EXPLANATORY STATEMENT

*Health Insurance Act 1973*

*Health Insurance (Section 3C General Medical Services – Cardiac Services) Determination 2020*

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 Table) shall, in specified circumstances and for specified statutory provisions, be treated as if it were specified in the Table.

The Table 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 (No. 2) 2020.*

**Purpose**

The purpose of the *Health Insurance (Section 3C General Medical Services – Cardiac Services) Determination 2020* (the Determination) is to list 10 new Medicare Benefits Schedule (MBS) items for cardiac investigation services from 1 August 2020. These amendments are part of the Government’s response to changes recommended by the clinician-led MBS Review Taskforce (the Taskforce) made during the 2018-19   
Mid-Year Economic and Fiscal Outlook (MYEFO) under the *Guaranteeing Medicare – strengthening primary care* measure.

The Determination will list 10 new cardiac diagnostic testing items to align with clinical guidelines regarding the types of medical practitioners who can conduct and interpret electrocardiograph testing, and clarify the requirements and frequency for exercise or pharmacological electrocardiogram stress testing for optimal patient safety.

The new items will replace the nine existing MBS cardiac items (11700, 11701, 11702, 11708, 11709, 11710, 11711, 11712 and 11722) which will be removed from the MBS on 1 August 2020 by the *Health Insurance Legislation Amendment (2020 Measures No. 1) Regulations 2020*.

The Government response to the Taskforce’s recommendations on cardiac diagnostic imaging will be implemented by the *Health Insurance (Section 3C Diagnostic Imaging Services – Cardiac Services) Determination 2020*. That instrument will list 19 new MBS items for cardiac diagnostic imaging services from 1 August 2020.

**Consultation**

Consultation was undertaken on the cardiac changes that were recommended by the MBS Review Taskforce, and announced in the 2018-19 MYEFO under the *Guaranteeing Medicare – strengthening primary care* measure.

The MBS Review was conducted by expert committees and working groups focusing on specific areas of the MBS. The Cardiac Services Clinical Committee (CSCC) report on changes to cardiac services was released for public comment and further consideration taken based on stakeholder feedback. The CSCC report was then presented to the Taskforce for finalisation and endorsement of the recommendations, before being presented to Government.

The Department has also undertaken consultation with key stakeholders on the cardiac changes, including the Cardiac Society of Australia and New Zealand, the Australian Medical Association, the Rural Doctors Association of Australia, the Royal Australian College of General Practice, the Australian and New Zealand Society of Cardiac and Thoracic Surgeons, the Australian Private Hospitals Association, as well as individual practitioners.

Details of the Determination are set out in the Attachment.

The Determination commences on 1 August 2020.

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

Authority: Subsection 3C(1) of the

*Health Insurance Act 1973*

ATTACHMENT

Details of the *Health Insurance (Section 3C General Medical Services – Cardiac Services) Determination 2020*

Section 1 – Name

Section 1 provides for the Determination to be referred to as the *Health Insurance (Section 3C General Medical Services – Cardiac Services) Determination 2020*.

Section 2 – Commencement

Section 2 provides that the Determination commences on 1 August 2020.

Section 3 – Authority

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

Section 4 – Definitions

Section 4 defines terms used in the Determination.

Section 5 – Treatment of relevant services

Section 5 provides that a clinically relevant service provided in accordance with the Determination shall be treated, as if it were both a professional service and a general medical service (the Table) and as if there were an item specified in the Table for the service.

Section 6 – Application of provisions of the general medical services table

Section 6 specifies provisions from the Table that apply as if items in the Schedule of the Determination were specified in the relevant provisions of the Table.

Subsection 6(1) of the Determination provides that items 11705 and 11731 in the Schedule have effect as if the items were specified in clauses 1.2.6 and 1.2.7 of the Table. Clauses 1.2.6 and 1.2.7 of the Table provide that medical practitioners must personally attend the service which must be performed on a single occasion, regardless if the medical practitioner, or a person on behalf of the medical practitioner, performs the service.

Subsection 6(2) of the Determination provides that items 11704, 11705, 11707, 11714, 11716, 11717, 11723, 11729 and 11730 in the Schedule have effect as if the items were specified in clause 1.2.11 of the Table. 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.

Schedule 1 – Relevant services (and application and limitation provisions in sections 7 and 8)

The Determination will list 10 new cardiac diagnostic testing items to align with clinical guidelines regarding the types of medical practitioners who can conduct and interpret electrocardiograph testing, and clarify the requirements and frequency for exercise or pharmacological electrocardiogram stress testing for optimal patient safety.

The Determination will list three distinct types of cardiac diagnostic investigations:

* four 12-lead electrocardiography items to detect and monitor potential cardiac disorders;
* three ambulatory diagnostic testing items to detect and monitor infrequent or unpredictable cardiac arrhythmias;
* two electrocardiogram exercise or pharmacology stress test items for patients with suspected or known heart disorders which are exacerbated by exercise; and
* one implanted loop record to investigate patients with cryptogenic stroke or recurrent unexplained syncope.

**12-lead electrocardiography items**

Schedule 1 of the Determination will list four new 12-lead electrocardiography items:

* Item 11704 for a trace and formal report service performed by a specialist or consultant physician.
* Item 11705 for a formal report service performed by a specialist or consultant physician, where the specialist reports on a trace from a 12-lead electrocardiography.
* Item 11707 for a trace service performed by a medical practitioner.
* Item 11714 for trace and clinical note service performed by a specialist or consultant physician.

Items 11704, 11707 and 11714 do not apply where the patient is an “admitted patient” of a hospital, per subsection 8(1) of the Determination. An “admitted patient” is defined in section 4 of the Determination and includes an episode of hospital treatment and an episode of hospital-substitute treatment where a benefit is paid from a private health insurer. Item 11705 is not subject to subsection 8(1) of the Determination, and can be performed out-of-hospital or for admitted hospital patients.

Items 11704 and 11705 are requested services which require the rendering specialist or consultant physician to produce a “formal report”, as defined in section 4 of the Determination, which must be provided to the requesting practitioner. The rendering specialist or consultant physician cannot perform the service unless it has been requested by another medical practitioner (a “requesting practitioner” as defined in section 4). Subsection 8(2) limits the rendering specialist or consultant physician and the requesting practitioner from having a financial relationship.

As a requested service, it is generally not expected that items 11704 or 11705 involve any clinical work beyond performing the formal report (and the trace for item 11704). The Taskforce recommended that an attendance should not be co-claimed with a diagnostic cardiac investigation in these circumstances. Subsection 8(7) limits item 11704 from being performed if the rendering specialist or consultant physician has performed an attendance on the same patient on the same day. Item 11705 is generally limit from being co-claimed with an attendance, but in exceptional clinical circumstances an attendance can be performed; see subsections 8(8) and (9).

Item 11707 is a trace only service and can be performed by any medical practitioner.

Item 11714 allows specialist and consultant physicians to perform an electrocardiography trace and interpret the results (in the form of producing a clinical note as defined in 4 of the Determination) where they consider it necessary for the management or treatment of the patient. No request is required for this service. There is no limitation on the claiming of an attendance with item 11714, as the Taskforce agreed that performance of an electrocardiography was part of routine assessment for patients presenting to specialist and consultant physicians for management of their cardiac condition.

**Ambulatory diagnostic testing items**

The Determination lists 3 items for ambulatory electrocardiogram testing:

* Item 11716 for a continuously recorded electrocardiogram, for 12 or more hours, performed by specialist or consultant physician, for certain patients.
* Items 11717 and 11723 for patient activated ambulatory electrocardiogram monitoring for patients with unexplained syncope, palpitation or other symptoms where a cardiac rhythm disturbance is suspected and where episodes are infrequent. The services are to be performed by specialist or consultant physician. Item 11717 is for ambulatory electrocardiogram monitoring of between 7 and 30 days, item 11723 is for ambulatory electrocardiogram monitoring of up to 7 days.

Items 11716, 11717 and 11723 do not apply where the patient is an “admitted patient” of a hospital, per subsection 8(1) of the Determination.

Subsections 7(1) to (3) provide the condition for how items 11716, 11717 and 11723 are instigated. Subsection 7(1) provides that a service to which an item applies can be requested by a requesting practitioner or referred. Subsection 7(2) specifies a service is taken to be referred if the specialist or consultant physician who renders the service to which items 11716, 11717 or 11723 applies is the patient’s treating practitioner, determines the need for a cardiac investigation that has not otherwise been scheduled, or performs a scheduled test but also provides an attendance where clinical management decisions are discussed with the patient. Services in all other circumstances are considered to be requested, per subsection 7(3).

If a service to which items 11716, 11717 or 11723 applies is instigated by a request, the service does not apply if the rendering specialist or consultant physician has performed an attendance on the same patient on the same day. An attendance can be performed in association with a service to which items 11716, 11717 or 11723 applies for a service that is referred, as the rendering specialist or consultant physician has performed additional clinical work beyond the cardiac investigation.

**Electrocardiogram exercise or pharmacology stress test items**

The Determination lists 2 items for exercise or pharmacological electrocardiogram stress testing for patients with suspected cardiac ischemia, a family history of (a heritable) arrhythmia, or a known cardiac diseased which may be exacerbated by exercise:

* Item 11729 for a multi-channel electrocardiograph exercise or pharmacological induced stress test performed by a medical practitioner on an adult patient.
* Item 11730 for a multi-channel electrocardiograph exercise or pharmacological induced stress test performed by a medical practitioner on a paediatric patient aged under 17 years.

The items can be performed as an out-of-hospital service or for admitted hospital patients.

The Taskforce recommended a number of changes to the electrocardiogram stress test services to clarify the requirements and frequency for testing to reduce low-value care and encourage best practice safety processes.

Subsection 8(3) requires that the items can only be performed if the patient is suitable for exercise or pharmacological induced stress testing. Subsections 8(4) and (5) exclude the performance of items 11729 and 11730 for patients who are asymptomatic and have a normal cardiac examination, as stress testing should not be used for screening. Subsection 8(4) also excludes the adult stress testing item (11729) from being performed for monitoring purposes of a known cardiac disease.

The Taskforce recommended changes on the frequency of testing and the co-claiming of attendances to reduce low-value care. The descriptors of items 11729 and 11730 limit each service from being performed more than once every two year. Subsection 8(10) of the Determination limits the adult stress testing item (11729) from being performed if the rendering specialist or consultant physician has provided an attendance on the same patient on the same day.

The Taskforce also recommended changes to the performance of exercise or pharmacological electrocardiogram stress testing for optimal patient safety. For a service to be performed, the person performing the monitoring and recording must be:

* in continuous attendance; and
* trained in “exercise testing” (as defined in section 4 of the Determination) and cardiopulmonary resuscitation.

A second person trained in cardiopulmonary resuscitation must be located at the premise and available to attend the electrocardiogram stress testing in an emergency.

**Implanted loop record**

The Determination lists item 11731 for the recording and reporting of data from an implanted electrocardiogram device by a medical practitioner. The service is for reporting of the data and ongoing management of the device, not the implementation of the device which should be performed under item 38285 of the Table.

**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 – Cardiac Services) Determination 2020*

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 3CGeneral Medical Services – Cardiac Services) Determination 2020* (the Determination) is to list 10 replacement Medicare Benefits Schedule (MBS) items for cardiac services from 1 August 2020.

In the 2018-19 Mid-Year Economic and Fiscal Outlook (MYEFO) under the *Guaranteeing Medicare – strengthening primary care* measure, the Government agreed to a number of recommendations made by the clinician-led MBS Review Taskforce (the MBS Review Taskforce) to cardiac services.

The Determination will list 10 new cardiac diagnostic testing items to align with clinical guidelines regarding the types of medical practitioners who can conduct and interpret electrocardiograph testing, and clarify the requirements and frequency for exercise or pharmacological electrocardiogram stress testing for optimal patient safety.

The new items will replace the nine existing MBS cardiac items (11700, 11701, 11702, 11708, 11709, 11710, 11711, 11712 and 11722) which will be removed from the MBS on 1 August 2020 by the *Health Insurance Legislation Amendment (2020 Measures No. 1) Regulations 2020*.

**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.

Analysis

This instrument advances the right to health and the right to social security by listing new cardiac items which will improve the quality of care, encourage high value care and reflect current best practice. The new services will clarify when and how cardiac services should be provided.

**Conclusion**

This instrument is compatible with human rights as it maintains the right to health and the right to social security.

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