90280, 90281 and 90282 can only be provided via video conference in a Modified Monash 4 to 7 area, per the meaning in the GMST.

For all video conference services, 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 distance requirement.

Clause 2.31.9 provides for restrictions on the number of services providing treatments under an eating disorder treatment and management plan. An item in Subgroup 4, which is for eating disorders psychological treatment services, cannot be provided if the service is provided more than 12 months after the plan is prepared, if 40 services have already been provided under the plan, or if the reviewing practitioner does not provide a recommendation that additional services should be provided.

A medical practitioner or consultant physician may recommend that additional services be provided under the plan, if the practitioner or consultant physician conduct a review of the plan and makes the recommendation in writing.

Clause 2.31.10 inserts 30 existing items (90250, 90251, 90252, 90253, 90254, 90255, 90256, 90257, 90260, 90261, 90262, 90263, 90264, 90265, 90266, 90267, 90268, 90269, 90271, 90272, 90273, 90274, 90275, 90276, 90277, 90278, 90279, 90280, 90281 and 90282) in Group A36 for eating disorder services rendered by medical practitioners working in general practice, psychiatry and paediatrics.

Subgroup 1 lists eight items (90250, 90251, 90252, 90253, 90254, 90255, 90256 and 90257) for eating disorder treatment and management plan services provided by medical practitioners working in general practice.

Subgroup 2 lists four items (90260, 90261, 90262 and 90263) for eating disorder treatment and management plan services provided by consultant physicians practising in the speciality of psychiatry or paediatrics.

Subgroup 3 lists six items (90264, 90265, 90266, 90267, 90268 and 90269) for reviews of eating disorder treatment and management plans provided by medical practitioners working in general practice, psychiatry and paediatrics.

Subgroup 4 lists 12 items (90271, 90272, 90273, 90274, 90275, 90276, 90277, 90278, 90279, 90280, 90281 and 90282) for eating disorders psychological treatment services provided by medical practitioners working in general practice with appropriate mental health training.

Item 56 inserts a definition for an eating disorder treatment and management plan and a definition for mental health skills training into Clause 7.1.1 Dictionary of the GMST.

- Part 5 – Transvaginal repair of pelvic organ prolapse and procedures for the excision of graft material

Part 5 inserts seven items (33570, 35571, 35573, 35577, 35581, 35582 and 35585) from the *Health Insurance (Section 3C General Medical Services—Transvaginal repair of pelvic organ prolapse and procedures for the excision of graft material) Determination 2018* into the GMST.

Item 57 inserts items 33570, 35571, 35573, 35577, 35581, 35582 and 35585 into subclause 1.2.6(1) of the GMST. Clause 1.2.6 specifies attendances included as a personal attendance by a medical practitioner. Clause 1.2.6 also provides that the item applies to a service provided in the course of a personal attendance by a single medical practitioner on a single patient on a single occasion.

Items 58 and 59 amend clause 5.10.17 of the GMST to provide that for items 35581 and 35582, the size of the excised graft material must be histologically tested and confirmed. The heading of clause 5.10.17 is also amended to clarify that these restrictions apply to items in Subgroups 4 and 6 of Group T8.

Items 60 to 62 insert existing items 35570, 35571, 35573, 35577, 35581, 35582 and 35585 into Schedule 1 of the GMST.

- Part 6 – Optical coherence tomography

Part 6 inserts one item (11219) from the *Health Insurance (Section 3C General Medical Services – Optical Coherence Tomography) Determination 2018* into the GMST. Item 11219 provides an imaging test, known as optical coherence tomography to determine if patients with ocular conditions can access treatment with certain medicines listed on the Pharmaceutical Benefits Scheme.

Item 63 inserts existing item 11219 into Schedule 1 of the GMST.

- Part 7 – General practitioner telehealth services

Part 7 inserts two items (2729 and 2731) from the *Health Insurance (Section 3C General Medical Services – General Practitioner Telehealth Services) Determination 2018* into the GMST. These services are for the provision of focussed psychological strategies for assessed mental disorders by a general practitioner by teleconference for patients who are located in a Modified Monash 4 to 7 area.

At the time of the video conferencing attendance, both the patient and the general practitioner will need to be located at least 15km by road from each other. As per clause 1.2.12 of the GMST, the patient or the general practitioner cannot travel to a place to satisfy this distance requirement.

Item 64 inserts existing items 2729 and 2731 into Schedule 1 of the GMST.

- Part 8 – Archival tissue retrieval

Part 8 inserts one item (72860) from the *Health Insurance (Section 3C Pathology Services – Archival Tissue Retrieval) Determination 2019* into the PST. This service is for the retrieval of stored pathology tissue samples.

Item 65 inserts a new clause 2.5.5A to provide for the application of item 72860. Clause 2.5.5A provides that item 72860 applies to a service (the relevant service) if an initial service that is described in an item in Group P5 (other than item 72860), P6 or P7 of the pathology services table was rendered in a patient episode for the patient, and following the initial service, the treating practitioner determines that one or more genetic tests in Group P7 (the subsequent P7 service) is clinically necessary for the patient. Following the request from the treating practitioner for the subsequent P7 service, the pathologist who rendered the initial service determines they are unable to perform the subsequent P7 service and consequently retrieves and reviews the archival tissue to select appropriate tissue samples for referral to a different accredited pathology laboratory for testing. The subsequent P7 service must be rendered in another patient episode, and the relevant service must also be rendered in the subsequent patient episode.

Tissue material must be collected from the initial service. The tissue material must be either biopsy material or a sample submitted for cytology from which a tissue block

was prepared, and the tissue material was archived in a formalin fixed paraffin embedded block.

Item 66 inserts existing item 72860 into Schedule 1 of the PST.

- Part 9 – Computed tomography services

Part 9 inserts one item (57357) from the *Health Insurance (Section 3C Diagnostic Imaging Services – Computed Tomography Angiography) Determination 2020* into the DIST. This service is for computed tomography angiography of the pulmonary artery for an initial investigation for pulmonary embolism.

Item 67 inserts existing item 57357 into Schedule 1 of the DIST.

- Part 10 – Neurological services

Part 10 makes minor changes to three neurosurgery items (39018, 39109 and 39113) to clarify that assistance is required in the provision of these services. These services involve the use of stereotaxy, which requires the use of an assistant to set up the stereotactic navigation and planning. This change will align these services with best practice and ensure patient safety.

Item 68 amends items 39018, 39109 and 39113 to insert "(Assist)" which clarifies that these services are provided with assistance.

- Part 11 – Other amendments

Part 11 makes minor administrative and editorial amendments to the DIST (refer to items 69 to 80 in the Regulations), the GMST (refer to items 81 to 93 in the Regulations), the PST (refer to items 94 to 96 in the Regulations) and the HIR (refer to item 97 in the Regulations).

Item 69 amends the item descriptor of cardiac item 55118 to clarify that this service cannot be provided in association with a service to which an item in Subgroup 3 applies. This is an administrative change which will align cardiac item 55118 with other cardiac items in the DIST.

Item 70 repeals and replaces clause 2.3.3 of the DIST to clarify the policy intent of this provision, which was recommended by MSAC.

Clause 2.3.3 provides that the schedule fee for an eligible x-ray service is increased by $74.75, in addition to the schedule fee amount listed in the relevant service, if a person provides a diagnostic imaging procedure (an x-ray) for one or more patients who are care recipients in a residential aged care facility. The service fee is only applicable for the first patient who is seen at the residential aged care facility during the attendance.

An eligible x-ray service is a diagnostic imaging procedure used in rendering a service to which items 57509, 57515, 57521, 57527, 57703, 57709, 57712, 57715, 58503, 58521, 58524, 58527 or 58903 applies. A service under these items must be

requested in order for it to be provided. In practice, the service can be requested in person, or via other means, such as via telephone or telehealth.

The updated clause clarifies that the requesting practitioner must personally attend the patient to request an eligible x-ray service at a residential aged care facility.

The updated clause also clarifies that an eligible x-ray service can only be requested in the following circumstances:

- Item 57509, 57515, 57521. 57527, 57703, 57709, 57712, 57715, 58521, 58524 or 58527 is requested where the patient has had a fall; or
- Item 58503 is requested where pneumonia or heart failure is suspected; or
- Item 58903 is requested where acute abdomen or bowl obstruction is suspected.

This provision was announced in the 2018-19 *Mid-Year Economic and Fiscal Outlook under the Guaranteeing Medicare – strengthening primary care* measure, commencing on 1 November 2019.

Items 71 and 72 amend the item descriptor of three computed tomography items 57352, 57353 and 57354 to specify that the service is to be requested by a medical practitioner (other than a specialist or consultant physician), as opposed to being requested by a general practitioner.

These items were recommended by the MBS Review Taskforce and were announced in the 2019-20 Budget under *Guaranteeing Medicare – improved patient access to diagnostic imaging* measure, commencing on 1 May 2020. This change will assist with patient access and clarify the intention of the MBS Review Taskforce recommendations for these changes.

Items 73 and 74 amend clause 2.4.1 of the DIST (including the heading) to reference the subgroups that apply to this clause, as opposed to the item range. Clause 2.4.1 is for the application of nuclear imaging services, other than positron emission tomography (PET) services. This is an administrative change.

Items 75 to 77 amend clause 2.4.6 and the heading of Subdivision B of Division 2.4 to clarify that the items specified in the table are in Subgroups 1, 2 and 3 of Group I4. This is an administrative change.

Items 78 and 79 move item 61505, which is for a computed tomography scan which can be performed by single photon emission tomography or positron emission tomography (PET), from *Subgroup 1 – Nuclear medicine – non PET* into new *Subgroup 3 – Adjunctive services*. This is an administrative change which will list item 61505 under a new subgroup which does not specify that the item cannot be performed by PET.

Item 80 repeals the definition of an *eligible x-ray procedure* in the DIST. This definition is no longer required as eligible x-ray services are specified in the updated clause 2.3.3 (refer to item 69 of the Regulations).

Item 81 amends clause 1.2.4 of the GMST to include items 6009 to 6015. Clause 1.2.4 provides a restriction to prevent co-claiming of certain items when performed on the same day as a surgical procedure under Group T8. This change will ensure consistency across specialist and consultant physician groups, and will ensure that patients receiving the same type of service from different providers will receive the same Medicare rebate.

Items 82 and 83 amend the item descriptor of items 12210, 12213, 12215 and 12217 to provide that these services cannot be provided in association with cardiac item 11713. This is an administrative change which will align these items with other sleep study items in the GMST.

Item 84 amends the item descriptor of item 15338 to clarify that this service can also be provided out of hospital and that this service does not require anaesthesia.

Items 85 and 86 amend the item descriptor of item 15900 for targeted intraoperative radiation therapy to enable this service to be provided by using the Xoft® Axxent® device.

Targeted intraoperative radiation therapy is usually delivered as part of a breast conserving surgical procedure and is an alternative treatment option for breast cancer patients.

This change will enable the Xoft® Axxent® device to be used as an alternative for early stage breast cancer. It is anticipated this change will be particularly appealing for women living in rural and remote areas who may otherwise opt for a mastectomy in order to avoid the inconvenience of prolonged travel to regional or metropolitan centres (or temporary relocation) while they undergo whole-breast external beam radiation therapy.

The item descriptor is also amended to include a restriction where the service can only be provided to one breast per lifetime to indicate appropriate use, and to specify the correct clinical terminology of "radiation therapy".

Item 87 amends the schedule fee for medical perfusion item 22060 from $408.00 to $612.00. This change was announced by Government in the 2020-21 Budget under the *Guaranteeing Medicare – Medicare Benefits Schedule review* measure.

Item 22060 is for patients requiring cardiopulmonary bypass and cardioplegia when undergoing cardiac surgery. The cardiopulmonary bypass involves pumping blood through an oxygenator (artificial lung) and then back into the aorta – bypassing the heart and lung. Cardioplegia is required to arrest the heart which is required in the majority of cardiac surgery.

The fee increase recognises that cardiopulmonary bypass and cardioplegia are essential components to item 22060, and also takes into consideration that item 22060 was generally co-claimed with item 22070 (which ceased on 1 November 2019).

Items 88 and 89 amend the item descriptor of dermatology items 30196 and 30202 to enable plastic surgeons to perform the procedure based on their clinical judgement.

Dermatology items 30196 and 30202 are for the excision of malignant neoplasm of skin or mucous membrane. Currently specialist general practitioners and plastic surgeons can perform these services if it has been proven by histopathology, or if it has been confirmed by the opinion of a specialist in dermatology where a specimen has been submitted for histologic confirmation. The dermatologist review requirement was added on 1 November 2018.

Based on expert medical advice, plastic surgeons routinely perform these services, though they currently must wait for the results of histopathology or consult a dermatologist before performing the service. This change will reflect best clinical practice by ensuring that plastic surgeons are able to perform the service based on their own expert opinion, without having to consult a dermatologist (provided a specimen has been sent for histopathology).

This change will also improve patient access, particularly in regional and remote areas, by removing the requirement for patients to wait for histopathology before returning for the procedure.

Item 90 removes item 30630 from the GMST. This service will still be available to patients, however, the legal basis of this item will be provided in a ministerial determination made under section 3C of the *Health insurance Act 1973*.

Item 91 repeals and replaces item 31516 for targeted intraoperative radiation therapy to amend the item descriptor to enable this service to be provided by using the Xoft® Axxent® device. The item descriptor is also amended to include a restriction where the service can only be provided to one breast per lifetime to indicate appropriate use, and to specify the correct clinical terminology of "radiation therapy".

Item 92 amends the item descriptor of ophthalmology item 42739 to clarify that the service requires the administration of anaesthetic by an anaesthetist, to ensure appropriate use.

A small number of ophthalmologists have been using item 42739 under circumstances where only oral sedation, or minimal amounts of intravenous sedation, are used with or without an anaesthetist being present. This is not the intent of the service and is not clinically appropriate.

The equivalent item without the provision for anaesthetic (42738) will still be available and has an equivalent fee.

Item 93 inserts new item 45658 for the correction of a congenital deformity of the ear for a patient in any age group.

Currently, only patients who are under 18 years of age can access a Medicare service (item 45659) for the correction of a congenital deformity of the ear. Item 45658 will be introduced to enable individuals of any age with constricted ear deformities to access this service.

Items 94 and 95 repeal and replace items 73296 and 73297, which is for the characterisation of germline gene mutation, to update the terminology and to align these items with related changes which were made on 1 August 2020.

Items 73296 and 73297 commenced on 1 November 2017 for the characterisation of germline gene mutation. Since this time, clinical terminology has progressed in the genetic testing field.

Following MSAC consideration (MSAC application 1554), on 1 August 2020, item 73295 was amended and two new items were introduced (73301 and 73302) so that specialists or consultant physicians treating patients with epithelial ovarian, fallopian tube or primary peritoneal cancer, would be able to request tests on the MBS of either tumour tissue or blood, to detect somatic and germline BRCA1 or BRCA2 variants. These changes were implemented in the *Health Insurance (Section 3C Co-Dependent Pathology Services) Amendment Determination (No. 5) 2020*.

As part of these changes, the term 'pathogenic or likely pathogenic gene variant' was included. The descriptors also specify 'ovarian, fallopian tube or primary peritoneal cancer', although all of these cancers are classed as 'ovarian cancer'.

The amended item descriptors for items 73296 and 73297 update the clinical terminology and align with related items. The updated item descriptor for item 73297 also specifies that patients cannot receive this service if they have previously received a service under items 73295 or 73297 (as well item 73296 which is currently specified in the descriptor). These changes are administrative in nature and will not change how the service is provided.

Item 96 amends the item descriptor of item 73357 to extend genetic testing to "biological" relative rather than "first-degree" relative. This change better reflects the intention of the item.

Item 97 removes six items 90350, 90355, 90360, 90361, 90362 and 90365 from subsection 28(1) of the HIR, as these items currently do not exist.

- Part 12 – Consequential amendments

Part 12 makes consequential amendments to clause 1.1.3 of the GMST as a result of the *Health Insurance Amendment (General Practitioners and Quality Assurance) Act 2020* (GPQA). These changes will commence at the same time as Schedule 1 to the GPQA.

Items 98 and 99 amend clause 1.1.3 of the GMST to clarify that the definition of 'general practitioner' is for the purposes of paragraph (b) (as opposed to paragraph (c)) of the *Health Insurance Act 1973*. The note under clause 1.1.3 is also amended to clarify that the definition of 'general practitioner' is in section 16 (as opposed to section 22) of the *Health Insurance Regulations 2018*.

Statement of Compatibility with Human Rights

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

Health Insurance Legislation Amendment (2020 Measures No. 3) Regulations 2020

This Regulation 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 Disallowable Legislative Instrument

The purpose of the *Health Insurance Legislation Amendment (2020 Measures No. 3) Regulations 2020* (the Regulations) is to amend the GMST, DIST, PST and HIR from 1 March 2021, and to amend the GMST at the same time as Schedule 1 of the *Health Insurance Amendment (General Practitioners and Quality Assurance) Act 2020* (the GPQA Act) commences.

The Regulations will implement some minor policy changes from the 2020-21 Budget under the *Guaranteeing Medicare – Medicare Benefits Schedule review* measure. The Regulations will implement minor policy changes which were recommended by the clinician-led Medicare Benefits Schedule (MBS) Review Taskforce (the MBS Review Taskforce) or the Medical Services Advisory Committee (MSAC). The Regulations will clarify the policy intent of three neurological services to enable assistance to be claimed through Medicare, where it is required, in the provision of these services.

The Regulations will also implement several editorial and drafting improvements to better reflect the original policy, which also includes incorporating items from eight legislative instruments which are made under subsection 3C(1) of the Act. Consequential amendments will also be implemented to align with the GPQA Act.

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 maintain rights to health and social security by ensuring access to publicly subsidised general medical services, diagnostic imaging services and pathology services are clinically and cost-effective.

Conclusion

This instrument is compatible with human rights because it maintains existing arrangements and the protection of human rights.

Greg Hunt

Minister for Health