EXPLANATORY STATEMENT

Health Insurance Act 1973

Health Insurance (Section 3C General Medical Services – Allied Health Services) Determination 2024

Subsection 3C(1) of the *Health Insurance Act 1973* (the Act) provides that the Minister may, by legislative instrument, determine that a health service not specified in an item in the general medical services table (the GMST) shall, in specified circumstances and for specified statutory provisions, be treated as if it were specified in the GMST.

The GMST is set out in the regulations made under subsection 4(1) of the Act. The most recent version of the regulations is the *Health Insurance (General Medical Services Table) Regulations 2021.*

This instrument relies on subsection 33(3) of the *Acts Interpretation Act 1901* (AIA). Subsection 33(3) of the AIA provides that where an Act confers a power to make, grant or issue any instrument of a legislative or administrative character (including rules, regulations or by-laws), the power shall be construed as including a power exercisable in the like manner and subject to the like conditions (if any) to repeal, rescind, revoke, amend, or vary any such instrument.

Purpose

The purpose of the *Health Insurance (Section 3C General Medical Services – Allied Health Services) Determination 2024* (the Determination) is to repeal and remake the *Health Insurance (Allied Health Services) Determination 2014* (the Former Determination), which is due to sunset on 1 April 2024. This remake will ensure that Medicare benefits continue to be payable for allied health services performed by those practitioners.

As part of the remake, the Determination makes administrative changes, which will include:

- aligning the Determination with other legislative instruments underpinning the Medicare Benefits Schedule;
- updating schedule fees in the Determination to incorporate current indexed fees, as indexation has previously been applied through a provision;
- ensuring qualification requirements align with current professional standards;
- providing clearer links between items and related provisions;
- implementing subgrouping in larger groups of items; and
- removing references to ceased items and legislative instruments.

The Determination will also implement the following changes, which were agreed to by Government in the 2023-24 Budget:

- Increase the age limit for case conference services for complex neurodevelopmental disorders and disabilities from under 13 to under 25 years of age to align these services with other items for complex developmental disorder and eligible disability services.

- Amend 13 items for allied health services provided to a patient who is of Aboriginal or Torres Strait Islander descent to streamline access to up to 10 allied health services in a calendar year.

Consultation

Consultation was undertaken with following peak bodies regarding the administrative changes to qualification requirements in Schedule 1 of the Determination:

- Audiology Australia;
- Australian Association of Social Workers;
- Australian Chiropractors Association;
- Australian College of Audiology;
- Australian College of Mental Health Nurses;
- Australian Diabetes Educators Association;
- Australian Physiotherapy Association;
- Australian Podiatry Association;
- Australian Psychological Society;
- Dietitians Australia;
- Exercise & Sports Science Australia;
- National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners;
- Occupational Therapy Australia;
- Optometry Australia;
- Orthoptics Australia;
- Osteopathy Australia; and
- Speech Pathology Australia.

The following stakeholders were consulted on the amendments to expand patient access to case conference services for complex neurodevelopmental disorders and were supportive of the change:

- Audiology Australia;
- Australian Autism Alliance;
- Australian Medical Association;
- Australian Physiotherapy Association;
- Australian Podiatry Association;
- Australian Psychological Society;
- Consumer representatives;
- Indigenous Allied Health Australia;
- Occupational Therapy Australia;
- Orthoptics Australia;
- Osteopathy Australia;
- Royal Australian College of General Practitioners;
- Services for Australian Rural and Remote Allied Health; and
- Speech Pathology Australia.

The following stakeholders were consulted on the amendments to streamline access to allied health services for patients of Aboriginal or Torres Strait Islander descent and were supportive of the change:

- Australian Medical Association;
- Consumer representatives;

- Indigenous Allied Health Australia;
- Indigenous Urban Institute of Health;
- National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners;
- Royal Australian College of General Practitioners; and
- Services for Australian Rural and Remote Allied Health.

No consultation was undertaken regarding the other administrative changes as these amendments are considered machinery in nature and are not intended to change the operation of allied services specified in the Determination.

The Determination is a legislative instrument for the purposes of the *Legislation Act 2003*.

The Determination commences on 1 March 2024.

Details of the Determination are set out in the Attachment.

Authority: Subsection 3C(1) of the *Health Insurance Act 1973*

ATTACHMENT

Details of the *Health Insurance (Section 3C General Medical Services – Allied Health Services) Determination 2024*

Section 1 – Name

Section 1 provides for the Determination to be referred to as the *Health Insurance (Section 3C General Medical Services – Allied Health Services) Determination 2024* (the Determination).

Section 2 – Commencement

Section 2 provides for the Determination to commence on 1 March 2024.

Section 3 – Authority

Section 3 provides that the Determination is made under subsection 3C(1) of the *Health Insurance Act 1973*.

Section 4 – Interpretation

Section 4 defines terms used in the Determination.

Subsection 4(1) updates the definitions currently contained in subsection 4(1) of the *Health Insurance (Allied Health Services) Determination 2014* (the Former Determination) to:

- insert definitions for relevant National Boards;
- insert a definition for ***case conference service*** to clarify that the specified services are health services for the purposes of section 12 of the *Health Insurance Regulations 2018*;
- update the definition for the COVID-19 Determination to the Telehealth and Telephone Determination following the implementation of ongoing telehealth arrangements;
- amend definitions for eligible allied health professionals to ensure all relevant services are referenced;
- make other administrative amendments, including removing obsolete definitions, references to ceased items and gendered language.

Section 5 – Schedules

Section 5 of the Determination 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.

Section 6 – Treatment of allied health services

Section 6 provides that a clinically relevant service provided in accordance with the Determination shall be treated, for relevant provisions of the *Health Insurance Act 1973* and *National Health Act 1953*, and regulations made under those Acts, as if it were both a professional service and a medical service and as if there were an item specified in the general medical services table for the service.

Section 7 – Limitation on services provided to admitted patients

Subsection 7(1) of the Determination provides that an item in Schedule 2 of the Determination does not apply to a service if the service is provided to a patient who is an admitted patient. This limitation is currently specified in the item descriptors of allied health services listed in the Former Determination. The Determination removes this limitation from the item descriptors of allied health services listed in Schedule 2. Note, the term ***admitted patient*** is defined in subsection 4(1).

Section 8 – Effect of election to claim private health insurance for an allied health service

Subsection 8(1) of the Determination specifies that an item in Schedule 2 applies to an allied health service only if a private health insurance benefit has not been claimed for the service. This provision is currently specified in section 9 of the Former Determination.

Section 9 – Telehealth eligible areas

Section 9 of the Determination defines the term ***telehealth eligible area*** for the purposes of relevant items in Schedule 2 of the Determination. This definition refers to Modified Monash areas 4 to 7, which are defined in accordance with the definitions in the general medical services table. The term telehealth eligible area is currently defined at section 6D of the Former Determination. The definition at section 9 updates the current definition to align allied health services with the current 2019 Modified Monash Model used by the Department of Health and Aged Care, which applies to all other Medicare Benefits Schedule (MBS) services. This change will ensure consistent arrangements for all MBS services with geographical restrictions.

Section 10 – Application of case conference items generally

Section 10 provides general application provisions for allied health case conference service items (10955, 10957, 10959, 80176, 80177, 80178, 82001, 82002 and 82003 in Schedule 2).

Subsection 10(2) provides that references to ***community case conference***, ***multidisciplinary case conference***, ***multidisciplinary case conference team***, ***participate*** and ***mental health case conference*** have the meaning given by the specified provisions in the general medical services table. To summarise these terms in relation to allied health case conference items:

- ***community case conference*** means a case conference for community based patients. This is intended to exclude patients residing in residential aged care facilities or admitted to hospital.

- ***multidisciplinary case conference*** describes the activities that are undertaken as part of the case conference.

- ***multidisciplinary case conference team*** means a team of at least three persons who are involved in managing the patient's care. The team must involve at least one medical practitioner and two other persons (one who may be a medical practitioner) who are providing different types of care or services to the patient. The other persons may include allied health professionals, home and community service providers and care organisers.

Unpaid carers and family members of the patient do not count towards the minimum of three formal service providers. Note, **subclause 1.1.2(5)** provides additional limitations relating to the multidisciplinary case conference team for patients with a chronic or terminal disease, **subclause 2.3.2(5)** provides additional limitations relating to multidisciplinary case conference team for mental health case conference services and **subclause 5.1.5(3)** provides additional limitations relating to the multidisciplinary case conference team for patients diagnosed with, or suspected of having, a complex neurodevelopmental disorders or an eligible disability.

- ***participate*** describes the activities that a formal member of the multidisciplinary case conference team must undertake if they are not organising and coordinating the conference. These activities include acquiring and recording the patient's agreement to the allied health practitioner's participation in the conference.

- ***mental health case conference*** means a process by which a multidisciplinary case conference team carries out all of the following activities relevant to a patient's mental health:
  (a) discussing the patient's history;
  (b) identifying the patient's multidisciplinary care needs;
  (c) identifying outcomes to be achieved by members of the multidisciplinary case conference team giving mental health care and service to the patient;
  (d) identifying tasks that need to be undertaken to achieve these outcomes, and allocating those tasks to members of the multidisciplinary case conference team;
  (e) assessing whether previously identified outcomes (if any) have been achieved.

Subsection 10(3) provides that allied health case conference service items will apply if the patient is not in attendance (in person or remotely). This does not preclude the patient (or carer) from attending, where appropriate.

Subsections 10(4), (5) and (6) relate to the attendance requirements for the multidisciplinary case conference team for allied health case conference services. Subsection 10(4) requires that the minimum number of members of the multidisciplinary case conference must attend on the one occasion.

Subsection 10(5) provides that the minimum number of members is three and subsection 10(6) provides that attendance by the minimum number of members includes attending in person or remotely (by phone or video conference). The allied health case conference services could not be performed if fewer than three of the members did not meet to discuss the patient's condition.

For example, a multidisciplinary case conference team includes a general practitioner (GP), an eligible allied health practitioner and a specialist. The GP, eligible allied health practitioner and specialist discuss the patient's condition on the phone. In that scenario, the eligible allied health practitioner can claim the allied health case conference service as the minimum number of participants met on the one occasion.

It is important to note this is a minimum number of members for the multidisciplinary case conference team. Other persons can participate as part of the multidisciplinary case conference team.

Paragraph 10(7)(a) provides that the eligible allied health practitioner may participate as a member of the multidisciplinary case conference team by attending in person or by a remote attendance method (phone or video conference). Paragraph 10(7)(b) provides that the eligible allied health practitioner can participate through another attendance method than other members of the multidisciplinary case conference team. See **subclauses 1.1.2(6)**, **2.3.2(6)** and **5.1.5(4)** for the meaning of eligible allied health practitioner in relation to the relevant case conference items.

The provisions set out in section 10 are currently specified by section 14 of the Former Determination.

Schedule 1 – Qualification requirements for allied health professionals

Schedule 1 sets out the qualification requirements for various allied health professionals to provide the following allied health services set out in the Determination:

1. Aboriginal and Torres Strait Islander health services;
2. Audiology health services;
3. Chiropractic health services;
4. Diabetes education health services;
5. Dietetics health services;
6. Eating disorder psychological treatment services;
7. Exercise physiology health services;
8. Focussed psychological strategies health services;
9. Mental health services;
10. Non-directive pregnancy support counselling health services;
11. Occupational therapy health services;
12. Optometry health services;
13. Orthoptic health services;
14. Osteopathy health services;
15. Physiotherapy health services;
16. Podiatry health services;
17. Psychological therapy health services;
18. Psychology health services; and
19. Speech pathology health services.

Schedule 1 updates the qualification requirements currently specified in Schedule 1 of the Former Determination to ensure they reflect current qualification requirements and inserts relevant qualification requirements for eating disorder psychological treatment services, which were not included in the Former Determination. Further administrative amendments have also been made to remove references to State and Territory law where appropriate. Several of the allied health professions specified in Schedule 1 are governed by a National Board established under section 31 of the National Law, which is now reflected in Schedule 1 to provide greater clarity for relevant allied health professionals.

The document published by Occupational Therapy Australia titled ‘Occupational Therapy Australia Mental Health Endorsement Criteria’, as in force on 1 March 2023, which is

mentioned in item 8 of Schedule 1, is incorporated by reference. This document is freely available at https://www.otaus.com.au/membership/ota-member-programs/mental-health-endorsement.

The document published by the Australian Association of Social Workers (AASW) titled 'AASW Accredited Mental Health Social Worker Application Criteria', as in force on 1 July 2022, which is mentioned in items 8, 9 and 10 of Schedule 1, is incorporated by reference. This document is freely available at https://www.aasw.asn.au/professional/aasw-credentials/mental-health/.

Schedule 2 – Allied health services

Part 1 – Services and fees—general

Part 1 of Schedule 2 of the Determination sets out the provisions and items for allied health services related to chronic disease management in Group M3.

Clause 1.1.1 provides application and limitation provisions for allied health services specified in Subgroup 1 of Group M3. In accordance with subclause 1.1.1(1), an item in Subgroup 1 of Group M3 only applies to a service if:

- The patient is referred to the eligible provider for the allied health service by a medical practitioner using a referral form that has been issued by the Department or a referral form that contains all the components of the form issued by the Department. The form issued by the Department is available on the Department's website.
- The service is provided to patient individually and in person.
- After the service, the eligible provider gives a written report to the referring medical practitioner in accordance with subparagraphs (i) to (iii).

The requirements set out in subclause 1.1.1(1) are currently specified in the item descriptors of the relevant allied health services listed in the Former Determination. The Determination removes these requirements from the item descriptors of allied health services listed in Subgroup 1 of Group M3.

Subclause 1.1.1(2) provides that an item in Subgroup 1 of Group M3 does not apply to a service if the patient has already been provided 10 services in the same calendar year to which any of the following items apply:

- an item in Subgroup 1 of Group M3;
- an item in Group M11; or
- item 93000, 93013, 93048 or 93061 of the *Health Insurance (Section 3C General Medical Services – Telehealth and Telephone Attendances) Determination 2021* (the Telehealth and Telephone Determination).

The limitation in subclause 1.1.1(2) is consequential to the changes to items in Group M11 (refer to **Part 6**). This new limitation will ensure eligible patients have access to a maximum of 10 allied health services per calendar under a chronic disease management plan (a GP Management Plan and Team Care Arrangements, or multidisciplinary care plan) and/or following a health assessment. Patients will continue to have access to a maximum of five services per calendar year to which an item in Subgroup 1 of Group M3 applies.

Clause 1.1.2 provides limitation provisions related to allied health case conference items for patients with a chronic or terminal disease (items 10955, 10957 and 10959 in Subgroup 2 of M3). These items will be referred to as 'chronic disease management case conference services' for the purpose of explaining the relevant provisions in Part 1. These limitations are currently specified in section 15 of the Former Determination.

Subclause 1.1.2(2) provides that a chronic disease management case conference service can only be undertaken for a patient that has a chronic or terminal condition. A chronic condition is defined as a medical condition that has persisted for more than six months, or is expected to persist for more than six months. Patients with these conditions who are admitted to a hospital are not eligible for a chronic disease management case conference service.

Subclause 1.1.2(3) provides that a particular chronic disease management case conference service cannot be performed if the patient has received that chronic disease management service within the past 3 months, unless in exceptional circumstances.

Subclause 1.1.2(4) specifies the meaning of exceptional circumstances for the purpose of subclause (3). Exceptional circumstances mean there has been a significant change in the patient's clinical condition or care circumstances that necessitates the performance of the service. This is the same requirement as the exceptional circumstances provision which applies to GP management plans, team care arrangements and multidisciplinary care plan services performed by GPs in the general medical services table.

Subclause 1.1.2(5) requires the multidisciplinary case conference team for chronic disease management case conference services to include at least one medical practitioner (who is not a specialist or consultant physician). This would commonly be the GP who organises and coordinates the case conference, it but may also include a medical practitioner working in general practice who performs that role.

Subclause 1.1.2(6) specifies the types of eligible allied health practitioner. This is the same list of allied health practitioners who can perform the individual allied health attendance services in Subgroup 1 of Group M3.

Clause 1.1.3 provides the table of items in Group M3 for chronic disease management services. This clause introduces new subgroups to Group M3. Subgroup 1 contains allied health attendance items for chronic disease management services and Subgroup 2 contains chronic disease management case conference services. The schedule fees for items in Group M3 reflect the current fees for allied health services following 1 November 2023 indexation. Note, section 17 of the Former Determination, which applies annual indexation to allied health items, has been removed as all listed fees have been updated to reflect the current fees.

Part 2 – Services and fees—psychological therapy and focussed psychological strategies

Part 2 of Schedule 2 of the Determination sets out the provisions and items for allied health services related to psychological therapy and focussed psychological strategies in Groups M6 and M7.

Division 2.1 provides the general provisions related to psychological therapy and focussed psychological strategies services specified in Groups M6 and M7. The items listed Groups M6

and M7 in Part 2 of Schedule 2 of the Determination provide patients with access to services under the *Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS* (Better Access) initiative. These items will be referred to as 'Better Access services' for the purpose of explaining the relevant provisions in Division 2.1.

Clause 2.1.1 provides limitation provisions for listed items for Better Access services as follows:

- Subclause 2.1.1(2) provides that an item listed in subclause (1) only applies to a service if it is one of the first 10 relevant services provided to the patient, or to a person other than the patient as part of the patient's treatment, in the calendar year. Under the Better Access initiative, eligible patients may access up to 10 Better Access services per calendar year.
- Subclause 2.1.1.(3) defines the term ***relevant service*** for the purposes of this clause, listing all Better Access services in the general medical services table, the Determination and the Telehealth and Telephone Determination.
- Subclause 2.1.1(4) provides the requirements for Better Access services provided to a person other than the patient as part of the patient's treatment, which include:
    (a) the referring practitioner or the allied health practitioner providing the service must determine it clinically appropriate to provide the service to a person other than a patient and make a written record of this determination;
    (b) the practitioner providing the service must explain the service to the patient, obtain the patient's consent for the service and make a written record of the consent;
    (c) the service must be provided as part of the patient's treatment; and
    (d) in relation to a particular patient, no more than two services to which any of the 48 items for Better Access services provided to a person other than the patient apply may be provided in a calendar year.

Clause 2.1.2 provides limitation provisions for listed items for Better Access group therapy services as follows:

- Subclause 2.1.2(2) provides that, in relation to a particular patient, no more than 10 services to which any of the items listed in subclause (1) apply may be provided in a calendar year.
- Subclause 2.1.2(3) provides that an item for a Better Access group therapy service may apply to a service where only three patients attend if four were due to attend and one of the patients is unable to attend. This provision ensures patients are not unfairly disadvantaged where another patient is unable to attend a scheduled group therapy session.

Clause 2.1.3 provides limitation provisions for listed items for Better Access group therapy telehealth services as follows:

- Subclause 2.1.3(2) provides that, in relation to a particular patient, an item listed in subclause (1) only applies to service if the service is one of the first 10 relevant services provided to that patient in a calendar year.
- Subclause 2.1.3(3) provides that an item in subclause (1) does not apply to a service if the patient or allied health professional travelled to satisfy the requirement in paragraph (d) of the item descriptor.
- Subclause 2.1.3(4) defines the term ***relevant service*** for the purpose of this clause, listing all items for Better Access group therapy services in the Determination.

Subclause 2.1.4(1) defines the term ***referring practitioner*** for the purpose of Better Access services listed in the Determination (items 80000 to 80175). In the Former Determination, this definition applied to a limited range of items and all other items specified the referral requirements for Better Access services in the item descriptor. However, the revised provision applies to all Better Access services in Part 2 of Schedule 2 of the Determination and the referral requirements have been removed from relevant item descriptors.

Subclause 2.1.4(2) inserts a new provision, which requires referrals provided by a specialist or consultant physician in accordance with subclause (1) to meet the requirements set out in subclause 2.1.5. This is an administrative change intended to clarify the relationship between the referral requirements at clauses 2.1.4 and 2.1.5.

Clause 2.1.5 provides the referral requirements for Better Access services where the patient is referred by a psychiatrist or paediatrician, specifying the items under which referrals by different medical practitioners must be provided.

The general requirements for Better Access services in Division 2.1 (clauses 2.1.1, 2.1.2, 2.1.3, 2.1.4 and 2.1.5) are currently specified in sections 6, 6A, 6C, 6E and 7 of the Former Determination.

Clause 2.2.1 of Division 2.2 provides the table of items in Group M6 for psychological therapy services. This clause introduces a new subgroup to Group M6. Subgroup 1 contains existing items psychological therapy services. The schedule fees for items in Group M6 reflect the current fees for allied health services following 1 November 2023 indexation. Note, section 17 of the Former Determination, which applies annual indexation to allied health items, has been removed as all listed fees have been updated to reflect the current fees.

Division 2.3 provides the provisions and items for focussed psychological strategies health services in Group M7.

Clause 2.3.1 provides requirements related to focussed psychological strategies health services. Subclause 2.3.1(1) provides that a person must complete focussed psychological strategies continuing professional development each continuing professional development (CPD) year. Note, the term ***CPD year*** is defined in subsection 4(1).

Subclause 2.3.1(2) provides that clause 2.3.1 allies to a person who is an allied health professional in relation to the provision of a focussed psychological strategies health service and is not a general registrant psychologist.

Subsection 2.3.1(3) provides that a person is required to keep written records of their participation in focussed psychological strategies continuing professional development for a period of two years from the end of the CPD year to which the focussed psychological strategies continuing professional development relates.

Subsection 2.3.1(4) provides that, other than when seeking reregistration, when a person seeks to become an allied health professional during a CPD a year that person will be registered until the end of the CPD year and will have until the end of the CPD year to meet the focussed psychological strategies continuing professional development on a pro-rata basis, with units being calculated from the first day of the month immediately succeeding the date of registration.

Under paragraph 2.3.1(5)(a), the Minister may decide to remove an allied health professional's name from the register kept by the Chief Executive Medicare if the Minister is satisfied that the allied health professional does not comply with the focussed psychological strategies continuing professional development. Under paragraph 2.3.1(5)(b), the Minister may then notify the Chief Executive Medicare to remove the name of the allied health professional from the register. Under subclause 2.3.1(6), before the Minister provides notice to the Chief Executive Medicare under subsection 2.3.1(5)(b), the Minister must notify the allied health professional in writing of the decision, the reasons for the decision and the allied health professional's reconsideration rights under clause 2.3.2.

Subclause 2.3.1(7) sets out certain requirements that must be met before a person, whose name was removed from the register of allied health professionals in relation to the provision of focussed psychological strategies services, may be reinstated to the register. These requirements are that:

- the person provides evidence of completing the necessary number of units that would have been required for them to meet the 10 units in the year that they failed to comply; and
- the person completes focussed psychological strategies continuing professional development for the CPD year in which they were reregistered. For the year of reregistration, the CPD year is taken to have commenced on the date the person is reregistered.

Subclause 2.3.1(8) provides for the Minister to grant an exemption from focussed psychological strategies continuing professional development if special circumstances exist. This may include circumstances where it has not been practical for an allied health professional to complete the focussed psychological strategies continuing professional development due to ill health, maternity/paternity leave or other special circumstances.

Subclause 2.3.1(9) provides that upon receiving notification under paragraph (5)(b) the Chief Executive Medicare shall not remove the name of the allied health professional from the register until notified that where:

a) the allied health professional has sought a review of the decision to remove, the decision has been affirmed; or
b) the allied health professional has sought time to complete the number of units required to satisfy the Minister that the allied health professional complies with subsection 2.3.1(1), the Minister has given notice under subsection 2.3.2(9)(c) where the Minister was not satisfied that the units were completed; or
c) neither a) or b) applies, the time for apply for reconsideration referred to in subsection 11(2) has expired.

Subclause 2.3.1(10) provides that nothing in clause 2.3.1 prevent the Chief Executive Medicare from including or removing the name of a general registrant psychologist from the register. Subclause 2.3.1(11) defines the terms ***general registrant psychologist*** and ***register*** for the purpose of this clause.
The provisions specified in clause 2.3.1 are currently specified in section 10 of the Former Determination.

Clause 2.3.2 enables an allied health professional who has been notified of a decision by the Minister to remove their name from the register of allied health professionals to either:

- apply to the Minister for a reconsideration of that decision under subclause 2.3.2(1); or

- request a further 28 days in which to complete the required number of units under subclauses 2.3.2(6) and 2.3.2(8). Pursuant to subclause 2.3.1(7), a request for further time takes the place of a right to request a reconsideration decision under subclause 2.3.1(1).

Under subclause, 2.3.2(4), the Minister has 28 days from the receipt of an application for reconsideration of a decision to remove a person's name from the register to make a reconsideration decision. Under subclause 2.3.2(5), the Minister must notify the applicant in writing of the outcome of the reconsideration and reasons for the decision.

Under paragraph 2.3.2(9)(a), where a person who has requested further time to complete their focussed psychological strategies continuing professional development requirements fails to complete those requirements to the Minister's satisfaction, the Minister must proceed as if the person applied under subsection 2.3.2(1) for a reconsideration of a decision to remove the person's name from the register of allied health practitioners. Under paragraphs 2.3.2(9)(b) and (c), the Minister is required to make a reconsideration decision and notify the person in writing of the reconsideration decision and the reasons for the decision.

Under subclause 2.3.2(10), the Minister must provide a written copy of a decision made under section 10 to the Chief Executive Medicare.

The provisions set out in clause 2.3.2 are currently specified section 11 of the Former Determination.

Clause 2.3.3 provides limitation provisions for mental health case conference services in Subgroup 2 of Group M7 (items 80176, 80177 and 80178) as follows:

- Subclause 2.3.3(2) provides that the patient must either:
  (a) be referred for a psychological therapy health or focussed psychological strategies health service; or
  (b) have an eating disorder treatment and management plan.
- Subclause 2.3.3(3) that item 80176, 80177 or 80178 only applies to a service specified if a service under any of the items has not been performed for the patient in the previous three months, unless exceptional circumstances exist;
- Subclause 2.3.3(4) defines exceptional circumstances for the purposes of subclause (3). Exceptional circumstances mean there has been a significant change in the patient's clinical condition or care circumstances that necessitates the performance of the service.
- Subclause 2.3.3(5) provides that item 80176, 80177 or 80178 only applies to a service if the patient requires ongoing care from a multidisciplinary case conference team which includes at least one medical practitioner (including a general practitioner, but not a specialist or consultant physician).
- Subclause 2.3.3(6) provides that item 80176, 80177 or 80178 only applies to a service if the service is provided by an allied health professional who meets the qualification requirements outlined in Schedule 1 of the Determination in relation to the provision of a:
  (a) psychological therapy health service;
  (b) focussed psychological strategies health service; or
  (c) dietetics health service.

Clause 2.3.4 provides the table of items in Group M7 for focussed psychological strategies health services. This clause introduces new subgroups to Group M7. Subgroup 1 contains attendance items for focussed psychological strategies health services and Subgroup 2 contains

mental case conference services. The schedule fees for items in Group M7 reflect the current fees for allied health services following 1 November 2023 indexation. Note, section 17 of the Former Determination, which applies annual indexation to allied health items, has been removed as all listed fees have been updated to reflect the current fees.

Part 3 – Services and fees—pregnancy support counselling

Part 3 of Schedule 2 of the Determination sets out the provisions and items for allied health services related to pregnancy support counselling in Group M8.

Subclause 3.1.1(1) provides that an item in Group M8 only applies to a service provided individually and in person. Subclause 3.1.1(2) provides that an item in Group M8 may apply to a service used to address any pregnancy related issues for which non-directive counselling is appropriate. The requirements set out in clause 3.1.1 are currently specified in the item descriptors of pregnancy counselling services listed in Group M8 of the Former Determination. The Determination removes these requirements from the item descriptors of services listed in Part 3 of Schedule 2.

Clause 3.1.2 provides the table of items in Group M8 for pregnancy support counselling services. The schedule fees for items in Group M8 reflect the current fees for allied health services following 1 November 2023 indexation. Note, section 17 of the Former Determination, which applies annual indexation to allied health items, has been removed as all listed fees have been updated to reflect the current fees.

Part 4 – Services and fees—group services

Part 4 of Schedule 2 of the Determination sets out the provisions and items for allied health services related to group services in Group M9.

Clauses 4.1.1, 4.2.1 and 4.3.1 provide the tables of items in Group M9 for allied health group services related to diabetes education, exercise physiology and dietetics respectively. These clauses introduce new subgroups to Group M9 as follows:

- Subgroup 1 contains allied health group items for diabetes education services;
- Subgroup 2 contains allied health group items for exercise physiology services; and
- Subgroup 3 contains allied health group items for dietetics services.

Each subgroup in Group M9 includes an item for assessing the patient's suitability for the relevant group service and an item for the relevant group service. The schedule fees for items in Group M9 reflect the current fees for allied health services following 1 November 2023 indexation. Note, section 17 of the Former Determination, which applies annual indexation to allied health items, has been removed as all listed fees have been updated to reflect the current fees.

Part 5 – Services and fees—complex neurodevelopmental disorder and disability services

Part 5 of Schedule 2 of the Determination sets out the provisions and items for allied health services related to complex neurodevelopmental disorders or disabilities in Group M10.

Clause 5.1.1 provides application provisions for complex neurodevelopmental disorder or disability items in Group M10 as follows:

- Subclause 5.1.1(2) defines the term ***eligible practitioner*** for the purposes of a patient with a confirmed, or suspected, complex neurodevelopmental disorder and for the purposes of a patient with a confirmed, or suspected eligible disability. Note, the term ***eligible disability*** is defined in subsection 4(1).
- Subclause 5.1.1(3) defines the term ***treatment and management plan*** for the purposes of a patient with a confirmed, or suspected, complex neurodevelopmental disorder and for the purposes of a patient with a confirmed, or suspected eligible disability.
- Subclause 5.1.1(4) provides that an item mentioned in subclause (1) only applies to a service if the eligible allied health practitioner providing the service meets the credentialing requirements for the provision of a complex neurodevelopmental disorder or disability service.
- Subclause 5.1.1(5) also allows patients to receive a service to which item 82000, 82005, 82010 or 82030 applies, where the patient has been referred by an eligible allied health practitioner to a second eligible allied health practitioner, if:
    (a) the patient was referred to the first eligible allied health practitioner by an eligible medical practitioner; and
    (b) the referral from the eligible medical practitioner is valid; and
    (c) the eligible medical practitioner has been consulted and agreed to the referral to the second eligible allied health practitioner; and
    (d) the first eligible allied health practitioner has documented the eligible medical practitioner's agreement in the patient's notes.
- Services under items 82000, 82005, 82010 and 82030 will continue to be available following referral by an eligible medical practitioner.
- Subclause 5.1.1(5) provides that item 82000, 82005, 82010 or 82030 only applies to a service if the patient has received less than 8 services in the patient's lifetime to which any of items 82000, 82005, 82010, 82030, 93032, 93033, 93040 or 93041 apply.
- For the purposes of items 82000, 82005, 82010 and 82030, subclause 5.1.1(7) provides that where the same eligible allied health practitioner has provided a patient with four services to which any of items 82000, 82005, 82010, 82030, 93032, 93033, 93040 or 93041 apply under a single referral, the eligible allied health practitioner must request the provision of additional services from the eligible medical practitioner who initially referred the patient before providing any of the remaining available services. The eligible allied health practitioner must make a record of the medical practitioner's agreement in the patient's notes.
- Subclause 5.1.1(8) provides that item 82015, 82020, 82025 or 82035 will only apply to a service provided to a patient if in the patient's lifetime the patient has been provided less than 20 services to which any of items 82015, 82020, 82025, 82035, 93035, 93036, 93043 or 93044 apply.

The provisions set out in clause 5.1.1 are currently specified in section 8AA of the Former Determination.

Clause 5.1.2 provides the referral requirements for complex neurodevelopmental disorder and disability services where the patient is referred by a consultant physician specialising in the practice of the consultant physician's field of psychiatry or paediatrics, specifying the items under which referrals by different medical practitioners must be provided. These requirements are currently specified in section 8 of the Former Determination.

Clause 5.1.3 provides the referral requirements for disability services where the patient is referred by a specialist, consultant physician or general practitioner, specifying the items under

which referrals by different medical practitioners must be provided. These requirements are currently specified in section 8A of the Former Determination.

Clause 5.1.4 provides that for the purposes of items 82000, 82005, 82010 and 82030, at the completion of a course of assessment, the allied health professional must provide a written report to the medical practitioner who initially referred the patient. This requirement is currently specified in section 9A of the Former Determination. Note, the term ***course of treatment*** is defined in subsection 4(1).

Clause 5.1.5 provides limitation provisions for allied health case conference items for patients with a complex neurodevelopmental disorder or an eligible disability. These items will be referred to as the 'complex neurodevelopmental disorder and disability case conference services' for the purpose of explaining the relevant provisions in this clause.

Subclause 5.1.5(2) provides that a complex neurodevelopmental disorder and disability case conference service can only be undertaken for a patient that:

- is a patient younger than 25 years of age; and
- the patient has been diagnosed with, or is suspected of having, a complex neurodevelopmental disorder or an eligible disability.

Under the current arrangements in the Former Determination, only patients under the age of 13 years old are eligible for complex neurodevelopmental disorder and disability case conference services. From 1 March 2024, these services will be available to patients under the age of 25 years old, aligning the eligibility requirements for these services with other complex neurodevelopmental disorder and disability services. This change was agreed to by Government as part of the 2023-24 Budget.

Subclause 5.1.5(3) relates to the requirements of the multidisciplinary case conference team for the complex neurodevelopmental disorder and disability case conference services.

For patients with, or suspected of having, a complex neurodevelopmental disorder, subparagraph 5.1.5(3)(a)(i) requires that the team must include a consultant physician in the practice of the consultant physician's specialty of paediatrics or psychiatry. This would commonly be the practitioner who organises and coordinates the case conference.

For patients with, or suspected of having, an eligible disability, subparagraph 5.1.5(3)(a)(ii) requires that the team must include a GP, specialist or consultant physician. This would commonly be the practitioner who organises and coordinates the case conference.

Subsection 5.1.5(4) specifies the types of eligible allied health practitioner. This list includes the allied health practitioners who can perform the individual allied health attendance services in Group M10 of the Determination as well as eligible Aboriginal health workers, eligible Aboriginal and Torres Strait Islander health practitioners, eligible mental health nurses and eligible mental health workers.

The requirements set out in clause 5.1.5 are currently specified in section 16 of the Former Determination.

Clause 5.1.6 provides the table of items in Group M10 for complex neurodevelopmental disorder and disability services. This clause introduces new subgroups to Group M10. Subgroup 1

contains allied health attendance items for complex neurodevelopmental disorder and disability services and Subgroup 2 contains complex neurodevelopmental disorder and disability case conference services. The schedule fees for items in Group M10 reflect the current fees for allied health services following 1 November 2023 indexation. Note, section 17 of the Former Determination, which applies annual indexation to allied health items, has been removed as all listed fees have been updated to reflect the current fees.

Part 6 – Services and fees—Aboriginal and Torres Strait Islander services

Part 6 of Schedule 2 of the Determination sets out the provisions and items for allied health services for patients of Aboriginal or Torres Strait Islander descent in Group M11. These items will be referred to as 'Aboriginal and Torres Strait Islander services' for the purpose of explaining the relevant provisions in Part 6.

Clause 6.1.1 provides application and limitation provisions for Aboriginal and Torres Strait Islander services specified in Group M11. In accordance with subclause 6.1.1(1), an item in Group M11 only applies to a service if:

- The patient is referred to the eligible provider for the service by a medical practitioner using a referral form that has been issued by the Department or a referral form that contains all the components of the form issued by the Department. The form issued by the Department is available on the Department's website.
- The service is provided to patient individually and in person.
- After the service, the eligible provider gives a written report to the referring medical practitioner in accordance with subparagraphs (i) to (iii).

The requirements set out in subclause 6.1.1(1) are currently specified in the item descriptors of the relevant Aboriginal and Torres Strait Islander services listed in the Former Determination. The Determination removes these requirements from the item descriptors of the services listed in Group M11.

Clause 6.1.2 provides the table of items in Group M11 for Aboriginal and Torres Strait Islander services. This table of items in Group M11 implements the Government's response to MBS Review Taskforce recommendations relating to primary care. Items 81300, 81305, 81310, 81315, 81320, 81325, 81330, 81335, 81340, 81345, 81350, 81355 and 81360 have been amended to allow patients of Aboriginal or Torres Strait Islander descent to access up to 10 allied health services per calendar under a chronic disease management plan and/or following a health assessment. Eligible patients will have access to a total of 10 services to which any item in Group M11 or Subgroup 1 of Group M3 or item 93000, 93013, 93048 or 93061 of the Telehealth and Telephone Determination applies per calendar year. Patients will continue to have access to a maximum of five services per calendar year to which an item in Subgroup 1 of Group M3 applies.

This change is intended to make access to allied health services under the MBS easier for First Nations Australians who have chronic disease management arrangements (GP Management Plan and team care arrangements or a multidisciplinary care plan) or have had a health assessment. The changes to Aboriginal and Torres Strait Islander services were agreed to by Government as part of the 2023-24 Budget.

The schedule fees for items in Group M11 reflect the current fees for allied health services following 1 November 2023 indexation. Note, section 17 of the Former Determination, which

applies annual indexation to allied health items, has been removed as all listed fees have been updated to reflect the current fees.

Part 7 – Services and fees—audiology services (diagnostic)

Part 7 of Schedule 2 of the Determination sets out the provisions and items for allied health services related to audiology in Group M15.

Clause 7.1.1 provides request requirements for diagnostic audiology services in Group M15, excluding item 82301. Subclause 7.1.1(2) provides that the request must be in writing and must contain:

- the date of request;
- the name of the eligible practitioner who requested the service and either the address of the practitioner's place of practice or the provider number in respect of the practitioner's place of practice; and
- a description of the service which provides sufficient information to identify the service as relating to any of items 82300 to 82332, excluding item 82301, but need not specify the item number.

A service to which item 82301 applies does not require a request.

Subclause 7.1.1(2) provides that a request for a service under one of the relevant items may be for the performance of more than one diagnostic audiology service making up a single audiological assessment but cannot be for more than one audiological assessment.

The request requirements set out in clause 7.1.1 are currently specified section 12 of the Former Determination.

Clause 7.1.2 provides the table of items in Group M15 for diagnostic audiology services. The schedule fees for items in Group M15 reflect the current fees for allied health services following 1 November 2023 indexation. Note, section 17 of the Former Determination, which applies annual indexation to allied health items, has been removed as all listed fees have been updated to reflect the current fees.

Part 8 – Services and Fees – eating disorders services

Part 8 of Schedule 2 of the Determination sets out the provisions and items for allied health services related to eating disorders in Group M16.

Clause 8.1.1 provides application and limitation provisions for eating disorder services in Group M16. Subclause 8.1.1(1) provides a list of evidence-based psychological therapies which must be used as part of an eating disorder mental health treatment service for a Medicare benefit to be paid under an item listed in Subgroup 2 of Group M16.

Subclauses 8.1.1(2) to (4) provide conditions regarding when a patient may access eating disorder psychological treatment services under an item in Subgroup 2 of Group M16, and how many of these services a patient may access.

Subclause 8.1.1(2) provides that an item in Subgroup 2 of Group M16 does not apply to a service for providing treatment under an eating disorder treatment and management plan if:

- The service is provided more 12 months after the plan is prepared. Patients requiring further treatment will need a new eating disorder treatment and management plan to provide a comprehensive and coordinated treatment plan for the next 12 month.
- The patient has been provided 40 services under the plan. Accordingly, a patient can have no more than 40 eating disorder psychological treatment services in a 12 month period from the date the plan is provided.
- The patient has received 10 services under the plan and a recommendation has not been given by a reviewing medical practitioner for additional services to be provided under the plan.
- The patient has received 20 services under the plan and recommendation has not been given by both a medical practitioner (other than a specialist or consultant physician) and a consultant physician practising in the specialty of psychiatry or paediatrics for additional services to be provided under the plan.
- The patient has received 30 services under the plan and a recommendation has not been given by a reviewing medical practitioner for additional services to be provided under the plan.

Subclause 8.1.1(3) provides the requirements for a recommendation by a reviewing medical practitioner for additional services to be provided under an eating disorder treatment and management plan. Paragraph 8.1.1(3)(a) provides that the recommendation that additional services be provided under the plan must be made as part of a service to which an item in Subgroup 3 of Group A36 of the general medical services table or Subgroup 25 or 26 of Group A40 of the Telehealth and Telephone Determination applies. Paragraph 8.1.1(3)(b) provides when the service where the recommendation is given must be provided and paragraph 8.1.1(3)(c) provides that the practitioner must record the recommendation in the patient's records.

Subclause 8.1.1(4) provides the list of services which are considered services providing treatments under a plan for the purposes of this clause and are counted towards a patient's total services provided under an eating disorder treatment and management plan.

Subclause 8.1.1(5) provides that an item in Subgroup 1 of Group M16 does not apply to a service if the patient has received 20 eating disorder dietetic treatment services in a 12 month period from when an eating disorder and treatment plan was prepared. Note, the term ***eating disorder dietetic treatment service*** is defined in subsection 4(1).

Subclause 8.1.1(6) defines the term ***eligible patient*** for the purposes of items in Subgroup 2 of Group M16. A patient is an eligible patient if the patient meets the requirements specified in clause 2.31.2 of the general medical services table.

The provisions set out in clause 8.1.1 are currently specified in section 6AA of the Former Determination.

Clause 8.1.2 provides the reporting requirements for eating disorder services in Group M16. Subclause 8.1.2(1) provides that the relevant allied health professional must provide the referring medical practitioner with a written report on assessments carried out, treatment provided and recommendations for future management of the patient's condition at required intervals. Subclause 8.1.2(2) provides the required intervals at which reports must be provided to the referring medical practitioner. These requirements are currently specified in section 6AB of the Former Determination.

Clause 8.1.3 provides the referral requirements for eating disorder services, specifying the items under which referrals by different medical practitioners must be provided. These requirements are currently specified in section 8B of the Former Determination.

Clause 8.1.4 provides that items 82359, 82367, 82375 and 82383 do not apply to a service if the patient or allied health professional travelled to satisfy the requirement that the patient be a distance of at least 15 km by road from the allied health professional. This provision is currently specified in section 6AC of the Former Determination.

Clause 8.1.5 provides the table of items in Group M16 for eating disorder services. Items in Group M16 are separated into the following Subgroups:

1. Eating disorder dietitian services;
2. Eating disorder psychological treatment services provided by eligible clinical psychologists;
3. Eating disorder psychological treatment services provided by eligible psychologists;
4. Eating disorder psychological treatment services provided by eligible occupational therapists; and
5. Eating disorder psychological treatment services provided by eligible social workers.

The schedule fees for items in Group M16 reflect the current fees for allied health services following 1 November 2023 indexation. Note, section 17 of the Former Determination, which applies annual indexation to allied health items, has been removed as all listed fees have been updated to reflect the current fees.

Schedule 3 – Repeals

Item 1 repeals the whole of the *Health Insurance (Allied Health Services) Determination 2014*.

Statement of Compatibility with Human Rights

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

Health Insurance (Section 3C General Medical Services – Allied Health Services) Determination 2024

This 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 (Section 3C General Medical Services – Allied Health Services) Determination 2024* (the Determination) is to repeal and remake the *Health Insurance (Allied Health Services) Determination 2014* (the Former Determination) which is due to sunset on 1 April 2024. This remake will ensure that Medicare benefits continue to be payable for allied health services performed by those practitioners.

As part of the remake, the Determination makes administrative changes, which will include:

- aligning the Determination with other legislative instruments underpinning the Medicare Benefits Schedule;
- updating schedule fees in the Determination to incorporate current indexed fees, as indexation has previously been applied through a provision;
- ensuring qualification requirements align with current professional standards;
- providing clearer links between items and related provisions;
- implementing subgrouping in larger groups of items; and
- removing references to ceased items and legislative instruments.

The Determination will also implement the following changes, which were agreed to by Government in the 2023-24 Budget:

- Increase the age limit for case conference services for complex neurodevelopmental disorders from under 13 to under 25 years of age to align these services with other items for complex developmental disorder and eligible disability services.
- Amend 13 items for allied health services provided to a patient who is of Aboriginal or Torres Strait Islander descent to streamline access to up to 10 allied health services in a calendar year.

Human rights implications

This instrument engages 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.

The right of equality and non-discrimination

The rights of equality and non-discrimination are contained in articles 2, 16 and 26 of the International Covenant on Civil and Political Rights (ICCPR). Article 26 of the ICCPR requires that all persons are equal before the law, are entitled without any discrimination to the equal protection of the law and in this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

Analysis

This instrument maintains the rights to health and social security and the right of equality and non-discrimination by ensuring eligible patients continue to have access to Medicare benefits for allied health services listed in the Determination. This instrument also advances these rights by expanding the age limit for complex neurodevelopmental disorder and disability case conference services to under 25 years of age and by providing easier access to 10 allied health services per calendar year for patients of Aboriginal or Torres Strait Islander descent.

Conclusion

This instrument is compatible with human rights as it maintains and advances the right to health, the right to social security and the right of equality and non-discrimination.

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