Health Insurance (1994-1995) General Medical Services Table Regulations 1994 No. 362

EXPLANATORY STATEMENT

STATUTORY RULES 1994 No. 362

Issued by authority of the Minister for Human Services and Health

Health Insurance Act 1973

Health Insurance (1994-1995) General Medical Services Table Regulations

The Health Insurance Act 1973 (the Act) provides for payments by way of medicare benefits, payments for hospital services and payments for matters concerning related committees and tribunals.

Section 133 of the Act provides that the Govern or- General may make regulations for the purposes of the Act.

Section 4 of the Act provides that the regulations may prescribe a table of medical services (the table), (other than diagnostic imaging services and pathology services). The Health Insurance (General Medical Services Table) Regulations, Statutory Rules 1993 No. 272 and 1994 No. 112 currently prescribe such a table.

Section 9 of the Act provides that medicare benefits shall be calculated by reference to the fees for general medical services set out in the table.

The purpose of the Regulations is to prescribe a new table of general medical services and rules of interpretation which will incorporate a general fee increase, the introduction of new services, the deletion of obsolete services and the amendment to the descriptions and/or fees of other services. The Regulations also provide for the repeal of Statutory Rules 1993 No. 272 and 1994 No. 112 which give authority for the table which is to be replaced.

Details of the regulations are as follow:

Regulation 2 provides for the regulations to commence on 1 November 1994.

Regulation 3 repealed Statutory Rules 1993 No. 272 and 1994 No. 112 which gave authority for the table which has been replaced.

Regulation 4 prescribes the new table of general medical services and rules of interpretation.

Rules of Interpretation

A new rule and amended rules have been introduced for the purpose of interpreting the table. These are as follow:

(a) the definition of "general intensive care unit" in rule 1(1) has been amended to require that the support specialist or consultant physician must be exclusively rostered to the intensive care unit.

(b) the definition of "neo-natal intensive care unit" in rule 1(1) has also been amended to require that the support specialist or consultant physician must be exclusively rostered to the intensive care unit.

(c) the explanation of the symbol "(AUn)" in rule 1(4) has been amended to reflect the change in the method of describing anaesthetic units attributed to items in the table, now, e.g. (Anaes. 17726 = 16B + 10T).

(d) a new rule (Rule 5) has been inserted to define the formula used to indicate the level of anaesthetic units allocated to individual operative procedures in the table.

(e) the dollar amounts stated in rules 6, 16 and 17 have been amended to reflect changes resulting from the general fee increase.

(f) the item numbers in rules 9 and 10 have been adjusted to take into account item numbers added to and deleted from the table.

(g) the heading for rule 20 has been amended to include the words "and Maxillofacial" after the word "Oral", for clarification.

(h) in rule 21 the words "and who is accredited by the Minister for the purposes of this rule" have been inserted after the word "law" in subrule (1)(a).

(i) in rule 22 the words "and maxillofacial" have been added after the word "oral" in subrules (1) and (2)(a), for clarification.

(j) item 16506 has been deleted from rule 28 and item 16516 has been deleted from rules 28 and 29 to reflect the deletion of these items from the table from 1 May 1994.

(k) the item range in rule 31 has been extended from 46510 to 46534 to take account of new items introduced into the table.

(l) the amount in rule 36 has been increased to $13.70 to reflect the increase in the value of one anaesthetic unit.

The remaining rules are unchanged.

Table of Services and Fees

The fees for services in the table have been adjusted in line with the announcement made in the 1994/1995 Budget. Fees have been adjusted as follow:

Range of items	Fee Adjustment
(a) 3 - 51	0.635 per cent
(b) 52 - 96	no increase
(c) 97 - 98	0.635 per cent
(d) 104 - 159	1.27 per cent
(e) 160 - 173	0.635 per cent
(f) all other items	1.27 per cent

Other changes incorporated in the table flow mainly from reviews facilitated through the Medicare Benefits Consultative Committee. These changes involve the introduction of new services, the deletion of obsolete services and amendment to the descriptions and/or fees of other services. The changes are designed to ensure that the table reflects current medical practice. Details of these changes are as follow:

(a) a major review of paediatric surgery items (items 43801 to 44136) - items covering paediatric surgery have been restructured to reflect developments in this area which have made paediatric surgery a well established and complex specialty dealing with unique disorders and

involving delicate and intricate operative techniques completely different to other branches of surgery. The capacity to treat neonates suffering major congenital malformations is an advance not previously covered.

(b) a major restructure of anaesthetic services (items 17701 to 18118) - a review of these services acknowledged that the items no longer reflected the scope, complexity or value of anaesthetic services because of changes in anaesthetic practice. The key elements of the restructure are a reallocation of average anaesthetic times to reflect current practice; an increase in the value of one anaesthetic unit from $13.05 at November 1993 levels to $13.70 at November 1994 levels; widening of the range of unit allocations reflecting anaesthesia complexity from a maximum of 8 units to 20 units; the removal of the general practitioner and specialist fee differential for the pre-anaesthetic examination of a patient; and significantly increased fees for an anaesthetic administered for Caesarean Section and for epidural anaesthesia.

(c) a redefinition of the item relating to injection sclerotherapy of varicose veins (item 32500) - this item has been amended to ensure that Medicare benefits are only paid in "clinically relevant" circumstances. There has been an increase in recent years of the incidence of the treatment of superficial lesions on the legs for "cosmetic" reasons. In addition, the fee for item 32500 covering injection sclerotherapy of varicose veins has been reduced as the fee was originally set on the basis that the service was provided by specialists. Changing techniques have facilitated a move out of the specialist area.

(d) a review of items covering ambulatory electrocardiographic (ECG) monitoring (items 11708 to 11713) - Items covering ambulatory ECG (Holter) monitoring have been restricted to those circumstances where ECG recordings are interpreted and reported on by a specialist or consultant physician (due to concerns about patient safety resulting from use of the investigation by inadequately trained providers). The items have been further restricted to prevent the inappropriate use of these items for ambulatory blood pressure monitoring.

(e) the removal of the remaining general practitioner and specialist fee differentials in the obstetrics area of the table (items 16506 and 16516) - following the removal of the general practitioner and specialist fee differentials for the global confinement items at the 1 May 1994 changes to the table (introduced in response to a significant decline in general practitioner involvement in these services, particularly in rural areas), the remaining fee differentials in this area have now been removed.

(f) other changes to the areas of hand surgery (Items 46300 to 46534), ophthalmology (Items 42503 to 42827), intensive care (items 13815 to 13888), ENT surgery (items 41500 to 41910), varicose veins surgery (items 32500 to 32517) and psychiatry (items 153 and 159) - some additions and amendments have been made to services in these areas to clarify intent or to remove ambiguities.

(g) the introduction of a new optometrical consultation item (item 106) - a new item to cover attendances by participating optometrists which are less than 15 minutes duration (item 10906) has been introduced to cover the situation where the full initial consultation fee is not warranted (e.g. removal of foreign body or ingrown eyelash).

(h) the descriptions of all other services are unchanged.

The Regulations come into effect on 1 November 1994.