Health Insurance (General Medical Services Table) Regulations 2004 2004 No. 308

EXPLANATORY STATEMENT

STATUTORY RULES 2004 NO. 308

Issued by the Authority of the Minister for Health and Ageing

Health Insurance Act 1973

Health Insurance (General Medical Services Table) Regulations 2004

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

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

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 Subsection 4(2) of the Act provides that, unless sooner repealed, regulations made under section 4 cease to be in force and are taken to have been repealed on the day next following the 15th sitting day of the House of Representatives after the end of a period of 12 months beginning on the day on which the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

A table of general medical services is currently prescribed by the *Health Insurance (General Medical Services Table) Regulations 2003* (the 2003 Regulations). The table was amended by the *Health Insurance (General Medical Services Table) Amendment Regulations 2003 (No.2)* and *(No.3)*, and the *Health Insurance (General Medical Services Table) Amendment Regulations 2004 (No.1)*, *(No.2)*, *(No.3)*, *(No.4)*, *(No.5)*, *(No.6)* and *(No.7)*. The 2003 Regulations were notified in the *Gazette* on 16 October 2003 and commenced on 1 November 2003.

The purpose of the Regulations is to repeal the 2003 Regulations and the amending regulations, and to prescribe a new table of general medical services for the 12 month period commencing on 1 November 2004. The new table sets out the items of general medical services which are eligible for Medicare benefits, the amount of fees applicable in respect of each item and rules for interpretation of the table. The new table replaces the table contained in the 2003 Regulations.

The Regulations make a number of changes as part of the ongoing management of the table. The changes:

- provide for the annual indexation of the fees paid for all items in the table, excluding item 173 (acupuncture performed by a medical practitioner) and the items in Group A2 which relate to other medical practitioners (with the exception of emergency attendance after hours items). Fees will be increased by 2.1%;

- provide additional fee increases for six items of vascular studies;

- introduce three new rules;
- amend four existing rules;
- introduce ten new items;
- amend forty-two existing items;
- duplicate 41 existing items of oral and maxillofacial surgery. The items are currently available to dental practitioners, and the duplicated items will be available to medical practitioners; and
- remove seven items which are no longer current clinical practice.

The new rules and items, and amendments to existing rules and items have been recommended by reviews conducted by the Medical Services Advisory Committee and ongoing reviews by the Medicare Benefits Consultative Committee. The reviews are designed to ensure that the table reflects current medical practice and encourages best practice.

Details of the Regulations are set out in the Attachment.

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

The Regulations commence on 1 November 2004.

ATTACHMENT

DETAILS OF THE *HEALTH INSURANCE (GENERAL MEDICAL SERVICES TABLE) REGULATIONS 2004*

Regulation 1 provides for the Regulations to be referred to as the *Health Insurance (General Medical Services Table) Regulations 2004*.

Regulation 2 provides for the Regulations to commence on 1 November 2004.

Regulation 3 repeals Statutory Rules 2003 Nos. 255, 318 and 359, and Statutory Rules 2004 Nos. 65, 77, 126, 183,184, 237 and 267.

Regulation 4 defines, for the purpose of the Regulations, **Act** to mean the *Health Insurance Act 1973* and **this table** to mean the table of general medical services set out in Schedule 1.

Regulation 5 provides that the new table of general medical services and rules of interpretation are set out in Schedule 1.

In addition to completely re-making the *Health Insurance (General Medical Services Table) Regulations 2003*, the General Medical Services Table 2004:

- provides for the annual indexation of the fees paid for all items in the table, excluding item 173 (acupuncture performed by a medical practitioner) and the items in Group A2 which relate to other medical practitioners (with the exception of emergency attendance after hours items). Fees will be increased by 2.1%;

- provides additional fee increases for six items of vascular studies;

- introduces three new rules;

- amends four existing rules;

- introduces ten new items;

- amends forty-two existing items;

- duplicates 41 existing items of oral and maxillofacial surgery. The items are currently available to dental practitioners, and the duplicated items will be available to medical practitioners; and

- removes seven items which are no longer current clinical practice.

Part 2 - Rules of Interpretation

Rule 3

Rule 3 provides definitions for the purposes of the table. The Regulations amend rule 3 to introduce a definition of ***approved day hospital facility***. An approved day hospital facility will be defined to have the same meaning as day hospital facility within the meaning of the *National Health Act 1953*. There are many items in the table that refer to an approved day hospital facility and the introduction of the definition clarifies the meaning of the term.

New rule 5

Subsection 10(2) of the *Health Insurance Act 1973* specifies that the Medicare benefit payable for services provided in a hospital or day hospital facility is 75% of the Schedule fee, and that services provided out of hospital attract a rebate of 85% of the Schedule fee.

New rule 5 introduces the symbol "(***H***)" to identify the services that can only be provided in a hospital or approved day hospital facility and consequently attract a benefit of 75%. This will ensure that benefits are paid appropriately, and that claims cannot be made if the service was provided out of hospital, or purported to be provided out of hospital, and therefore attract a higher rebate of 85%.

The introduction of rule 5 (and rules 15 and 60, below) make it necessary to renumber all rules (except rules 1 to 4).

Rule 11

Rule 11 will be amended to delete items 14103, 14120, 14122, 14126, 14128, 14130 and 14132. These items will be deleted from the table as they no longer accord with clinical practice (see Skin Surgery, below).

Rule 12

Rule 12(3) will be amended to include items 11722 and 11820, as these items are services that must be provided by medical practitioners.

Rule 12 will also be amended to delete items 14103, 14120, 14122, 14126, 14128, 14130 and 14132. These items will be deleted from the table as they no longer accord with clinical practice (see Skin Surgery, below).

New rule 15

New rule 15 precludes the payment of benefits for any item in the range 1 to 10941 if the service is provided at the same time as, or in connection with, any of the services specified in new Part 4 of the table (see new Part 4, below).

Rule 16

Rule 16 will be amended to clarify that items 51700 to 53706 in Category 4 of the table apply only to services provided by dental practitioners who, prior to 1 November 2004, were approved by the Minister to perform oral and maxillofacial surgery (see Oral and Maxillofacial Surgery, below).

New rule 60

New rule 60 defines, for the purposes of new item 903, **residential medication management review**, as a collaborative service provided by a medical practitioner and a pharmacist to review the medication management needs of a permanent resident of a residential aged care facility.

Part 3 - Services and Fees

Residential medication management review

New item 903 provides for participation by a medical practitioner and a pharmacist in a collaborative residential medication management review of a permanent resident of a residential aged care facility. The item stipulates patient eligibility and the activities that must be performed by the medical practitioner. Benefits will not be payable more than once in a twelve month

period in respect of the same person, except where there has been a significant change in medical condition or medication regimen.

Ophthalmology

Items 11240, 11241, 11242 and 11243 will be amended to include partial coherence interferometry (PCI) as an alternative to unidimensional ultrasonic echography for measuring the eye prior to lens surgery. PCI uses a dual laser beam to measure the length of the eyeball before cataract surgery to determine the appropriate lens to be inserted. The inclusion of PCI follows an assessment of the technology by the Medical Services Advisory Committee.

Vascular fees

The fees for items 11602, 11604, 11605, 11610, 11611 and 11614 for venous and arterial studies will be increased. In November 2003, items for vascular studies were clarified to better reflect current clinical practice. These changes have resulted in unintended savings estimated at $490,000. The changes to the fees will bring expenditure under the items back to pre-November 2003 levels.

Cardiac investigations

An implantable electrocardiography (ECG) loop recorder is a device used to detect the cardiac causes of syncope or sudden loss of consciousness associated with abnormal heart rhythm. Following an assessment of the technology by the Medical Services Advisory Committee, three new items will be introduced to provide for:

- interpretation of the data obtained from the recorder (item 11722);
- implanting a recorder under the skin (item 38285); and
- removing the recorder (item 38286).

Skin surgery

Laser photocoagulation

Items 14100, 14106, 14109, 14112, 14115, 14118 and 14124 will be amended to ensure they accord with current clinical practice, and that Medicare benefits are paid for specified clinical conditions that are proven to benefit from laser treatment.

Items 14103, 14120, 14122, 14126, 14128, 14130 and 14132 will be removed because they no longer accord with clinical practice.

Skin tags

Item 30195 will be amended to expressly exclude the removal of skin tags. This clarifies that the item is for removal of benign neoplasms of the skin using the methods specified in the item. Skin tags can be removed on an attendance basis.

Multiple specimens

Items 31220 and 31225, which provide for the removal of multiple skin lesions, will be amended to clarify that all lesions excised should be sent for histological examination.

Shave excision

Items 31255, 31260, 31265, 31270, 31275, 31280, 31285 and 31290 provide for the removal of basal cell carcinoma or squamous cell carcinoma of differing sizes and anatomical sites by surgical excision requiring suture. These items will be amended to exclude shave excision as a method of removal under the items.

Plastic Surgery

Abdomen closure and breast reconstruction

Items 30165, 30168, 30171, 30174, 30177, and 30178 will be amended to correctly refer to breast reconstruction item 45530, not item 45533.

Item 45530 will be amended to include a reference to items 30165, 30168, 30171 and 30177, the effect of which will be that benefits can only be paid if item 30178 is claimed on the same day.

Item 45533 will be amended to include a reference to item 30178 so that benefits cannot be paid if any of the items 30165, 30168, 30171, 30174, 30177, and 30178 is claimed on the same day.

Liposuction for diabetic contouring

Item 31346 will be amended to include liposuction for the treatment of contouring problems of the upper arm or thigh due to repeated insulin injections in diabetics, in accordance with current clinical practice.

Augmentation mammaplasty

Item 45528, which provides for augmentation mammaplasty where surgery can be indicated for congenital malformations, disease and trauma of the breast, will be amended to include malformation of breast tissue arising from other clinical conditions, but excluding hypomastia.

Gynaecology

IUD and endometrial biopsy

New item 35502 will be introduced to provide for insertion of a therapeutic intrauterine device (IUD) for idiopathic menorrhagia (excessive uterine bleeding for which no organic reason can be found) with biopsy of the endometrium (lining of the uterus).

Clinical practice dictates that endometrial biopsy should be taken before the insertion of a therapeutic IUD for the control of idiopathic menorrhagia to exclude endometrial pathology. This is recommended in the approved product information for therapeutic IUDs.

Stress incontinence

Item 35599, which provides for sling operation for stress incontinence using the patient's tissue or mesh, will be amended to clarify that the technique can also include the use of surgical tape. Surgical tape is now available as an alternative to mesh for sling operation for stress incontinence, and has been in common usage in Australia and internationally for a number of years.

Assistance for tubal ligation at the time of Caesarean section

Item 35691 provides for sterilisation by tubal ligation when performed at the time of caesarean section. Assistance is always necessary at Caesarean section, and is also required for tubal sterilisation. Item 35691 will be amended to allow the payment of benefits for assistance. This is consistent with item 35688, which provides assistance for tubal ligation when performed as an independent procedure.

Cardiac surgery

Cardiac septostomy

Item 38270 will be amended to clarify that the item is for 'isolated atrial septostomy', which is a more accurate description.

Closure of atrial septal defect

New item 38743 will be introduced for closure of atrial septal defect using a septal occluder (or disc) device by a transcatheter approach, and to provide for the payment of benefits for anaesthesia and assistance. Atrial septal defect is commonly known as a 'hole in the heart'. Surgical procedures to correct this defect have traditionally been performed by open surgery under item 38742. A catheter based approach to insert a septal occluder to close the hole is now widely used in Australia.

Spinal and peripheral nerve stimulation for pain management

Items 39130 to 39139 provide for spinal nerve stimulation for pain management. These items will be amended to clarify that the items are for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris, to preclude their use for indications for which the treatment is not yet proven. Minor changes will also be made to better reflect the sequence of the treatment and to restructure the fees for the items accordingly.

Three new items, 39135, 39137 and 39138, will be introduced to expressly provide for the payment of Medicare benefits for peripheral nerve stimulation.

Oral and maxillofacial surgery

Forty-one oral and maxillofacial surgery items in Category 4 of the Table will be duplicated in Category 3 of the Table. The new item numbers will be in the range 45799 to 45899. Only medical practitioners can claim items in Category 3, while Category 4 items are available to dental practitioners who have been approved by the Minister to perform oral and maxillofacial surgery.

In line with international best practice, practitioners performing oral and maxillofacial surgery in Australia are required to have both dental and medical qualifications. The effect of duplicating these items in Category 3 will be to ensure that benefits for oral and maxillofacial surgery are paid only when performed by practitioners with dual medical and dental qualifications. The Category 4 items will remain available only to those dental practitioners who were approved to perform oral and maxillofacial surgery prior to 1 November 2004.

Orthopaedic surgery

New item 50201 will be introduced for biopsy of aggressive or potentially malignant bone or deep soft tissue tumour involving neurovascular structures. Biopsy of bone or deep soft tissue tumours that involve neurovascular structures has a greater complexity and carries a higher risk. Vessels and nerves surrounding the tumour cannot be dissected with the tumour because of the risk of contamination, and the surgeon must painstakingly excise the tumour without damaging the neurovascular structures. Skilled surgical assistance is required to minimise the risk of

inadequate exposure resulting in trauma to the major blood vessels or nerves, potentially resulting in death. The new item provides a higher fee for the surgeon and permit the payment of benefits for assistance for more complex biopsies.

New Part 4 Non-medicare services

New Part 4 lists medical services that are not eligible for a Medicare rebate as provided for in new Rule 15. Services will be listed in Part 4 following the Minister's endorsement of a recommendation of the Medicare Services Advisory Committee that a service is not supported by evidence to be safe, effective or cost-effective. Alternatively, the Minister may decide on policy grounds that a particular service cannot attract a Medicare rebate, and these will be included in Part 4 from time to time. These services will be known as non-medicare services.