Australian Government
Department of Home Affairs

Medical Officer of the Commonwealth (MOC) Advice Pack

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Introduction

1.1 Purpose and background

The MOC Advice Pack provides policy guidance for Medical Officers of the Commonwealth (**MOCs**) when formulating their professional opinion in determining whether visa applicants who undertake Immigration Medical Examinations (**IMEs**) meet the Health Requirement.

Most visa applicants applying for a visa to visit or migrate to Australia must meet certain Health Requirements outlined in the *Migration Regulations 1994* (**the Regulations**) and policy framework. A key focus of the Health Requirement is to protect the Australian community from increased public health risks, including Tuberculosis (**TB**), emerging health epidemics and biosecurity risks.

Most visa subclasses are subject to the Health Requirement as a criterion for visa grant. The Health Requirement is set out in the Public Interest Criteria (PIC) 4005, 4006A* and 4007) in Schedule 4 of the Regulations. The purpose of the Health Requirement is to:

- Protect the Australian community from threats to public health,
- Contain public expenditure on health and community services, and
- Safeguard the access of Australian residents to health and other community services in short supply.

***Note**: PIC 4006A only applies to subclass 457 legacy caseload as it was repealed in March 2018.*

1.2 Scope

This advice pack is primarily for the use of MOCs engaged with the Migration Medical Services Provider (**MMSP**) contracted to the Department of Home Affairs (**the Department**) to provide health assessments on IMEs conducted in Australia and offshore. It is also used by MOCs engaged directly by the Department in the provision of opinions and when undertaking quality assurance activities on the services provided by the MMSP.

The MOC Advice Pack is limited to providing policy guidance and processing instructions relevant to the MOC opinion. Clinical guidance is beyond the scope of this document and MOCs should refer to the relevant Notes for Guidance papers, available on LEGEND, for guidance on the clinical aspects of their opinions.

The Department may issue further directives subsequent to the release of this document. MOCs need to ensure that any such directives are considered in conjunction with this document when undertaking an assessment.

***Note:** Non-migrating family members (**NMFMs**), and people who intend to apply for a visa, but are yet to do so, are also captured in this guidance document. For the purposes of this document, they are all regarded as 'applicants'.*

2.1 Structure

To assist MOCs in navigating this document, it is comprised of the following Parts:

Part A: Public Health Threat – Assessment of Tuberculosis (TB)

Part B: Public Health Threats – Other

Part C: Significant Cost Threshold (SCT)

Part D: Prejudice to Access (PTA)

Part E: Non-Standard MOC Assessments

Part F: Drafting a MOC Opinion

Part G: MOC opinion outcomes

Part H: Other duty of care/clinical issues

Part I: MOC auditing responsibilities

Important: Where a MOC opinion is provided, it is important to remember that a MOC must provide an individual assessment against the relevant criteria specified in the Regulations, taking into consideration current policy guidelines which are outlined in the Sch4/4005-4007 - The Health Requirement – Procedural Instruction (PI) – VM-1027 (the Health PI).

MOC assessment outcomes, which are reflected in this guide, are only recommendations designed to encourage consistency in decision making and in the MOC opinion process. MOCs should consult the Health PI for specific guidance regarding the legal and policy framework within which they must operate.

All MOC opinions reference relevant regulatory criteria. The Department's online database, LEGEND, contains information on migration legislation, policies, and operational materials. MOCs can access relevant sections of the Regulations through LEGEND.

2.2 Additional resources

2.2.1 Australian Panel Member Instructions

The Australian Panel Member Instructions (**Panel Instructions**) provide guidance to the Panel Member Network, consisting of physicians and radiologists (**Panel Members**) who conduct IMEs both within and outside of Australia. Physicians and radiologists employed by the MMSP in Australia also form part of the network and are guided by the Panel Instructions in undertaking IMEs and in carrying out their responsibilities as a Panel Member. The Panel Instructions are available in electronic format on the Department's website.

Link: https://immi.homeaffairs.gov.au/support-subsite/files/panel-member-instructions.pdf

2.2.2 Notes for Guidance

The *Notes for Guidance for Medical Officers of the Commonwealth* (**NfG**) papers provide clinical guidance to MOCs with emphasis on conditions which may result in failure to meet the Health Requirement. They are maintained and updated by the MMSP, approved by the Department, and are publicly available through LEGEND.

The NfG papers detail background to specific medical conditions and include clinical information to assist MOCs in forming their opinion. They also provide guidance on the methods in calculating the estimated cost for health care and community services and consideration of prejudice of access to services. The NfG papers aim to ensure transparency and consistency in forming MOC opinions.

2.3 Further assistance

Additional information or questions about this document should be directed to the Health Policy mailbox at s. 22(1)(a)(ii) **@homeaffairs.gov.au** in the first instance.

3.1 Glossary

Table 1 – MOC Advice Pack terms

Term	Acronym	Definition
Administrative Appeals Tribunal	AAT	Conducts independent merits review of administrative decisions made under Commonwealth laws.
Antiretroviral Therapy	ART	Drugs that inhibit the activity of retroviruses such as HIV.
Blood Borne Virus	BBV	Viruses which are transmitted through contaminated blood and other body fluids.
Content Manager	CM	A departmental enterprise document and records management system for physical and electronic information designed to help businesses capture, manage, and secure business information in order to meet governance and regulatory compliance obligations.
Chest X-ray	CXR	Radiological image of chest.
Communicable Diseases Network of Australia	CDNA	Provides national public health co-ordination and leadership, and supports best practice for the prevention and control of communicable diseases.
Deferred		Processing of the applicant's visa application cannot continue until they provide the additional information requested by the MOC.
Deoxyribonucleic Acid	DNA	The nucleic acid containing the genetic code that determines the proteins produced by cells, which in turn determines the makeup of all living cells and many viruses. It consists of two long strands.
Department of Health and Aged Care	DHAC	A department of the government of the Commonwealth of Australia which seeks to promote, develop, and fund health and aged care services for the Australian public.
Department of Home Affairs	Department	The Department of Home Affairs is responsible for centrally coordinated strategy and policy leadership in relation to domestic and national security arrangements, law enforcement, emergency management, counter-terrorism, social cohesion, the protection of our sovereignty, the integrity of our border and the resilience of our national infrastructure.
Disease Modifying Anti-Rheumatic Drugs	DMARDs	Drugs used to modify the course of disease in immunological conditions.
Does Not Meet	DNM	The applicant has not met the Health Requirement and a visa cannot be granted unless a health waiver is available and exercised.
Ebola Virus Disease	EVD	An uncommon, potentially lethal viral haemorrhagic fever.
Exposure Prone Procedures	EPP	Medical or surgical procedures with increased risk of transmission of BBV.
Extensively-Drug Resistant Tuberculosis	XDR-TB	TB which is resistant to at least four of the core anti-TB drugs.
Health Assessment Portal	HAP	A departmental system that allows officers to record client health declaration data, determine what health examinations clients are required to undertake, and generate health identifiers and documentation.

Term	Acronym	Definition
Health Care Worker	HCW	People employed in a health care environment for the purposes of MOC assessments.
Health Undertaking	HU	An agreement that an applicant makes with the Australian Government to attend a health clinic in Australia to follow-up on the condition for which the Health Undertaking was requested.
Health Requirement		For most visas, this is Public Interest Criteria 4005 or 4007. Other visas may include alternative health requirements, such as Medical Treatment visas or Protection visas.
Hepatitis B Virus	HBV	A vaccine-preventable hepatotrophic virus that causes both acute and chronic liver disease.
Hepatitis C Virus	HCV	A hepatotrophic virus that causes both acute and chronic liver disease.
Human Immunodeficiency Virus	HIV	A currently incurable BBV that targets the immune system and that can lead to Acquired Immune Deficiency Syndrome (AIDS) if untreated.
Immigration Medical Examination	IME	Medical examinations required to assess whether an applicant meets the Health Requirement as part of the visa application process.
Interferon Gamma Release Assay	IGRA	A blood test used to identify previous exposure to TB. It tends to remain positive lifelong for this group.
International Classification of Diseases	ICD	The International Classification of Diseases (ICD) is a medical classification list containing codes for diseases and injuries.
Latent Tuberculosis Infection	LTBI	A state of persistent TB organisms in the body without overt signs or symptoms of disease.
Medical Officer of the Commonwealth	MOC	Qualified medical practitioners employed by the Department or the Medical Migration Services Provider.
Medical Treatment Visa	MTV	A visa which allows people to travel to Australia for medical treatment or consultations, or to support someone needing medical treatment or to donate an organ.
Meets		The applicant has met the Health Requirement and the visa can be granted if all other criteria are met.
Meets (Reduced Stay)		The applicant has met the Health Requirement and the visa can be granted if all other criteria are met. The period for which the delegate intends to grant the visa should not be longer than the visa period for which health was assessed.
Meets with Undertaking		The applicant will meet the Health Requirement if they provide the visa officer with a signed undertaking form (form 815).
Migration Medical Service Provider	MMSP	A service provider contracted by the Department to complete applicants' IMEs in Australia via a network of panel clinics and undertake health assessments of onshore and offshore cases.
Multi-Drug Resistant Tuberculosis	MDR-TB	TB which is resistant to two first line anti-TB drugs (rifampicin and isoniazid).

Term	Acronym	Definition
Multiple Sclerosis	MS	A chronic degenerative, often episodic disease of the central nervous system.
No clearance required		An applicant for a XD-785, UO-786, XE-790, CD-851 or XA-866 visa has completed their required health examinations and no conditions considered to be a threat to public health have been identified.
Panel Member Instructions	PMI	Guidance for the Panel Member Network, consisting of physicians and radiologists who conduct IMEs both within and outside of Australia.
Pharmaceutical Benefits Scheme	PBS	A program of the Australian Government that provides subsidised prescription drugs to residents of Australia, as well as certain foreign visitors covered by Reciprocal Health Care Agreements.
Procedural Instruction	PI	Provides guidance and recommendations to departmental staff (formerly the Procedure Advice Manual - PAM).
Polymerase Chain Reaction	PCR	A test used to identify DNA (for instance, for TB bacteria and drug resistance genes) that has a high specificity and positive predictive value
Public Interest Criteria	PIC	Health, character and security requirements prescribed in Schedule 4 of the *Migration Regulations 1994* that an applicant must meet prior to visa grant.
Ribonucleic Acid	RNA	A nucleic acid present in all living cells. Its principal roles are to act as a messenger carrying instructions from DNA for controlling the synthesis of proteins (mRNA), and for translating the mRNA code into protein (rRNA). It consists of a single strand of nucleotides.
The Notes for Guidance for Medical Officers of the Commonwealth	NfG	Provides clinical guidance to MOCs about specific health conditions in relation to the Health Requirement.
Tuberculin Skin Test (also known as a Mantoux test)	TST	A skin prick test to determine previous exposure to TB. It is conducted over 48-72 hours.
Tuberculosis	TB	An infectious disease caused by *Mycobacterium tuberculosis* which often targets the lungs (pulmonary) but may also affect other parts of the body (extra-pulmonary).
Visa Processing Officer	VPO	Departmental officer who processes visa applications for people wanting to come to Australia.

4 Advice Pack

4.1 Part A: Public health threat - assessment of Tuberculosis

A visa applicant with tuberculosis (**TB**) or a disease or condition that may result in the applicant being a 'threat to public health' in Australia or a danger to the Australian community will not meet the Health Requirement. This Health Requirement cannot be waived – see PIC 4005(1)(a) and (b), and 4007(1)(a) and (b).

Sub-clause (1)(a) of PIC 4005 and PIC 4007 require that an applicant is 'free from tuberculosis'. TB is the only health condition specified in the Regulations which precludes the grant of a visa. Consequently, an applicant who is not free from TB will not meet the Health Requirement and cannot be granted a visa until they are free from TB.

Under the Health Requirement policy, the requirement to be 'free from tuberculosis' is considered as being free from active TB, either pulmonary and/or extra-pulmonary. That is, an infection with *Mycobacterium tuberculosis* that is actively replicating, as evidenced through clinical, radiological or pathological signs.

In practice, the applicant is considered 'free from TB' where the applicant has:

- No clinical or radiological signs that give rise to suspicion of active TB or
- Clinical or radiological signs that might represent active TB, however, appropriate further investigation has ruled this out or
- Confirmed active TB, however, has completed an appropriate course of treatment with monitoring having demonstrated clearance of bacteria on pathological testing, resolution of symptoms, and radiological stability.

MOCs are required to assess health cases by taking into consideration clinical findings, overall TB risk, radiological findings and latent TB infection testing when required. If there are chest x-ray (CXR) abnormalities these will determine if additional testing to exclude active TB is required. For offshore cases, MOCs cannot rely on TB clinics or chest specialists who indicate sputum testing is not required (e.g., based on lack of symptoms or clinical signs, or based on national TB protocols). MOCs should always exercise discretion and caution in assessing cases.

If there is any suggestion of active TB (see Panel Member Instructions for details), further investigation is required in the form of pathology testing and specialist review.

Onshore specialist TB service reports may be accepted and a health clearance be provided by a MOC even in the absence of sputum testing if the State and Territory health Clinic advises that the client is considered to be free from TB.

4.1.1 Assessing Tuberculosis through the IME

Medical history

Visa applicants are required to complete a health declaration as part of the IME process. The declaration includes disclosing whether they have a history of TB. Where a declaration of TB is made, the panel physician should obtain additional information from the applicant which is to form part of the IME record (either through eMedical or paper forms). These cases should be B-graded for MOC assessment.

If a history of TB is declared, further investigation to exclude TB is not required unless current clinical or radiological features are present which suggest active disease.

Exceptions to this rule include instances where:

- Previous drug-resistant TB is known or suspected. All such cases, even if adequately treated and/or with a normal CXR, require further investigation to exclude active TB.

- Applicants declare HIV infection. Such cases require further investigation to exclude active TB, even if they are clinically well and radiologically normal.
- Applicants declare they are receiving TB treatment. The treatment will need to be completed with successful monitoring results demonstrated before a health clearance can be provided. Full details of the original diagnosis and treatment regimen should be requested at the initial MOC assessment, if not already provided.

If applicants declare that they have previously had, or are currently undergoing, treatment for **latent TB**, this does not preclude health clearance which requires the absence of active TB.

Note: *Offshore applicants receiving treatment for latent TB may have their health case finalised with a Health Undertaking which requires appropriate follow up once onshore. Refer to TB Health Undertakings for further information.*

However, the health declaration is only one source of information and MOCs are to have regard for clinical and radiological indicators which might be suggestive of TB.

Clinical signs

All applicants who are required to complete an IME, or who make a significant health declaration, will be required to undergo a physical examination (501 exam). As part of the examination, panel physicians are directed to:

- question applicants about signs and symptoms of TB and
- conduct a thorough respiratory examination.

Any applicant with a clinical presentation that is consistent with active TB requires further investigation, even if their CXR is normal. This is particularly the case for children, who typically have paucibacillary disease with more subtle radiological findings than occur in adults.

Radiological signs

In most cases, decisions to investigate for suspected TB are made solely on the radiological appearance, in the absence of a declared history or detectable physical findings.

While MOCs should have regard to the report from the panel radiologist, it is their responsibility to independently and carefully evaluate the CXR for signs of TB.

Findings which can be consistent with active TB

- CXR findings: Any cavitating lesion or overt pleural effusion will require further investigation, regardless of whether such investigation was conducted previously.
- If these findings are present, radiologists are directed to answer 'present' to Q7 of the 502 exam (strong suspicion of active TB). If they have done this, the 603 exam will be auto-added at the time of IME, and the health case cannot be submitted until this additional exam is complete. If they have not done this, MOCs will need to request the 603 exam in the initial MOC opinion.
- MOCs must be mindful of interpreting test results in cases of pleural effusion. Pleural TB is a form of extra-pulmonary TB, and the pleural effusion it produces is often sterile on TB microscopy and culture. Sputum test results may be negative in cases of pleural TB, unless pulmonary disease is also present. MOCs should consider the presence of TB if a patient presents with pleural effusion from an endemic area and/or a comorbidity of HIV.

In general, findings which may represent TB will require further investigation, unless previous CXRs or other test results are available which rule out active disease.

- Fibro-nodular and fibro-calcific lesions should be investigated as routine. So should pulmonary nodules (single/multiple pulmonary nodules/masses ≥ 1 cm), unless they are calcified with distinct borders.
- Non-calcified hilar or mediastinal masses may indicate extra pulmonary disease. Supplemental tests may be clinically indicated in the presence of a negative sputum finding.

- Ragged apical thickening is a lower risk finding which should be investigated with clinical discretion. Younger persons, those at higher risk (e.g. refugees), or those going into higher-risk settings in Australia (e.g. health care workers) will require this finding investigated. Those at lower risk (e.g. older visitors) may not require investigation.

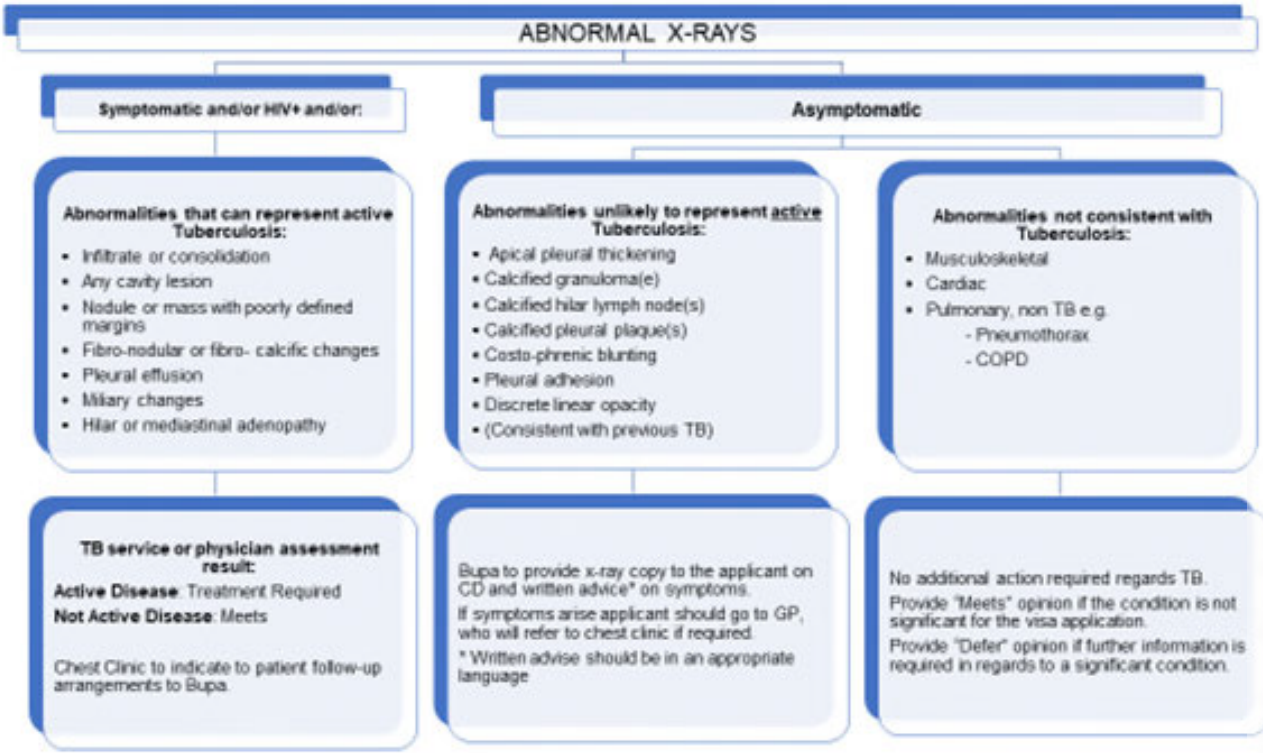
Minor findings, occasionally associated with TB disease

In general, such findings do not require further investigation to exclude active TB. Exceptions would be where the applicant is at higher risk, such as being a recent contact of an active TB case, or having a history of TB treatment which was not adequate.

Minor findings which in isolation are not usually associated with TB disease

These findings are insignificant and should not be investigated, bearing in mind that certain applicants (such as those with HIV or a history of drug-resistant TB) require further investigation regardless of CXR appearance.

For onshore applicants, MOCs should refer to the 'TB Abnormal X-Ray Flowchart' document as guidance in determining which cases should be given a 'Deferred' opinion and referred to a state/territory chest clinic for review and possible treatment.



4.1.2 Assessing Tuberculosis through further investigation

With the exception of applicants for whom the 603 exam has been auto-added due to strong suspicion of TB identified by the radiologist, all applicants requiring such investigation must be MOC-deferred. The health case must remain in deferred state until active TB has either been excluded or successfully treated.

The 603 exam requires a combination of specialist review, sputum testing, repeat chest imaging and other testing as clinically appropriate to identify if the applicant has active TB.

Specialist review

It is important that a chest or respiratory specialist further evaluates the applicant once suspicion of TB is identified. It is also important that TB investigation and (if needed) treatment is overseen by an appropriately qualified person, and their specialist TB report forms a key component of the 603 exam.

It may not always be possible for applicants to access a specialist for such oversight. In these cases, a report from a suitably qualified and experienced panel physician is often the preferred alternative, as they are better placed to understand the visa health process and requirements than other clinicians.

Sputum testing

Sputum samples are the primary testing tool to identify pulmonary TB. The reliability of sputum testing is dependent on the quality of specimen collection and subsequent laboratory processing.

Panel Members are responsible for ensuring that the laboratories used for sputum testing have either:

- relevant International Organisation for Standardisation (ISO) accreditation,
- the equivalent national or state accreditation in the country in which they are located, or
- are working towards that accreditation.

Ideally, laboratories should be equipped to perform both first and second-line drug sensitivity testing (DST). Panel members must be able to provide evidence of this to the Department upon request (eg. email confirmation from the laboratory, reference to laboratory's website etc).

MOCs should always be cautious when interpreting sputum test results. Poor specimen collection, storage or culture technique may produce false negatives. Even in the best laboratories, no TB test has 100% sensitivity and specificity, meaning MOCs must always consider the overall clinical picture in combination with sputum results. If there is any doubt, six months CXR stability can be sought as a reliable alternative marker from the initial 502 examination.

Two categories of sputum testing are available in the form of microbial and molecular tests.

a) Sputum testing – Microbial tests (smear and culture):

- Smear technique involves obtaining a sputum specimen, smearing it across a glass slide, and staining it to make mycobacteria visible under a microscope through colour contrast. The usual (and oldest) staining technique uses an acid-fast stain (such as the Ziehl-Neelson stain), so the bacteria it identifies are also known as acid-fast bacilli, or AFB.
- A more sophisticated staining technique involves fluorescence microscopy, with the specimen stained with a fluorescent agent (such as auramine) which makes the Mycobacteria 'glow' against a dark background. This higher visibility gives fluorescence a higher sensitivity than acid-fast staining.
- MOCs are not required to specify which type of staining should be used. In higher quality laboratories, both techniques are often used on the same sample, whereas lower quality laboratories would be likely to use AFB staining only..
- The advantage of sputum smear is that it is quick, cheap, and relatively easy. The disadvantage is that it has lower sensitivity to detect disease as there may be insufficient bacteria in the specimen to be identified by microscopy. For this reason, additional testing (such as culture or molecular testing) is required. However, treatment commencement need not be delayed pending such results. A positive smear in combination with clinical and/or radiological signs of TB is sufficient indication that TB treatment is required.
- Sputum culture is usually performed in a liquid medium using the Bactec automated culture system or on solid media, if available. It is not the responsibility of the MOC to direct laboratories as to a choice of media type. The only practical difference for MOCs is that liquid culture can be declared negative if no growth occurs after six weeks, whereas the equivalent period for solid culture is eight weeks.

- If Mycobacterium Tuberculosis (MTB) is isolated, drug sensitivity testing (DST) is required for first line drugs. If resistance is found, testing for second-line drugs will be performed if the lab has the capability. Panel Members must refer to a laboratory that has the capability for second line DST.
- Where active TB is suspected, negative smear and culture results are required, to determine an applicant is free from TB.

b) Sputum testing – Polymerase Chain Reaction (PCR) or molecular tests

- More recently, PCR testing for TB has emerged as an additional TB diagnostic tool. PCR tests identify DNA of TB bacteria and drug resistance genes and have a high specificity and positive predictive value. Compared to sputum smear alone, PCR tests are considered a more sensitive initial diagnostic test. In some resource-poor and isolated settings, PCR tests have largely replaced microbial testing, due to ease of use, affordability, and portability. PCR tests require only one to two sputum samples to be collected.
- The most commonly used PCR tests are the Cepheid GeneXpert MTB/RIF, MTB/RIF Ultra and MTB-XDR assay. These are portable tests which can be used in the field as well as the laboratory and can identify TB and rifampicin drug resistance within hours. Although smear and culture remains the gold standard test for TB diagnosis as it can provide more detailed drug susceptibility testing, results can take weeks to be finalised, potentially delaying the commencement of treatment. The newer GeneXpert MTB/RIF Ultra and MTB-XDR assays are preferred as they are more sensitive than the original assay.
- The other PCR test likely to be encountered in the IME setting is a line probe assay (LPA) manufactured by Hain Lifesciences, sometimes referred to as the 'Hain test'. LPA is much more expensive and difficult to perform than GeneXpert, and is only found in high quality laboratories. However, LPA products have the capability to test for a wider drug-resistance profile than Xpert MTB/RIF, and are therefore favoured by laboratories that encounter substantial numbers of drug-resistant cases.

In the IME setting, molecular tests act as an adjunct to smear and culture, which remains the default requirement in all cases. Panel members are encouraged to request molecular tests in certain situations, as outlined in the Panel Member Instructions. **MOCs should be aware that these tests do not replace the need for culture for visa applicants who need to demonstrate that they are free from TB, unless the clinic has been 'enabled' to use molecular testing as part of the 603 examination (see below). However, a positive molecular result should not be ignored if made available to a MOC as part of the IME process.**

The below table provides guidance on the actions that should have been taken by the treating chest physician, as part of the 603 examination, if molecular test results were available.

Microbial result	Molecular test result	Action
1. Positive smear	Positive MTB, negative drug resistance	First-line Rx required.
2. Positive smear	Positive MTB, positive drug resistance	Second-line Rx required, awaiting confirmation through culture-based DST if/when available.
3. Positive smear	Negative MTB	Consider NTM infection. If clinical and/or radiological signs of active TB, and/or young applicant, Rx should be commenced. If asymptomatic older applicant with CXR consistent with previous TB, Rx commencement can be delayed pending culture result.
4. Negative smear	Positive MTB	Unlikely scenario in IME as negative smear specimens not usually tested. In this situation the applicant cannot be considered free from TB. Rx is likely to be required. Delaying Rx until the culture result is available is only advisable if clinical and radiological signs are not consistent with active TB.

5. Positive culture	Positive MTB, negative drug resistance	First-line Rx required, subject to change pending culture-based DST results.
6. Positive culture	Positive MTB, positive drug resistance	Implement second-line Rx awaiting culture-based DST results for confirmation.
Rx: medications; NTM: non-tuberculous mycobacteria *See also:* World Health Organization operational handbook on tuberculosis. Module 3: Diagnosis. Rapid diagnostics for tuberculosis detection*. 30 Jun 2020. p.28*		

4.1.3 GeneXpert enabled clinics

The Department has recently approved the use of Cepheid GeneXpert MTB/RIF, MTB/RIF Ultra and MTB-XDR for cases deferred for a 603 examination in select panel clinics that have limited access to an accredited TB laboratory and/or where integrity of samples are compromised given long transit times to the laboratory. For these GeneXpert 'enabled' clinics, deferred cases may have initial GeneXpert testing in place of smear and culture. Given higher sensitivity, GeneXpert MTB/RIF Ultra and MTB-XDR are the preferred assays, however, GeneXpert MTB/RIF assay can be used where MTB/RIF Ultra and MTB-XDR is not available. Clients being tested with GeneXpert MTB/RIF Ultra or MTB-XDR will require one sputum test while those with GeneXpert MTB/RIF will require a second sputum test if the original test did not detect TB.

If Xpert is recorded as **positive** on the 603, eMedical will automatically generate three smears, three cultures and drug sensitivity testing for completion. When Xpert detects MTB, a rifampicin (RIF) resistance result is also generated, with RIF resistance likely to signify MDR-TB. An appropriate course of treatment will need to be provided, with Expert Medical Panel (EMP) referral following treatment completion. Applicants who have TB detected on GeneXpert testing should be deferred for a 607, which involves referral to the country's National TB Program, where possible, for commencement of TB treatment.

For GeneXpert enabled clinics, MOCs should delete the 603 default text and paste the following text:

> *Respiratory specialist (pulmonologist) investigation and report required for current status regarding tuberculosis. A recent chest x-ray showed <add details>.*
>
> *Please include the following information:*
>
> *- Clinical examination findings;*
>
> *- Results of 1 Xpert MTB/RIF Ultra (preferred) OR 2 Xpert MTB/RIF (taken on different days);*
>
> *- Old chest x-rays for comparison (if available). Reports can be submitted if images available are not digital;*
>
> *- Repeat PA image 3 months after the initial CXR;*
>
> *- Any previous reports regarding any treatment of tuberculosis;*
>
> *If TB has been excluded, please exclude other pathology that could cause the abnormal x-ray findings.*

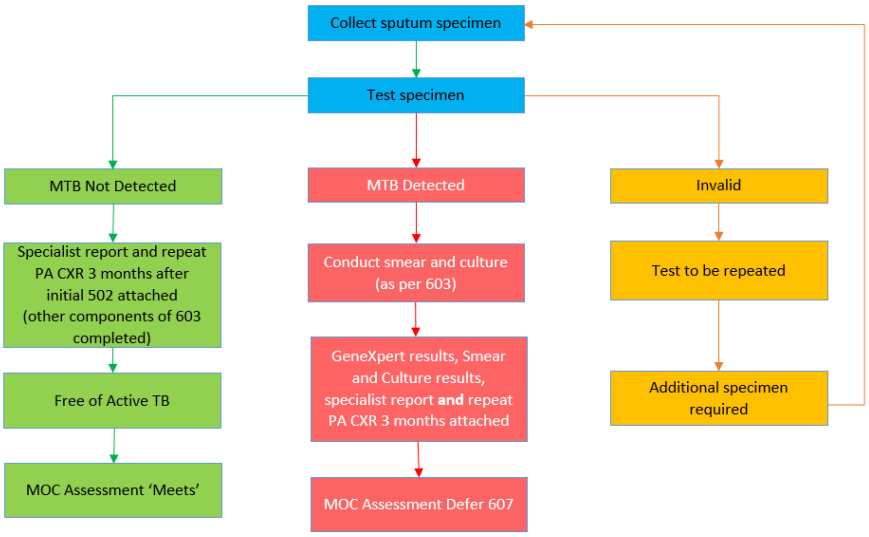
Both positive and negative GeneXpert cases should have a specialist report and repeat chest x-ray three (3) months after the 502.

Given GeneXpert has a slightly lower test sensitivity than culture, applicants who return a negative GeneXpert result, the assessing MOC should request smear and culture testing if they still deem the case to be at high risk of active TB (i.e. given chest x-ray findings or other signs on history or examination).

4.1.4 MOC GeneXpert Flowcharts

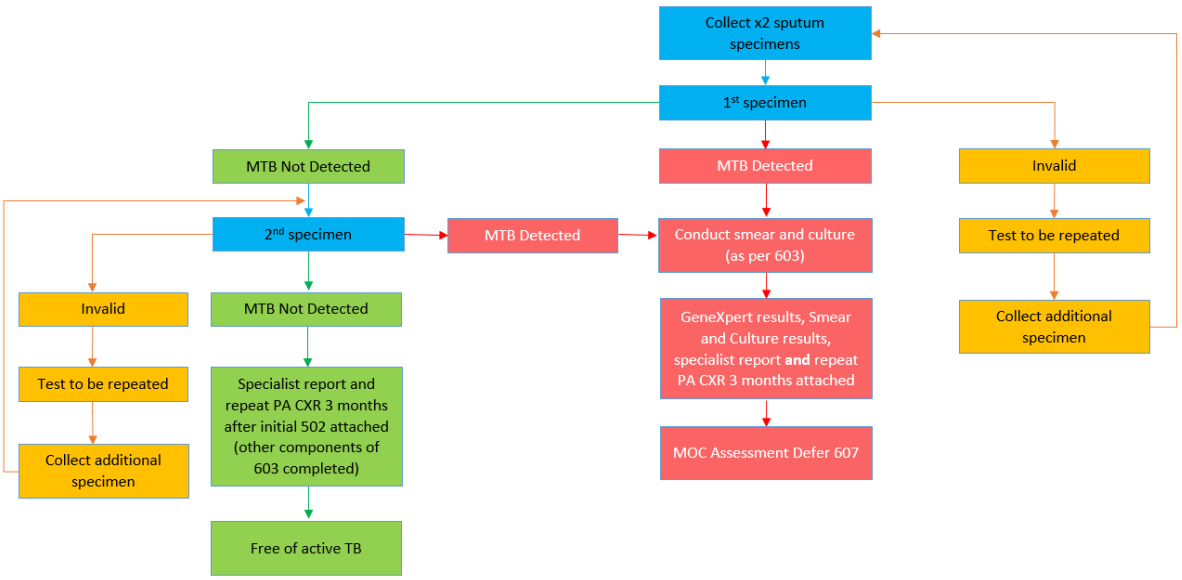
Updated December 2023

MOC: GeneXpert® MTB/RIF Ultra Process



Updated December 2023

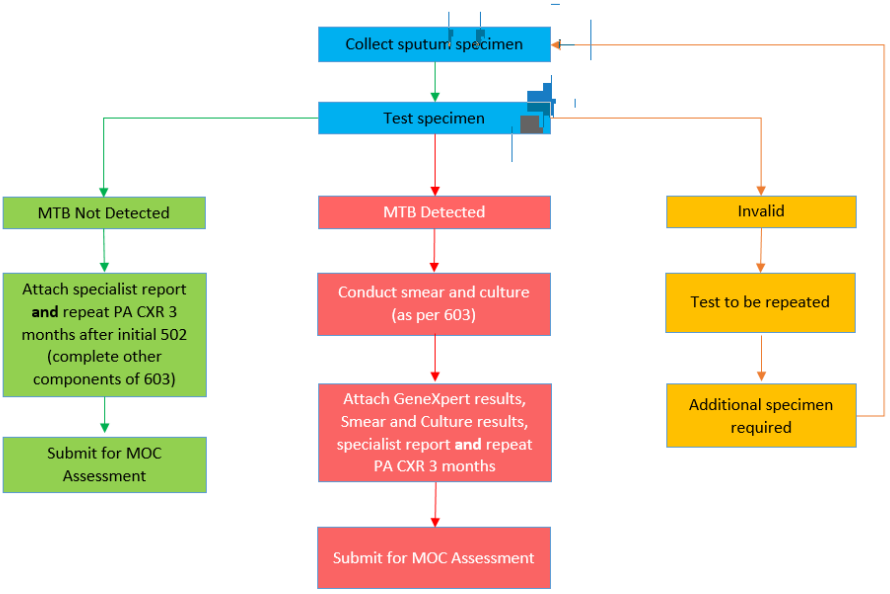
MOC: GeneXpert® MTB/RIF Process



4.1.5 Panel clinic GeneXpert Flowcharts

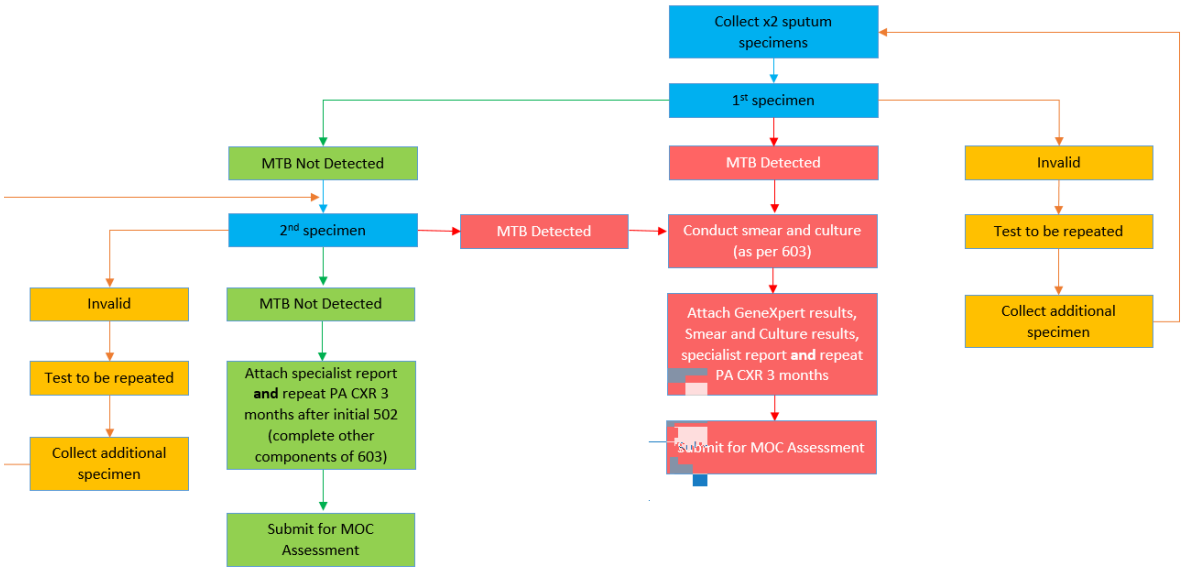
Updated December 2023

Clinic: GeneXpert® MTB/RIF Ultra Process



Updated December 2023

Clinic: GeneXpert® MTB/RIF Process



Tuberculosis treatment

It is understood that TB treatment is often complex and clinicians may be faced with challenges in ensuring patient compliance.

Any applicant who has any combination of the following will require treatment for TB:

- Positive microbiological and/or molecular test results with MTB identified

- A CXR with findings consistent with active TB
- Clinical symptoms and signs that are strongly suspicious for active TB

What if the applicant refuses TB treatment?

Some applicants may be resistant to a diagnosis of TB and treatment. It is the responsibility of the panel physician and the attending chest physician to explain to the applicant the need for treatment and counsel them. However, in some cases, applicants may not accept this advice and refuse treatment. If this occurs and this information is available to the MOC, the MOC should specify the need for treatment through a 607 defer exam request.

If the applicant refuses the MOC request, a DNM should be provided to the effect that they are not free from TB.

Panel Members must ensure that visa applicants requiring TB treatment are managed according to standard regimens as outlined in the Panel Instructions. Directly Observed Therapy (DOT) administered by a health care worker is the best way of ensuring compliance with therapy. Treatment records should be comprehensive.

In well-resourced countries TB management is usually to a high standard, as evidenced in their own TB incidence rate, in such countries a clearance certificate from the National TB program may be sufficient evidence of satisfactory treatment, especially if end of treatment cultures are negative.

In some, under-resourced countries, TB management practices vary widely and panel members are required to provide or oversee TB treatment using standard drug regimens and DOT. In these cases treatment records should include evidence of DOT.

Note: *For offshore cases, Panel Members must ensure that they refer cases to DOT Centres with appropriate accreditation to ISO standard, or the national or state equivalent in the country in which they are located, or are working towards that accreditation. For onshore cases, applicants are referred to local state/territory health authorities for further testing/monitoring and/or treatment.*

Treatment monitoring

To ensure the applicant is responding to treatment, monitoring for improvement in symptoms, resolution or stability of CXR findings and negative sputum tests is essential. Monitoring options and responsibilities for panel physicians are documented in the Panel Instructions.

Health clearance cannot be provided unless <u>all</u> of the following have occurred:

- An adequate course of treatment has been completed and documented
- Sputum smear, if positive, has converted to negative
- Sputum culture, if positive, has converted to negative on specimens collected on two occasions at least one month apart
- CXR appearance has either improved or stabilised at an interval of three months or more
- Clinical signs and symptoms of active TB, if present, have resolved
- Applicant has completed a HIV examination

Note: *Under current health settings, any visa applicant who is diagnosed with active TB must be tested for HIV due to clinical risk with this cohort. The 707 HIV examination must be manually added as it is not automatically added if a visa applicant is found to have active TB.*

It is not necessary for MOCs to request post-treatment sputum collection unless negative sputum results as per above have not been documented by treatment monitoring. However, a clinical report and post-treatment CXR is required in all offshore cases as evidence of treatment success and as part of the applicant's file in the event of onshore follow-up being required through a Health Undertaking.

Note: *For onshore cases, the Department supports a practice in accepting onshore specialist TB service reports when assessing whether the applicant is 'free from TB' after completion of the required treatment. Health Undertakings are NOT appropriate for onshore applicants –* ***refer to <u>TB Health Undertakings</u>.***

Treatment failure is defined by persistently positive sputum results in the face of continued treatment. In pan-susceptible cases, most guidelines define treatment failure as positive sputum culture after four months of treatment. Treatment failure usually signifies an inadequate regimen, due to undiagnosed drug resistance, inadequate dosing, or patient non-compliance with medication. In cases of treatment failure, a DNM opinion must be provided.

What if the MOC is not satisfied that the applicant has been treated to point of cure?

In instances where a MOC is not satisfied that the applicant has been treated to the point of cure, the case may be deferred for 12 months for further documentation, e.g. serial CXR, at the discretion of the assessing MOC.

4.1.3 Drug-resistant Tuberculosis

The management of drug-resistant TB (especially multi or extensively drug-resistant [MDR- or XDR-] TB) can be complex and requires specialist input. The minimum treatment period for pan-susceptible TB is six months, but this period can be significantly longer if drug-resistance is identified, and a subsequent monitoring period may be required before the applicant can be found to be 'free from TB'.

All cases where drug resistance has been identified (mono, poly, multi or extensively drug-resistant), either before or during the IME process, require review by an Expert Medical Panel (EMP) of TB specialists in Australia, once treatment has been completed.

The Department liaises directly with the EMP, which collectively provides advice about any additional testing or monitoring which may be required.

Once all TB treatment records are available, MOCs must complete the appropriate referral template (at Annexure C) to facilitate this referral. The case should be placed 'on hold' in HAP with the wording 'Drug-Resistant TB has been identified. Case has been sent to EMP for further advice'.

This referral should be forwarded to s. 22(1)(a)(ii) @homeaffairs.gov.au. It will then be forwarded to the EMP. CXR attachments do not need to be provided routinely but may be included if particularly relevant, or at the request of the EMP.

The completed template, with advice received from the EMP, will be returned to the MOC so that a MOC opinion can be provided.

***Note**: If comprehensive treatment records are not provided to the MOC (that is, if the treatment was not overseen by the panel physician), the MOC should use their discretion, noting that deferral is not mandatory and premature referrals to the EMP should be avoided.*

4.1.4 MOC assessment and 719 TB screening test

The 719 TB test is either a Tuberculin Skin Test (TST - sometimes also referred to as a Mantoux test), or an Interferon Gamma Release Assay (IGRA - the most widely available being a Quantiferon Gold test). TST is generally preferred in the absence of previous Bacillus Calmette–Guérin (BCG) vaccine. Generally, IGRA tests are preferred where available, particularly in children under five years who have received the BCG vaccine, especially in the previous five years."

The Department uses the 719 TB screening test for TB screening in children, especially those from high TB risk countries where they comprise a highly vulnerable group. (See https://www.rch.org.au/immigranthealth/clinical/Tuberculosis_screening/ for more information.)

The following visa cohorts require 719 TB screening as prescribed in the *Migration Regulations 1994 - Specification of Required Medical Assessment - **IMMI 15/144*** (**IMMI 15/144**) and/or provided for in the Health PI:

- Children from higher TB risk countries (as specified in **IMMI 15/144**) who are 2 to under 11 years of age and applying for a permanent and/or provisional visa.
- Children who are 2 to under 11 years of age and applying for a protection, refugee or humanitarian visa (visa subclasses specified in the Health PI).

- Any visa applicant known to be a close household contact of a person diagnosed with active pulmonary or extra-pulmonary TB within the 5 year period prior to the applicant's IME, irrespective of visa class or age.
- Applicants from a higher TB-risk country who are:
    - 15 years and older intending to work as (or study to be) a doctor, dentist, nurse or ambulance paramedic, or
    - Intending to work as, or study or train to be, a health care worker or work within a health care facility, or within aged care or disability care while in Australia.

This screening is primarily designed to assist in identifying children who might require further testing (usually a CXR) to exclude active disease, and to identify those who have latent TB infection (LTBI).

Note: *the 719 TB test is not required for non-migrating family members (NMFM), even if they are asked to undertake an IME.*

4.1.5 What is considered to be a positive latent TB screening test result?

For the purposes of immigration health screening:

- A TB test is considered positive if the TST is greater than or equal to 10mm induration, or the IGRA test is reported as positive.
- TST results less than 10mm, or a negative IGRA, should be regarded as a negative (719) TB test.
- A TST is deemed positive if greater than or equal to 5mm induration for those applicants who are immunosuppressed or proceed to testing because they are a close household contact within the last five years. (See https://www1.health.gov.au/internet/main/publishing.nsf/Content/cdi4103-d for more information.)

All cases with a positive TST or IGRA or cases with an indeterminate IGRA **require review by a MOC.** Decisions should be made according to current Australian Department of Health guidelines**.**

All applicants with a positive 719 TB test require a CXR to exclude active pulmonary TB. In children, a lateral CXR as well as a standard image is required. MOCs should defer cases with a positive 719 test if this imaging has not already been provided.

For applicants with an indeterminate IGRA, further testing is recommended for applicants with a history of immunosuppression (i.e. HIV) or TB exposure, or where there is other clinical suspicion of TB infection.

Applicants with a positive 719 TB test and a negative CXR and without clinical findings have latent TB infection (LTBI). In the presence of epidemiological risk factors such as high prevalence area or close contacts, it is particularly important to exclude active TB. LTBI does not preclude a health clearance, even if the applicant is on treatment for LTBI, and MOCs should finalise these cases in HAP if no additional significant health conditions have been identified. If offshore, a 'Meets with Health Undertaking' is appropriate. If onshore, a 'Meets' opinion is appropriate, as referral for ongoing care will be provided by the panel physician as part of their duty of care.

Children with abnormal CXR findings will need specialist review (paediatrician or pulmonologist) as children with active TB may have no or atypical respiratory symptoms, extra-pulmonary TB and/or negative sputum results.

Children aged less than five years, regardless of whether or not they are from a higher or lower TB risk country, who:

- declare close household contact with TB, or
- display clinical symptoms of TB, or
- are immunocompromised.

Any child in these groups must undergo CXR examination and specialist paediatric review, regardless of symptomatology or clinical findings, or the result of the 719 examination.

4.1.6 TB Health Undertakings

A Health Undertaking is an agreement that an applicant makes with the Australian Government to attend a health clinic in Australia to follow up on a medical condition. TB Health Undertakings require the visa applicant attends a local state/territory chest clinic after their arrival in Australia. Due to workload demands of these clinics it is important that only those applicants at greatest risk are referred.

Onshore applicants and TB Health Undertakings

Health Undertakings are not required for onshore applicants (except certain visa applicants, for example, onshore protection visa applicants*).

In practice (for all other onshore visa applicants), this means that following completion of the required IME with the MMSP, these visa applicants will either receive a 'Deferred' opinion or a 'Meets' opinion after review by a MOC.

If an applicant has a 'Deferred' opinion, they will be referred by the MOC to the relevant state/territory chest clinic for review and possible treatment. The MOC will finalise the health outcome only after the state/territory chest clinic advises that the applicant is not considered a threat to public health. This is usually in the form of an 'onshore TB specialist service report', advising that the applicant has either had active TB excluded or has been discharged.

***** *Further information on Health Undertakings for onshore protection visa applicants is available at 4.2.3 of these instructions.*

Offshore applicants and TB Health Undertakings

In general, for applicants with a history of, or an increased risk of developing active TB, or who have latent TB diagnosed at the IME, and where no other significant health condition is identified, MOCs should provide a 'Meets with Health Undertaking' opinion for all **offshore** applicants in the following groups:

- applicants intending permanent stay in Australia
- applicants intending temporary stay of 12 months or more
- applicants intending temporary stay of less than 12 months where there are exceptional circumstances based on clinical review
- higher risk applicants such as health care workers and immunocompromised persons, irrespective of the period of stay
- Applicants from a higher TB-risk country who are;
    - 15 years and older intending to work as (or study to be) a doctor, dentist, nurse or ambulance paramedic, or
    - Intending to work as, or study or train to be, a health care worker or work within a health care facility, or within aged care or disability care while in Australia

and where they fit into one of the following three categories:

- Latent TB Infection - i.e. the 719 test (IGRA or TST) is positive
- Persons who are at risk of reactivation of LTBI (e.g. those with abnormal CXRs but in whom active TB has been excluded)
- Any previous TB treatment in the past five years regardless of whether the CXR is normal or not.

4.1.7 Processing TB cases in HAP

Cases where active TB needs exclusion require further investigation. In some cases this will have taken place prior to MOC assessment (e.g. if automatically deferred). If not, the MOC should defer the case using the 603 deferral code for chest clinic investigation. MOCs must edit this code to clearly advise the radiological abnormality identified, and to provide explicit instructions about what tests are required, and

remove requests for information which has already been made available, to avoid confusing the panel physician.

Sputum (or other appropriate specimen) collection and testing is required in all such cases. If culture results are positive, DST is also required in all cases. Molecular testing is encouraged where available, and MOCs should assess these results as clinically appropriate as described earlier. If sputum tests are negative, a minimum of three months radiological stability is required to confirm disease inactivity. This means that the repeat CXRs must be at least three months after the initial CXR.

All applicants who require treatment or who have commenced treatment for TB should be deferred with the 607 exam. TB needs to be managed and monitored as outlined in the Panel Instructions. The 607 exam text should be edited to ensure sputum testing occurs as part of treatment monitoring.

ICD codes and details of sputum testing results must be entered into HAP when available and when prompted. At case finalisation, the MOC should check details and edit if necessary (e.g. to add resistance patterns if those were not initially available). If this information is not provided by the panel physician, the MOC should defer requesting it.

Cases where active TB was identified during the IME process, or where the applicant was on treatment at the time of the IME, should be entered as **ACTIVE TB** (ICD A16.9) even though, at the time of the final MOC opinion, treatment would have been completed.

Cases where the applicant completed TB treatment prior to the IME (even if immediately prior) should NOT be entered as ACTIVE TB. The appropriate ICD code for these cases is INACTIVE TB (even if TB is cured) as these cases will need onshore follow up by way of a Health Undertaking.

Table 2 – 600 series codes for additional information collection that MOCs may use in the following situations

Code	Description	When MOCs should use:
601	Sputum smears and cultures	If sputum tests were not provided according to panel instructions (e.g. at end of treatment).
602	TB specialist's report	If previous treatment for TB has been indicated in the history and insufficient detail has been provided or is unavailable (e.g. in previous health cases).
603	Respiratory Specialist investigation on current state of tuberculosis	Most cases needing further investigation.
604	Chest clinic investigation about radiological abnormality	Usually to investigate a CXR abnormality which is unlikely to be TB related (e.g. possible malignant condition).
607	Continued anti-tuberculosis treatment	If initial diagnosis has been confirmed and treatment is ongoing.
608	Await tuberculosis culture results	If smears are available but cultures have not been provided. Should only occur in paper cases where panel are advised to notify the Department if smear positive
610	Pulmonologist's report	This is for non-TB related chest conditions.

Note: *a complete list of examination codes and description is at Annexure A.*

4.2 Part B: Public health threats - other

4.2.1 Disease or condition considered to be a threat to public health

The Australian Department of Health and Aged Care (DHAC) provides information to the Department on diseases or conditions that may potentially be a threat to public health. Conditions which are considered to be a public health threat under current immigration health policy are discussed below.

Sub-clause (1)(b) of PIC 4005 and PIC 4007 require that an applicant is 'free from a disease or condition that is, or may result in the applicant being, a threat to public health in Australia, or a danger to the Australian community'.

This provision exists to provide for situations where unspecified conditions emerge which may pose such a threat. Temporary or country-specific arrangements may also be put in place to manage emerging health issues of particular concern, such as Poliomyelitis or Ebola Virus Disease (EVD). Where this occurs, MOCs will be provided with specific instructions regarding such arrangements.

4.2.2 Blood Borne Viruses (BBVs)

Exposure Prone Procedures

The Health PI prescribes additional health examinations for visa applicants who intend to work as, or study to be, a doctor, dentist, nurse, or ambulance paramedic.

This group requires a medical examination (501), CXR examination (502), HIV (707), Hepatitis B (708) and Hepatitis C (716) tests, regardless of TB risk or visa class and a TB screening test (719) if from a higher TB risk country.

This screening is required to identify applicants who may be a threat to public health. Although HIV and Hepatitis are not generally considered to be threats to public health, HCW and HCS applicants assessed as having these conditions may be found to be a threat to public health if their viral loads are above threshold levels, as covered in the Communicable Diseases Network of Australia (CDNA) guidelines. This is based on guidelines provided by the Communicable Diseases Network of Australia (CDNA). These guidelines are available at https://www.health.gov.au/resources/publications/cdna-national-guidelines-healthcare-workers-living-with-blood-borne-viruses-perform-exposure-prone-procedures-at-risk-of-exposure-to-blood-borne-viruses?language=en

An **exposure-prone procedure (EPP)** as defined by the CDNA is a procedure where there is a risk of injury to the HCW resulting in exposure of the patient's open tissues to the blood of the worker. These procedures include those where the worker's hands (whether gloved or not) may be in contact with sharp instruments, needle tips or sharp tissues (spicules of bone or teeth) inside a patient's open body cavity, wound or confined anatomical space where the hands or fingertips may not be completely visible at all times.

Please see advice below for MOCs regarding assessing HCW/HCS cases where a BBV is identified as part of the IME process, and the circumstances under which MOCs should defer cases with the exam code 721 "**Health Care Worker Duty Statement**".

References to viral load levels are in accordance with the "*Australian national guidelines for the management of healthcare workers living with blood borne viruses and healthcare workers who perform exposure prone procedures at risk of exposure to blood borne viruses*". National Guidelines the Management of Healthcare Workers Living with Blood Borne Viruses and Healthcare Workers who Perform Exposure Prone Procedures at Risk of Exposure to Blood Borne Viruses

Hepatitis B	HCWs or HCSs who are HBV-DNA positive but where the viral load is below 200 IU/ml would not be regarded as being a public health risk in terms of meeting the health requirement.

	For HCWs or HCSs with a viral load at 200 IU/ml or higher, a Health Care Worker Duty Statement should be requested. The statement should confirm that the HCW or HCS will not perform EPPs until their viral load is below 200 IU/ml. If the applicant will work as or study to be a dentist, the statement should confirm that this activity will not occur until their viral load is below 200 IU/ml.
Hepatitis C	HCWs or HCSs who were HCV RNA detectable but undertook successful treatment with direct-acting antiviral (DAA) therapies such that they had no detectable HCV RNA ≥12 weeks after the completion of treatment or spontaneously cleared HCV RNA as demonstrated by two undetectable tests at least, 1 month apart, would not be regarded as being a public health risk in terms of meeting the health requirement. For HCWs or HCSs who are HCV RNA detectable, a Health Care Worker Duty Statement should be requested. The statement should confirm that the HCW or HCS will not perform EPPs until they have no detectable HCV RNA as demonstrated under the above requirements. If the applicant will work as or study to be a dentist, the statement should confirm that this activity will not occur until they have no detectable HCV RNA, as above.
HIV	HCWs or HCSs who are HIV positive with a viral load below 200 copies/ml and they are compliant with an effective Anti-Retroviral Treatment (ART) would not be regarded as being a public health risk in terms of meeting the health requirement. For HCW or HCS with viral loads at 200 copies/ml or higher, a Health Care Worker Duty Statement should be requested. The statement should confirm that the HCW or HCS will not perform EPPs until their viral load is below 200 copies/ml. If the applicant will work as or study to be a dentist, the statement should confirm that this activity will not occur until their viral load is below 200 copies/ml.

Health Care Duty Statements should be provided from prospective employers or educational institutions, however a statutory declaration can be submitted if such a statement is not available (e.g. if the applicant does not have a prospective employer). These statements are provided to their visa processing officer and uploaded into the HAP for MOC review.

All visa applicants who declared that they will work as, or study to be a doctor, dentist, nurse or paramedic, and who have a BBV infection, regardless of viral load level, should be placed on a Health Undertaking if offshore (refer to **Non-TB Health Undertakings** section). If onshore, the panel physician should consider appropriate duty of care referrals

Human Immunodeficiency Virus (HIV) testing

In addition to applicants who will undertake EPPs, HIV tests are undertaken for:

- all permanent visa applicants aged 15 and over (including some non-migrating family members)
- unaccompanied minor refugee children
- children who have been, or are to be, adopted by Australian residents
- children aged 14 years of age and younger with clinical suspicion for HIV infection, or who have a history of blood transfusions or haemophilia, or for whom the mother is HIV-seropositive
- temporary visa applicants with a declared history of being HIV seropositive and/ or clinical signs of AIDS
- persons known or found to be infected with Hepatitis C
- persons where there is evidence of previous or current intravenous drug use
- persons where active TB is diagnosed

- temporary visa applicants who declare that they will incur medical costs, or require treatment for HIV infection.

An HIV specialist report (exam code 722) will be automatically generated for applicants outside Australia who return a reactive/positive HIV test. CD4 and viral load results must be included in the specialist report.

For applicants in Australia a 722 is not generated, however where an applicant's HIV positive status is known at time of IME, and they are already undergoing HIV treatment, panel physicians are requested to upload any recent pathology results or General Practitioner (GP) or specialist report that the applicant brings to their IME. If these documents are not available at time of IME, panel physicians are to record the following details, where known, in eMedical under the Medical History section of the 501 exam:

- Year of diagnosis,
- Country of diagnosis,
- Antiviral therapy details, including date commenced, compliance to treatment and where the medication is sourced,
- The sexual health clinic, GP or specialist in Australia managing their HIV, including information on:
    - Last pathology blood test, and any known results from latest viral load and/or CD4 count
    - Last visit and/or next scheduled visit

If the MOC is satisfied that the information recorded does not indicate potential drug resistance or inadequate viral control, the MOC assessment can be made on the basis of the information provided. If the MOC is not satisfied of this, the case should be deferred for the provision of an HIV specialist report.

For applicants in Australia who are newly diagnosed with HIV at time of the IME, a specialist report or pathology results will not be required, and MOCs can proceed to finalise assessments without deferral / or waiting for a specialist report or CD4 pathology results. Such applicants are referred by panel physicians to their own GP or a suitable specialist for follow-up counselling and management.

4.2.3 Assessment of onshore protection visa applicants

This section relates to the assessment of health examinations completed by applicants who apply for the following visa subclasses:

- Protection (subclass 866) visa
- Temporary Protection (subclass 785) visa
- Temporary (Humanitarian Concern) (subclass 786) visa
- Safe Haven Enterprise (subclass 790) visa (SHEV)

The health PICs do not apply to Onshore Protection visa applicants.

The Regulations relating to health for these visa subclasses, require MOCs to assess whether the applicant might pose a public health risk to the Australian community.

In practice, this means where a MOC determines that the applicant is a public health risk to the Australian community, the MOC may request the applicant to complete a Health Undertaking (Form 815) before a decision is made on their visa application by the visa delegate. Arrangements must be made to place the applicant under the professional supervision of a health authority in a state/territory to undergo any necessary treatment.

Tuberculosis

A 'No Clearance Required' outcome can be provided for protection applicants with signs of inactive TB. If signs of active TB are present that would otherwise result in a 603 deferral (as outlined in Part A of this document), a 'No Clearance Required with Health Undertaking' outcome can be provided, unless compliance with a previous health undertaking is evidenced by an onshore chest clinic report.

Where active TB is suspected, in addition to the health undertaking, arrangements should be made to ensure that applicants are immediately referred to a state/territory chest clinic or respiratory specialist.

Human Immunodeficiency Virus (HIV)

Protection visa applicants with HIV and in whom TB has been excluded should be provided with a 'No Clearance Required with Health Undertaking' for HIV. The only exception to this is if they have previously been provided with a HIV Health Undertaking.

Hepatitis

A 'No Clearance Required with Health Undertaking' outcome is appropriate for Protection visa applicants who are identified as:

- HBsAg positive or
- HCV seropositive and
- have not previously been requested to sign up to a Health Undertaking.

An undertaking should not be requested if the applicant has previously been provided with a Hepatitis B or C undertaking.

***Note**: Refer to TB and Non-TB Health Undertaking sections for further information on Health Undertaking requirements*.

4.2.4 Assessment of Medical Treatment visa applicants

Medical Treatment visas (MTVs) allow non-citizens to either visit or stay in Australia for a short period of time to obtain medical treatment. In most cases MTVs are not appropriate for persons seeking to stay in Australia for beyond a one year period. However, in some instances MTVs are granted for a longer stay for applicants who are unfit to depart Australia due to their health conditions. This assessment is carried out by a MOC – refer to *Non-Standard MOC Assessments*.

The PIC Health Requirement (4005 to 4007) does not apply to MTV applicants seeking medical treatment. All applicants seeking medical treatment must, however, satisfy a visa delegate that they are free from a disease or condition that may result in the applicant being a threat to public health in Australia or a danger to the Australian community (subclause 602.212(2)(d) of Schedule 2 to the *Migration Regulations*). Under policy, this equates to the applicant being free from active TB. An applicant who poses such a threat will be found not to meet the Health Requirement, with a MOC opinion wording equivalent to those for the public health requirement of PIC 4005 or 4007.

Additionally, the visa delegate may also seek MOC advice where:

- a longer stay in Australia is requested by the applicant to ensure that the proposed length of treatment is consistent with applicant's health condition, or
- there is a concern that the applicant may be seeking to access a service in short supply.

MOC assessment and MTVs

Primary applicant

The primary applicant refers to the person seeking treatment, an organ donor, a support person for either of these, or a person seeking to satisfy the 'unfit to depart' criteria.

- Under policy, persons seeking treatment are required to undergo medical and CXR examinations (501 and 502) for the purpose of excluding TB, if they are from a higher TB-risk country, on the basis that they will be entering a hospital or health care environment. If TB is suspected, further investigation is required through the 603 exam. Once TB is excluded, a health clearance can be provided.

- MTV applicants seeking treatment who are from lower TB-risk countries will generally not be required to undergo health examinations unless information is known to the Department requiring medical examinations.
- MTV applicants seeking to donate an organ, or be a support person, are required to satisfy PIC 4005, and are from a higher TB-risk country are required to undergo health examinations as follows:
    - Children aged under 2 years – a medical examination (501) only
    - Children aged 2 years to less than 11 years – a medical examination (501) and a TB screening test (719)
    - Persons aged 11 years or older – a medical examination (501) and a chest x-ray (502)

Health undertakings cannot be used in relation to MTV applicants who are seeking medical treatment as they are not required to satisfy the health requirement. The MTV Regulations do not require the MOC to place such applicants under the supervision of a health authority. If MOCs are concerned about the TB status of such applicants, this needs to be resolved prior to visa grant rather than with onshore follow-up.

Special provisions to the above apply to the following applicants

- Papua New Guinea (PNG) citizens living in PNG's Western Province (south west PNG bordering Irian Jaya), and
- are approved by the Queensland Department of Health for medical evacuation to a hospital or for medical treatment in Queensland

There are no health related regulatory provisions for this group. The Department has arrangements in place with the Queensland government for residents of the Western Province of Papua New Guinea to be admitted to hospitals in Queensland **without having undergone** TB screening, on the basis that the necessary precautions will be in place.

Secondary Applicant

The Regulations allow a secondary MTV applicant to be granted if they are a family unit member of a person who has been granted an MTV under the 'unfit to depart' provisions. These applicants are not required to meet the Health Requirement unless they already hold an MTV and satisfy the criteria for permission to work in Australia, in which case they must satisfy PIC 4005.

4.2.5 Non-TB Health Undertakings

***Note**: there are no undertakings for onshore applicants with the exception of onshore protection visa applicants.*

Hepatitis B or C Undertakings

Are required for:

- Permanent applicants who are HbsAg+ve or HCV-seropositive and meet PIC 4005.
- Permanent applicants who are HbsAg+ve or HCV-seropositive and meet PIC 4007(1)(a) or (b).
- Temporary health care workers or students who are HbsAg+ve or HCV-seropositive, who meet PIC 4005, or meet PIC 4007(1)(a) or (b).
- Protection applicants who are HbsAg+ve or HCV-seropositive who have not previously been issued with a health undertaking.

Are NOT required for:

- Any applicant who is HbsAb+ve but HbsAg-ve.
- Any applicant who is HbsAg-ve and anti-HCV-seronegative after treatment for Hepatitis B or C.
- Temporary applicants not involved in health care.
- Any applicant who does not meet PIC 4005.

- Protection applicants who are HbsAg+ve or HCV-seropositive who have been issued with a health undertaking prior.

HIV Undertakings

Are required for:

- Any HIV+ permanent visa applicant who meets PIC 4007(1)(a) or (b)
- Any HIV+ health care student or worker, who meets PIC 4005, or meets PIC 4007(1)(a) or (b)
- Any HIV+ protection visa applicant who has not previously been issued with a health undertaking for HIV.

Are not required for:

- Any HIV+ temporary applicant not involved in health care (defined above)
- Any HIV+ applicant who does not meet PIC 4005
- Any HIV+ protection visa applicant who has previously been issued with a health undertaking for HIV.

Leprosy Undertakings

Leprosy is caused by a *mycobacterium* like tuberculosis, and is treated with similar agents for a similar duration (six months for pauci-bacillary leprosy, or 12 months for multi-bacillary leprosy).

As no active screening occurs for leprosy as part of the IME, and as the condition is rare in the visa applicant population, few cases are found. However, if a diagnosis is made on clinical or history grounds and confirmed on skin smear microscopy, the applicant should be deferred pending treatment completion as occurs with TB.

Once this treatment is complete, and assuming the applicant otherwise meets the Health Requirement for permanent stay, they can be issued with a health undertaking for leprosy.

Pregnancy Undertakings

Under policy, pregnancy undertakings are required only for protection visa applicants who are unable to undergo a CXR due to pregnancy.
Pregnancy undertakings are no longer in use in relation to PIC 4005 or 4007. Applicants from lower risk countries can complete their health assessment with the CXR set aside. Applicants from higher risk countries must undergo CXR examination, either with added shielding during pregnancy, or following delivery.

4.3 Part C: Significant cost threshold (SCT)

Assessing visa applicants against the significant cost threshold

MOCs must provide an opinion as to whether a visa applicant's condition or disease would be likely to result in health care and community services costs if a visa were to be granted.

Regulation 1.03 (Definitions) of the Regulations provides that 'community services' is taken to include an Australian social security benefit, allowance or pension. Under policy, the term is also taken to include:

- supported accommodation services (e.g. homes, hostels and large institutions)
- personal care services (e.g. attendant care and in-home support)
- respite care
- special education services (except Education Entry Payments)
- employment support
- equipment services and rehabilitation services
- community care

'Health care' is not defined under migration law. Health care is taken to include:

- ongoing medical services (e.g. renal dialysis)
- hospital services (both inpatient and outpatient care)
- residential and nursing home care services
- palliative care
- community health care
- outpatient consultations (e.g. general practitioners, specialists, allied health and other health care providers, if subject to a public subsidy, for example a Medicare rebate)
- rehabilitation services
- disability services
- medications subsidised by the Pharmaceutical Benefits Scheme (PBS).
- devices, prostheses and appliances covered by Medicare/NDIS.

Costs relevant to assessment

A visa applicant or NMFM cannot be found to meet the Health Requirement for the grant of certain visas if they have a disease or condition that is likely to result in a 'significant cost' to the Australian community in the areas of health care or community services – refer to 4005(1)(c)(ii)(A) and 4007(1)(c)(ii)(A). As of 1 September 2021, the policy threshold for the cost considered as 'significant' is **AUD 51,000**. This is also known as the significant cost threshold.

***Note**: MOCs should refer to the current Health Requirement PI for the SCT.*

4.3.1 Costs to be excluded from costing calculations for temporary visa applicants

Exclusions under legislation – Refer to PIC 4005(3) and PIC 4007(1B) for further information.

Where an applicant applies for a temporary visa (unless the visa subclass is specified in Legislative Instrument LIN 22/007), the below services outlined in the LIN 22/014 are to be **excluded** from the cost assessment:

- Social security payments
- Benefits derived from holding a health care card or pensioner concession card
- Provisions of pharmaceuticals listed under the pharmaceuticals benefits scheme (PBS) that if the person ceases to take would not be seriously detrimental to their life or wellbeing. Medications considered to be seriously detrimental if stopped include, but are not limited to:
    - antiretroviral therapy (ARV) in HIV management
    - immunosuppressant therapy for post-transplant applicant
    - interferon and immunomodulating therapy for Multiple Sclerosis (MS) (if PBS eligibility criteria satisfied at the time of assessment)
    - biological Disease Modifying Anti-Rheumatic Drugs (DMARDs) (if PBS eligibility criteria are satisfied at the time of assessment)
    - synthetic blood products or recombinant factors
    - iron chelation therapy
    - chemotherapeutic agents used to treat malignancies (if PBS eligibility criteria satisfied at the time of assessment).
- Services provided under the National Disability Insurance Scheme (NDIS).

On 1st April 2020, to be consistent with the roll out of the NDIS, the Department updated MOC costing models to reflect NDIS eligibility requirements. Under the NDIS, access to disability services is limited to Australian citizens and permanent residents, with temporary visa holders ineligible.

Note: *for Temporary visa applicants MOC cost assessments no longer include potential costs for state disability services in their costs assessments for temporary visa applicants.*

Permanent visa applicants

MOC cost assessments should not include potential costs for state disability services for permanent visa applicants, and instead assess costs against the disability services available under the NDIS. Noting that under departmental policy, MOCs assess an applicant against the Health Requirement for a permanent stay if the visa applicant has applied for a permanent or provisional visa.

***Note**: MOCs should refer to relevant NfG papers for costing information under the NDIS.*

4.3.2 Period relevant to Assessment

When assessing 'costs', a MOC must assess the visa applicant against the Health Requirement for:

- a period for which the Minister (or delegate of the Minister) *intends to grant the visa* if the visa applicant has applied for a *temporary* visa **unless** the temporary visa subclass is specified by the Minister in the Legislative Instrument LIN 22/007 (in which case the visa is considered to be a provisional visa, as it can lead to eligibility for a permanent visa).
- a *permanent stay* (i.e. a period commencing when the application is made) in Australia if the visa applicant has applied for a *permanent or provisional* visa

***Note:** Refer to PIC 4005(2) and PIC 4007(1A) for further information.*

4.3.3 Permanent and provisional visa applicants

Under policy, when assessing a permanent or provisional visa applicant against the significant cost threshold the time period for estimating costs should be calculated as follows:

- if *the applicant is aged less than 75 years:* a five year period or
- if *the applicant is aged 75 years or older:* a three year period.

Visa Type	MOC cost assessment period	
Permanent and Provisional	• Applicants aged 75 years or older	Three years
	• Applicants with a condition that is permanent and the course of the disease is inevitable or reasonably predictable (65% likelihood) beyond the five year period	A maximum of 10 years
	• Applicants with a reasonably predictable (65% likelihood) reduced life expectancy	A maximum of 10 years
	• All other permanent and provisional visa applicants	Five years

4.3.4 Temporary visa applicants

For temporary visa applicants, the estimated costs for their proposed stay in Australia must be assessed against the period for which the delegate intends to grant the visa.

Under policy, unless an assessment for a permanent stay is requested, all temporary visa applicants are assessed against the Health Requirement for the **maximum** period provided by the visa subclass (that is, the standard default HAP period) unless the VPO has varied the assessment period from the default value. **Therefore, MOCs must provide an opinion against the assessment period that is specified by HAP in the first instance*.**

For example, a student visa applicant with health care costs of $16,000 per annum, who will be granted a one year visa, should be found to meet the Health Requirement.

A student visa applicant with costs of $16,000 per annum, who will be granted a four year visa, would not meet the Health Requirement. This is because the total health care costs for that student of $64,000 exceed the significant cost threshold.

***** *While the (default) period is the maximum period for the relevant visa subclass, in practice, for visitor visa cases (i.e. over 75 visa applicants), only a 501 exam may be submitted by the visa applicant based on their intended length of stay, health declaration and the health matrix. For these health cases, the assessing MOC may provide an appropriate health clearance for a reduced stay where there are no significant findings or information available to suggest otherwise.*

Reduced Stay Period assessments for temporary visa applicants

- Under policy, where a significant health condition is identified and the applicant does not meet the Health Requirement for the default (maximum) period/stay duration, the MOC should provide a 'DNM' opinion in the first instance.
- It is then the responsibility of the visa delegate to request a re-assessment by a MOC for a shorter period of stay, if appropriate. When a new assessment is requested, the visa delegate will enter the revised assessment period into HAP to be applied by the MOC in providing their opinion against the revised period. The minimum stay period MOCs should cost against is three months (**exception –** applicants on dialysis seeking short term visits see below).
- If the applicant meets the Health Requirement for this reduced period, the MOC opinion in this scenario should be recorded as **Meets (Reduced Stay)** and the relevant assessment period displayed to alert other MOCs and visa delegates that the applicant has only met the Health Requirement for a shorter period of stay. The ICD code must be recorded accurately in HAP and any other pertinent comments included (e.g. the rationale for the decision). MOCs may also provide a comment for visa delegates using the MOC Comment function, outlining their reasons.

Assessments for temporary visa applicants unlikely to be able to depart

Scenario 1

In situations where it is clear that a client **will not be able to return home at the end of their proposed period of stay**, the following will continue to apply:

- In some circumstances, and if the costs are proportionately reduced, an applicant may technically meet the Health Requirement for a reduced period of stay but may have a condition inhibiting their ability to depart at the end of their proposed stay (e.g. requiring aged care accommodation due to cognitive disorder).
- In these circumstances, under policy, the MOC **should proceed with the DNM opinion** outlining the originally estimated costs (regardless of proposed duration of stay). The opinion should include explanatory statements that the applicant's condition is of such the severity that they are unlikely to be capable of departing Australia at the end of the proposed stay.

Unless:

- A temporary visa applicant is completing health examinations to the permanent standard and was assessed 'upfront' for a permanent stay in Australia. In this circumstance, if a DNM opinion is provided for permanent stay, the visa delegate is responsible for requesting a re-assessment for the appropriate temporary assessment period.

Note: *Where an assessment period for a permanent or provisional visa is required, and where it cannot be reduced, the applicants must be assessed for a permanent stay in Australia*

Scenario 2

There may be situations where the applicant's ability to depart after their intended period of stay cannot be fully ascertained based on the information on hand. In this instance, the following additional information is to be requested from the client:

- A specialist opinion detailing the current severity of the condition, prognosis (including any foreseeable deterioration) - at least over the proposed length of stay and
- A 'fitness to fly' assessment.

Note*: If the specialist report deems the applicant fit to fly with no expected clinical deterioration in the short term (over the intended period of stay), then, in the event of a request for a reduced length of stay, the costing may be apportioned to the reduced length of stay period.*

Please note that this applies to **both** conditions that are **progressive** and conditions that are **stable but particularly severe,** with the following caveats:

- Several conditions can be labelled 'progressive', the important factor to consider is the rate of progression and in turn determine (exercising clinical judgement) the clinical status of the individual as it applies to the current time, the last few months, and prognosis over the period of the requested visa stay. Panel Physicians and MOCs, should base their opinion and subsequent decisions on the progressive nature of the disease inclusive of the above factors.

If there is a discrepancy between the opinion of the Panel Physician and the current presentation of the individual, as per the information provided in the IME, then a specialist opinion is to be requested by the assessing MOC for additional clarification.

In scenarios where an applicant is considered Not Fit to Fly by the Panel Physician, then a 'fitness to fly' assessment should be sought from a specialist.

Note*: it is reasonable to apply the above to applicants who are already onshore in Australia.*

4.3.5 Hypothetical person test

When assessing the likely costs involved with a disease and/or condition for an applicant, MOCs **must apply the hypothetical person test**, which was clarified in *Robinson v Minister for Immigration and Multicultural and Indigenous Affairs and Another* (2005) 148 FCR 182.

MOCs must therefore take into account the cost of health care or community services for which a **hypothetical person with the same condition and level of severity as the applicant** would be eligible. This test is given effect in the health PICs which provide that the services require consideration '*regardless of whether the health care or community services will actually be used in connection with the applicant*'.

When considering if an applicant is likely to meet the Health Requirement, MOCs must **not** consider personal circumstances above and beyond the:

- nature of the health condition
- severity of the health condition
- age of the applicant
- type of visa applied for
- visa period

If a hypothetical person is likely to require a particular service on medical or other grounds, a MOC is required to assume that they will use it and include it in their costing estimate. The only exception are services (and hence related costs) which are specifically excluded for temporary visa applicants (excluding provisional visa applications) – see section on '*Costs to be excluded from costing calculations for temporary visa applicants'*.

4.4 Part D: Prejudice to access (PTA)

Assessing services in 'short supply'

A visa applicant or NMFM cannot be found to meet the Health Requirement where they have a 'disease or condition' likely to prejudice the access of an Australian citizen or a permanent resident to health care and/or community services - see 4005(1)c)(ii)(B) and 4007(1)(c)(ii)(B).

When deciding which health care services are in 'short supply', the Department takes guidance from the DHAC. Based on DHAC information the following health services are deemed in short supply:

- organ transplants (including haematopoietic stem cell transplants) and
- renal dialysis.

Where MOCs indicate that the visa applicant is unable to meet the Health Requirement on prejudice to access grounds, they will need to select the applicable services as the reason for their opinion. These services are listed in HAP.

***Note**: For the purposes of MOC costing, autologous (patient to themselves) and allogeneic (patient to another patient) haematopoietic stem cell transplants would be considered as services in short supply therefore invoking Prejudice to Access for the purposes of the Health Requirement.*

Key policy elements for MOC assessment and processing of Prejudice to Access cases

- MOCs should assess prejudice to access for a period up to a maximum of 10 years in line with the MOC cost assessment period specified in departmental policy.
- A costing is not required where an applicant is found not to meet the Health Requirement on prejudice to access grounds unless the cost is also significant, that is AUD 51 000 and above.

Occasionally, clients who are known to require renal replacement therapy, including dialysis, may seek to enter Australia for short periods (e.g. on holiday or to visit family). The Department will support this in applicants already on dialysis for a maximum period of ONE MONTH, provided the applicant has made his or her own arrangements **in advance**, and that suitable financial arrangements have been put in place (i.e. that the onshore dialysis unit has accepted the applicant and/or that a renal physician may oversee dialysis in case of peritoneal dialysis and has confirmed financial arrangements, in writing).

Visa officers should upload relevant documentation, confirming the arrangements in HAP. If this is not provided, MOCs should defer requesting this information. Once all the required information is available and assessed by the MOC, a time **limited 'Meets' opinion can be provided** for a maximum period of one month. Any extension to this should be discussed with the Department.

Note: *MOCs should ensure that the applicant's condition is stable and well controlled, and that urgent transplant is not considered likely.*

Note: *MOCs should refer to the relevant NfG papers for clinical and costing information in relation to prejudice to access cases*.

4.5 Part E: Additional medical exams required upon reaching age milestones

The legislative instrument which specifies the required exams for visa applicants includes that additional exams are required for applicants who reach particular age milestones, as follows:

	Age milestone	**Additional exams**
Permanent visa applicants	From higher TB risk countries, from 2 years of age	TB screening (719)
	From all countries, from 11 years	CXR (502)
	From all countries, from 15 years	eGFR (705) HIV Test (707)
Temporary visa applicants from higher TB risk countries	Intending stay in Australia of 6 months or more, from 11 years	CXR (502)
	Intending stay in Australia of 6 months or more, from 15 years	eGFR (705)

If an applicant reaches one of these age milestones after they have been requested to undertake an IME but before the IME takes place, any additionally required exams should be added by the panel or MMSP clinic.

If an applicant reaches one of these age milestones after their IME but before visa grant, it will be necessary for them to undertake the additional exam before the visa can be granted. In these cases, including where the applicant has already been assessed as meeting the health requirement, MOCs should provide a new assessment on the basis of the new exam and any previously undertaken exams (even if those exams are more than 12 months old). These cases should not be deferred in order to request exams that have already been undertaken.

In cases where the applicant was previously health cleared for a 'Provisional' visa (therefore a permanent visa assessment period), and then applies for the corresponding Permanent visa (for which a different HAP ID may be used), again, only the additional exam is required, even if the previous exams are more than 12 months old, or if the previous health clearance is more than 12 months old.

For additional clarity, applicants for the following Permanent visa subclasses can have their health assessments finalised on the basis of 'expired' health clearances for Provisional visas (even if recorded against previous HAP IDs) and any additional 'stand-alone' 502, 707 or 719 undertaken:

100 (Partner,),
143 (Contributory Parent),
191 (Skilled Regional)
801 (Partner),
808 (Confirmatory Residence),
864 (Contributory Aged Parent),
887 (Skilled – Regional),
888 (Business Innovation and Investment), and
892 (State/Territory Sponsored Business Owner)

Applicants for any visa, who undertook additional exams after a previous health clearance for the same visa application, can have a new assessment finalised on the basis of the previous exams (even if 'expired') and any additional exams.

4.6 Part F: Non-standard MOC assessments

There are situations where the Department may require a person's medical condition to be reviewed or assessed, to inform the visa process, other than in association with an IME assessment process. Such may also require consideration of the person's health and whether their medical condition would prevent or hinder the person's ability to travel in any capacity.

Type of assessment	Form of assessment	Relevant guidelines
Health Status Assessments	Form 1389	Immigration Compliance and Status Resolution Framework
Assessment of Medical Condition (Referred Health Assessment)	Form 1148	Health Procedural Instruction
Medical Treatment visas – Fitness to Depart Assessments (FTD)	Form 1148	MTV Procedural Instruction
Public Health Risk Assessments	Process via HAP	Health Procedural Instruction
Carer Visa Assessment	Contact Bupa via carervisa@bupamvs.com.au	N/A

4.6.1 Health Status Assessment – Form 1389

A Health Status Assessment (HSA) is an immigration status resolution tool that provides the Department with a professional opinion, by a MOC, on how a person's medical condition may impact on their ability to depart Australia and return to their home country. It assists a departmental Status Resolution officer or the Minister to consider immigration status resolution options and make appropriate decisions.

In general, the HSA will provide advice on the person's ability to travel, primarily on the basis of medical information provided by the person's physician (which is attached to the HSA referral to the MOC along with Form 1389). The assessing MOC may require the person to attend a physical examination and/or specialist appointment to further inform their opinion.

The relevant departmental officer will send the following documents to the assessing MOC:

- HSA referral via email
- Form 1389
- Any available medical information that supports the request

4.6.2 Assessment of Medical Condition (Referred Health Assessment) and Fitness to Depart Assessments (FTD) – Form 1148

These assessments will require consideration of the person's health condition and may include consideration as to whether any of the person's medical conditions would prevent or hinder his/her ability to travel in any way.

These may include:

- Persons who have applied for Ministerial Intervention to stay in Australia.
- Assessment of claims for Medical Treatment visa – medically unfit to depart Australia (50+ years).

- Persons with an 8503 waiver condition who claim they cannot depart Australia on the basis of medical claims. Waiver requests made on medical grounds may be referred for a review/assessment if doubts exist as to the genuineness or seriousness of the claim itself, or in relation to the evidence provided to support their claim. Refer to Div2.1/reg2.05 - Conditions applicable to visas - Waiver of 'no further application' conditions.

A departmental visa officer will send all the relevant documents along with a completed Form 1148 to the MMSP MOC/medical advisor, via email for an 'on the papers' assessment. The reviewing MOC/medical advisor will assess the information and provide their findings. If they cannot make an 'on the papers' assessment, the reviewing MOC/medical advisor will inform the departmental visa officer that the applicant needs to attend a physical examination. Form 1148 can also be used for an actual physical examination as part of this process.

4.6.3 Public health risk assessment (post health outcome)

In some situations MOCs will be requested to provide an opinion on public health risk ONLY. This generally occurs:

- Where a visa has been granted but the client has not entered Australia within the requisite period, which is known as the First Entry Date (FED) Schedule 8 visa condition 8504; or
- Where a DNM outcome was provided and a waiver has been exercised, but a visa decision is pending.

Process for assessing public health risk cases:

- A VPO will initiate a Public Health Check in HAP, which will trigger automated correspondence to be sent to the client, or the relevant visa office, requesting that the exams be undertaken. These will generally consist of a 501 medical examination and a 502 CXR examination (or a 719 TB screening test if the applicant is aged 2-10).
- After the PHC has been submitted in eMedical by the panel member, any case that is not auto-cleared will be assigned to the Public Health Check queue.
- MOCs need to provide an opinion about whether or not they consider the client to be a risk to public health (i.e. whether they have active TB), based, in the first instance, on the health examinations provided to them.

If the MOC considers the client to be no risk to public health, they should record as '**No threat to Public Health**' in the Action panel.

Note*: that a further MOC opinion against the Health Requirement is not required.*

If the CXR provided is abnormal, the MOC should review previous images and assess radiological stability. If there are new findings, then the following is advised:

1. Select the '**Defer advice**' option in the Action panel.
2. Request a medical examination by a panel physician specifically addressing clinical findings associated with TB.
3. Request a single sputum sample. This can be either a spot specimen, an early morning specimen the following day or an induced specimen (if appropriately labelled). The laboratory must perform smear testing (preferably auramine staining) and molecular testing (Xpert/MTB RIF or Hain GenoType MTBDR plus testing), if available, so as to identify any positive cases.

   If both smear and molecular tests are negative, it is not necessary to set up a culture.
4. If, following the above, there are findings consistent with active TB (e.g. clinical findings or positive sputum tests) then a formal request for additional information consistent with the standard 603 deferral is advised. In children, if the 719 test is now positive (and was previously negative), then the child should proceed to CXR screening.

5. A final outcome of '**No threat to Public Health'** should be recorded if additional information confirms that the client does not have active TB.
6. If active TB is confirmed, an outcome of '**Threat to Public Health**' should be recorded. Management of such clients will be the same as in the IME context.

   No threat to Public Health and **Threat to Public Health** are final outcomes. If a client is diagnosed with active TB, a subsequent finding of **No threat to Public Health** (ie, after successful treatment) can only be recorded against a new PHC.

4.6.4 Carer Visa Assessment

The Carer Visa Procedural Instruction provides information on Carer visas as well as the assessment process (Div1.2/Reg1.15AA). Regulation 1.15AA and Schedule 2, visa subclasses 116 and 836, specify that: Only a need arising from an existing **medical condition** of the Australian relative or a ***member of their family unit*** (regulation 1.12) who is also an Australian citizen, Australian permanent resident, or eligible New Zealand citizen can be considered on the need for a carer.

- The Australian relative or a member of their family unit must undertake a **medical assessment/medical examination** by a health service provider specified by legislative instrument. The health services provider currently specified for regulation 1.15AA is Bupa Medical Visa Services (Bupa Medical).
- The health service provider provides the relative a **certificate*,** which includes an **impairment rating.**
- The s65 visa delegates are bound by the health service provider certificate and impairment rating.

The Carer Visa Assessment Certificate will clarify whether or not the caree has:

- An impairment rating of 30 or more points based on the Social Security Tables for the assessment of work-related impairment for Disability Support Pension.
- A medical condition that is causing physical, intellectual or sensory impairment of the ability of that person to attend to the practical aspects of daily life.
- A need for direct assistance in attending to the practical aspect of daily life because of the medical condition.
- Because of the medical condition, the need for direct assistance in attending to the practical aspects of daily life that will continue for at least two years.

** All the aforementioned criteria must be met for a satisfactory carer visa assessment to be issued to the client.*

Medical assessment/examination

The Bupa medical examination (in most cases a physical examination) is undertaken either:

- at a Bupa Medical office in Australia;
- at one of Bupa's partner clinics (for example in a regional area); or
- in-home assessments (if appropriate).

All assessments must take place in Australia. There are no arrangements for the examination to be undertaken outside of Australia.

On-the-Paper Assessments

If the relative is in Australia and in hospital or in a residential care facility or there are significant medical reasons why the person requiring care cannot attend a physical examination, an assessment may be undertaken on the papers. Such assessments must be approved by a MOC in accordance with requirements set out in the contract between the Department and Bupa.

The Department has endorsed three specific categories for on-the-paper medical assessments of carer visas:

- Client is in a nursing home and is bed-bound (non-ambulant);
- Child who is a long-term hospital inpatient, and/or a hospital inpatient with clinical immunosuppression;
- Psychotic mental health patient in a mental health in-patient facility who represents a danger to the community.

Bupa Medical report and advice

After the assessment is finalised, Bupa sends the relative a covering letter enclosing a medical report for their information and a sealed envelope containing the certificate and a copy of the assessment report. The covering letter informs the relative that it is their responsibility to send the certificate to the Department so that it can be used in deciding whether the visa applicant satisfies visa requirements.

4.6.5 Review MOC (RMOC) Opinions

If an applicant has been advised by the department that their visa application has been refused on health grounds, and they choose to seek a review of that decision as part of the review process with the Administrative Appeals Tribunal (AAT), the MMSP MOC can review the opinion and provide a new MOC opinion for the purposes of the merits review process. A review fee applies which is payable by the review applicant.

RMOC for a permanent visa application and visa subclasses specified by the Minister in LIN 22/007

In the provision of a RMOC opinion for a permanent visa application and specified visa subclasses in LIN 22/007, the period in which to assess whether the person would be likely to require health care or community services, or meet the medical criteria for the provision of a community service, period commencing when the visa application was made, not when the applicant sought merits review. Consequently, MOCs are required to assess each case by taking into consideration the age of the applicant at the time of the visa application and take into account all relevant information provided by an applicant up until the time that the MOC makes their RMOC opinion, and not rely on outdated information. The MOC should also take into account any relevant policy guidance applicable at the time they make their opinion, unless there are good reasons for departing from the policy.

RMOC for a temporary visa application

In the provision of a MOC opinion for a temporary visa application, the period in which to assess whether the person would be likely to require health care or community services, or meet the medical criteria for the provision of community services, is the period for which the Minister intends to grant the visa. For the purposes of an RMOC opinion, this should be taken to be the period the previous MOC assessment was made against, and costed from the current date. The MOC should also take into account any relevant policy guidance applicable at the time they make their opinion, unless there are good reasons for departing from the policy.

4.7 Part G: Drafting a MOC Opinion

4.7.1 Overview

MOCs must record their opinions in the HAP. The HAP will then generate and file in Content Manager a formal opinion (form 884) based on current templates.

Once generated, the MOC opinion will be visible to visa officers. In most circumstances visa officers will provide the visa applicant with a copy of the MOC opinion if they don't meet the Health Requirement.

Examples of the templates generated by the HAP, and how the information that is entered into the HAP is populated into these templates, is provided at Annexure B. This wording is based on legal advice and reflects that of an opinion based on a hypothetical applicant with the same form and level of the condition.

In the event that a visa is refused and a review submitted to the Administrative Appeals Tribunal (AAT) or the courts, consideration will be directed as to whether the 'hypothetical person test' was applied and whether the assessment was considered against the appropriate regulation, as outlined in the MOC opinion.

4.7.2 Providing a lawful MOC opinion

The HAP assists MOCs to provide a lawful opinion by ensuring that, where possible, the MOC opinion references the following information:

- the correct health PIC (i.e. 4005 or 4007)
- the correct visa subclass
- the correct assessment period.

Note: *Visa officers are also expected to check this information for all DNM opinions*

However, MOCs still need to ensure that in entering information in HAP that the MOC opinion references:

- details of all health examination reports that have been considered in forming the opinion
- if there were conflicting reports, why one report was given more weight over another
- all conditions that enliven the PIC along with the severity of these conditions.

The HAP will provide MOCs with a non-exhaustive list of words to describe the severity of the applicant's condition:

- Active
- Advanced
- Asymptomatic
- Extensive
- Invasive
- Mild
- Mild-To-Moderate
- Moderate
- Moderate-To-Severe
- Profound
- Severe
- Significant
- Stable
- Symptomatic

When recording a DNM MOC opinion in the HAP, the more information about the health assessment outcome MOCs are able to provide the applicant, the easier it will be for them to understand why they have failed to meet the Health Requirement. Comment boxes are provided for each condition listed to enable MOCs to list the reasons.

Important: This information must explain why a hypothetical person with the same form and level of condition would not meet the Health Requirement. The applicant's personal circumstances (e.g. that they are currently in a special education class, or are stable on a cheaper medication not likely to be used by the hypothetical person) are **not** relevant.

4.7.3 Lawful MOC opinion checklist

To help ensure that a MOC Opinion is lawful MOCs need to:

- apply the hypothetical person test and in preparing their opinion, the advice relates to the health criteria only

- consider all relevant matters, including all available medical information, and disregard irrelevant matters
- cite details of all medical relevant reports in the opinion
- where conflicting reports exist, add a short statement to explain why one or more report(s) has been given more or less weight than another
- have proper regard to policy, including current the Health PI and other departmental instructions including this guidance document
- apply the NfGs that are current at the time of the MOC opinion
- ensure they do not depart from policy or directions in the MOC Advice Pack unless this has been discussed with and formally approved by the Department.

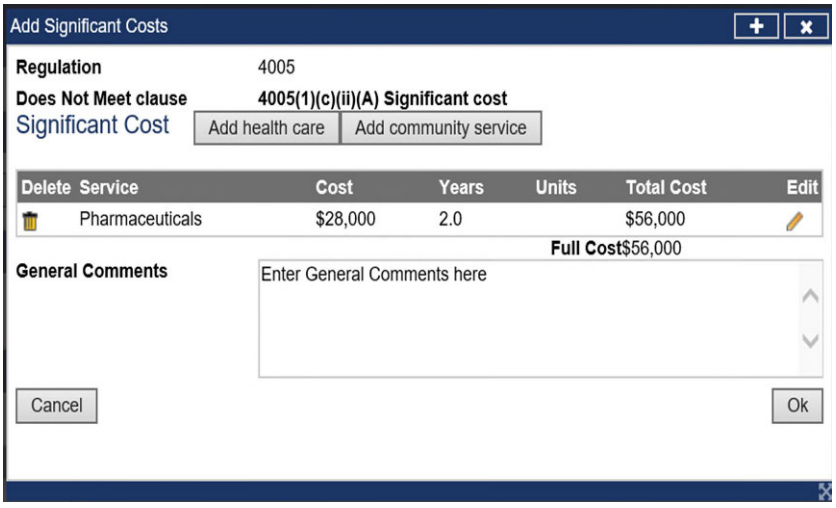
Note: *Should this occur; notes should be entered in the Notes field in HAP.*

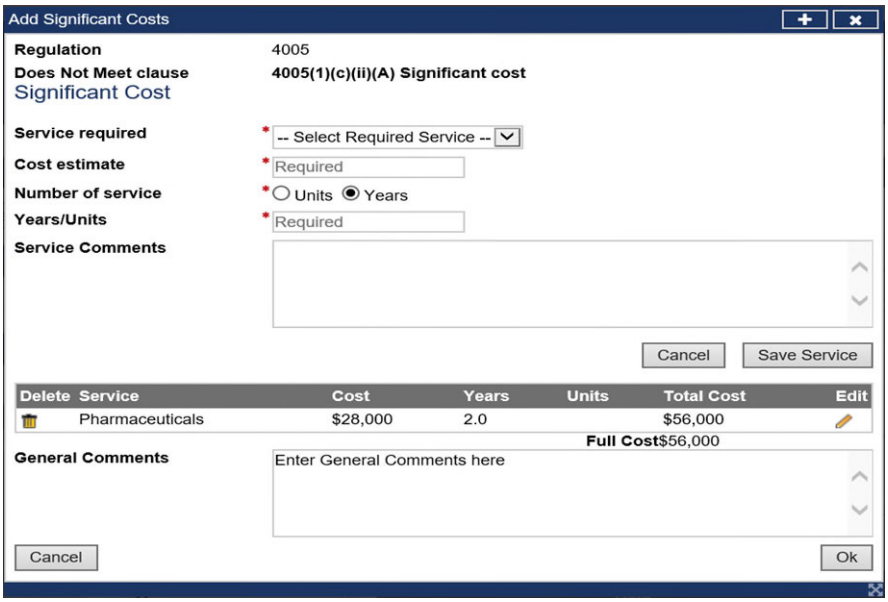
4.7.4 Recording estimated cost in HAP

Where an applicant is found not to meet the Health Requirement on significant cost grounds, a costing is required when recording a MOC opinion in the Department's HAP – regardless of whether a health waiver is available. This is to enable the Department to monitor the cost impacts and provide greater transparency to applicants.

As a result, MOCs need to record which services have been included in the cost assessment and the period for which they have been assessed.

This information will appear on the MOC opinion in summary for visa subclasses where a health waiver is available. See example screenshots of the *Add Significant Costs* windows below.





***Note**: Visa applicants or registered migration agents may request the detail of the costing information which has been recorded in HAP, or the estimated costs for a case, if no waiver is available. Visa officers will provide this by using the information recorded in HAP.*

To assist with Freedom of Information requests, and to increase transparency and consistency, MOCs must record in HAP the materials that they have referred to in providing their opinion in the '*General Comments'* field.

As an example, it is suggested that MOCs include the following information:

- which NfG paper(s) were used
- which parts/sections of the NfG paper(s) were used
- URLs of webpages and/or other sources (e.g. the website of the Australian Institute of Health and Welfare).
- Individual cost breakdown calculations should be included in the 'Service Comments' field.

Note**: MOCs may use the following as an example of text accompanying cost estimate line items **"Cost estimate based on NFG [insert disease/system] [insert month and year], including but not limited to Scenario [number]"

4.7.5 Recording prejudice to access information

Where an applicant is found not to meet the Health Requirement on prejudice to access grounds the MOC will be required to list any relevant services (i.e. those which will likely result in use of services which are listed as prejudice to access). If the prejudice to access also meets the significant cost threshold, this costing advice should also be entered in HAP.

4.8 Part H: MOC opinion outcomes

4.8.1 Types of MOC opinions

The table below summarises the type of opinions provided by MOCs and the steps required to be taken by visa processing officers.

MOC opinion	Explanation
Meets	The applicant has met the Health Requirement and the visa can be granted if all other criteria are met.
Meets (Reduced Stay)	The applicant has met the Health Requirement and the visa can be granted if all other criteria are met. The period for which the visa officer intends to grant the visa should not be longer than the period for which health was assessed.
Meets with Undertaking	The applicant will meet the Health Requirement if they provide the visa officer with a signed undertaking form (form 815)*.
Does Not Meet	The applicant has not met the Health Requirement and a visa cannot be granted unless a health waiver is available and exercised. **Note:** In certain circumstances a MOC should also enter that an undertaking be signed in the event a health waiver is to be exercised*.
Deferred	Processing of the applicant's visa application cannot continue until they provide the additional information requested by the MOC. Note: Should an applicant refuse to complete an exam a detailed reason should be recorded by the Panel Physician.
No Clearance Required	An applicant for a XD-785, UO-786, XE-790, CD-851 or XA-866 visa has completed their required health examinations and no conditions considered to be a threat to public health have been identified. **Note:** A MOC may ask that an undertaking be signed if a condition considered to be a threat to public health is identified*.
Awaiting application	See advice under *Front-end loaded health examinations*
Health Not Completed	This outcome is recorded by the MMSP in HAP if the applicant makes no contact or does not provide MOC requested health examinations, within a specified period after the request was sent. **Specified period:** **Onshore cases** – 90 days and no extension to provide the requested information was provided by the MMSP **Offshore cases** – 18 months if requested medical information is not provided. If the applicant contacts the MMSP advising of delays to comply with MOC request then HAP should be updated with relevant case notes and the outcome should remain deferred. Refer to - Managing deferred cases Tip- sheet for further information on the administrative process for reference

** For specific information on Health Undertakings – refer to relevant sections within this document.*

4.8.2 Front-end loaded health examinations

Front end loaded health examinations are submitted prior to a visa application.

From a MOC perspective, the processes for assessing a front-end loaded health case (i.e. examinations completed in advance of a visa application being lodged) are the same as for other health cases **except** that where it is determined that on the information available a 'DNM' opinion is warranted, under policy, they should **not** provide an opinion on this case until **after** a visa application has been lodged.

This ensures that before a DNM opinion is issued, all relevant information is available, including the proposed duration of visa grant. Importantly, the MOC provides an opinion as to whether a visa applicant (rather than an intended visa applicant) meets the Health Requirement in line with the Regulations at the time of visa decision.

For this reason, a 'DNM' option will not appear for a MOC to select in HAP until the relevant health case is linked to a visa application. Instead, the case will remain with a status of 'Awaiting Application' until a visa application is lodged.

Note: *Once a visa application is lodged, electronic health cases will simply return to the MOC assessment queue to be re-assessed. Paper health cases will be returned to the Application Received queue so administrative staff from the MMSP can collate the necessary paper work before sending the case to a MOC.*

4.8.3 Managing new information (post MOC opinion)

If visa applicants do not meet the Health Requirement, they are invited by the Department to submit additional health information for reconsideration. This is part of the 'Natural Justice' process.

4.8.4 Non-medical information is provided

In response to advice that they have not met the Health Requirement, visa applicants may provide **non-medical** information that is **not** relevant to the MOC opinion that they do not meet the Health Requirement (e.g. letters of support that raise compassionate circumstances that they want the MOC or Department to take into account).

Visa officers are asked to manage this information as MOC involvement is not required. As a result, if this information is provided to a MOC, it should not be actioned by the MOC. Instead, the MOC or an administrative officer on their behalf should email s. 22(1)(a)(ii) @homeaffairs.gov.au asking the helpdesk to:

- reverse the newly generated assessment in HAP (a new assessment is not required as explained above)
- advise the visa officer that this has been done because the new information provided is not of a medical nature and is not something that the MOC can consider.

4.8.5 Medical information is provided

Where an applicant does provide additional medical information prior to a decision on their visa application (e.g. a more recent specialist report), a visa officer should create a new assessment directly in the HAP and attach any relevant medical information provided by the applicant.

The MOC must then consider this information and provide a new assessment in HAP (i.e. a new MOC opinion), even if the additional medical information does not change the outcome, or the additional medical information is in fact not new. If this new MOC opinion is not provided any subsequent visa decision may be affected by jurisdictional error (this is a term used to describe visa decisions that contain an error of law).

When recording in HAP which information has been considered in providing a subsequent opinion, it is recommended that the following text also be added:

> *This opinion follows the receipt of additional medical information from the visa applicant subsequent to the earlier opinion of DD/MM/YYYY. The previous opinion should be disregarded for the purpose of visa decision, as this current opinion is based on the most up-to-date medical information available.*

Where a MOC provides a 'Meets' opinion in contrast to a previous DNM assessment, additional comments must be added by a MOC in HAP in the 'Case Officer Comments' field (in Assessment Settings) explaining the reasons why the applicant is now able to meet the Health Requirement (e.g. because they have undergone surgery, purchased a cochlear implant, are now in remission). The below is an example of text that could be considered:

> *This applicant's condition has significantly improved since the previous assessment /OR/ the medical information indicates that the applicant's condition is less severe than determined in the previous assessment (whichever applies).*
>
> *This opinion follows the receipt of additional medical information from the visa applicant subsequent to the earlier opinion of DD/MM/YYYY. The previous opinion should be disregarded for the purpose of the visa decision, as this current opinion is based on the most up-to-date medical information available.*

Note: *Where a new 'Does Not Meet' opinion is provided the applicant is provided with the opportunity to submit additional medical information. This is required in line with natural justice obligations. Consequently, this process may repeat, indefinitely until the visa application is finalised. Please note, however, that visa decisions are generally made in a timely fashion.*

4.9 Part I: Other duty of care/clinical issues

In the course of an assessment, MOCs may be presented with an applicant who meets the Health Requirement despite having a significant disease or condition which raises significant clinical concerns about the applicant's ability to safely travel to Australia (e.g. untreated pneumothorax). In these cases, the jurisdictional requirement to assess against the PIC applies and the MOC should provide the appropriate assessment outcome as per usual process.

Duty of care for advising applicants of their medical findings lies with medical practitioners who have conducted the original examination (i.e. the panel physician or radiologist) not with MOCs. However, if it is considered important that the applicant is reminded of their health condition prior to safe travel, a comment for the visa officer should be added to the assessment requesting that they remind the applicant of the need to consult their own doctors prior to travel to ensure any urgent health need is addressed that might put the applicant's life in danger.

4.10 Part J - MOC auditing responsibilities

Quality control, assurance and improvement are important parts of the IME process. MOC participation in auditing performance of panel members is mandatory and should be done routinely as part of the health case assessment.

There are two audit mechanisms where MOCs review cases conducted by offshore panel members:

- MOC audit of auto cleared cases – a sample of health cases consisting of 501 and 502 examinations from auto-cleared countries are reviewed to ensure the quality and monitor the performance of offshore panel members.
- MOC assessment of non-auto cleared cases – MOCs identify errors made by offshore panel members through their review of health cases for assessment from non-auto cleared countries and B-graded cases from auto cleared countries.

If a performance issue is identified during the health assessment process then this should be recorded using the HAP audit function. This information is used by Migration Health to provide relevant feedback to panel physicians.

Note: *a likely active TB case which is missed should immediately be escalated to the Migration Health section, via email in addition to providing a MOC Audit Comment so timely intervention and/or follow up is instigated.*

Panel audit issues are identified as Critical, Moderate or Minor. The following grading table should be used to complete the drop down boxes provided.

4.10.1 Panel Error Grading Table Framework

The Panel Error Grading Table Framework should be applied when auditing Auto-Cleared health cases. This framework may also be used as a guide when auditing non auto-cleared and 'B' graded health cases in HAP, until any required systems changes (to ensure consistency) are implemented.

Error Severity	Severity Definition	Error Categories with definitions – updated Feb 2022
Critical	Actions by the Panel Physician or Radiologist that have produced, or have the potential to produce, a visa grant event that should not occur.	· **Probable Active TB Not Reported** – e.g. missed opacities consistent with active TB and other findings consistent with active TB
		· **Severe Medical Condition Not Reported** – failure to identify a condition that would have prevented health clearance (i.e. known condition which would have been over the Significant Cost Threshold or Prejudice To Access condition; e.g. chronic immune deficiency requiring regular immunoglobulin infusions, Crohn's disease on infliximab, moderate to severe mental retardation)
		· **Fraud or Substitution**
		· **Other** – where the error does not fit any other critical error category
Moderate	Actions by the Panel Physician or Radiologist that have the potential to alter the health outcome.	**501**
		· **Moderate Medical Condition not reported** – failure to identify a potentially significant condition which would have required further investigation (deferral) or follow-up (e.g. absent breast, hepatitis B). Includes where positive result is reported as negative
		· **Inappropriate Grading** – when health case was A graded but should have been B graded
		Under-investigation - when eMedical exams should have been added/completed but were not (e.g. HIV/Hep B/Hep C/Liver Function tests/TST or IGRA/Serum Creatinine and eGFR/Syphilis/Mental State/ADL), and the lack of investigation may potentially affect the health outcome so MOC needs to defer for additional information/tests·
		· **Photograph Integrity Requirement Not Met** – e.g. photograph has not been uploaded to eMedical or photo clearly belongs to another person (i.e. applicant is male however photo is of a female (vice versa), applicant is a child however photo is of an elderly person, etc.) Note: any identity concerns should be noted however the responsibility for determining identity rests with the visa decision maker.
		· **Report/Result Integrity Requirement Not Met** – incorrect report/result or report/result belongs to another person
		· **Other -** where the error does not fit any other moderate error category
		502
		· **Probable Inactive TB Not Reported** (e.g. finding occasionally associated with TB disease)
		· **Moderate CXR Abnormality Not Reported** – abnormality that should have been B graded not recorded
		· **Inappropriate Grading** – CXR was A graded but should have been B graded
		· **CXR Integrity Requirements Not Met** - wrong reports/CXR attached
		· **Other** - where the error does not fit any other moderate category
Minor	Actions by the Panel Physician or Radiologist that do not satisfy the Panel Member Instructions but lack the potential to alter the health outcome.	**501**
		· **Inappropriate Grading** – when health case was B graded but should have been A graded
		· **Photograph Guidelines Not Followed** – Photograph is not of a biometric standard (client is too far, too close, photo is blurry, etc.)
		· **Reporting Guidelines Not Followed** – when the PMI is not followed such as untranslated reports, inadequate comments/history
		· **Over-Investigation** – unnecessary tests were done (e.g. HIV/Hep B/Syphilis)
		· **Other** – where the error does not fit any other minor category

		502
		· **CXR Quality – Poor quality image resulting in the CXR being non-diagnostic**
		· **Minor CXR Abnormality Not Reported** – abnormality that can be A graded not recorded as a supporting comment next to 'A' grading.
		· **Artefact**
		· **CXR Image** – Identifiers missing
		· **CXR Quality – Jpeg Image** (.dcm file not provided)
		· **CXR Technique** – Technical views/missed angles
		· **Inappropriate Grading** - CXR was B graded but should have been A graded
		· **Over-Investigation** – unnecessary CXR and/or unnecessary reviews
		· **Other** – where the error does not fit any other minor category

***Note**: MOCs must provide enough detail in the comments as to the specific error. For example, if lack of adherence to instructions is identified MOCs must specify exactly what was not adhered to.*

Annexure A – Examination code list

Examination Codes
104 Cardiologist's report
106 Psychiatrist's report
108 Endocrinologist's report – e.g. for Diabetes
111 Rheumatologist's report
112 Neurologist's report
114 Ophthalmologist's report
115 Nephrologist's report
117 Gastroenterologist's report
119 Oncologist's report
122 Geriatrician's report
124 Paediatrician's report and school report (if applicable)
125 Specialist report
501 Medical examination
502 CXR examination
503 CXR image
504 Posteroanterior (PA) CXR examination
508 Posteroanterior (PA) CXR image
509 Lordotic CXR examination
510 Lateral CXR examination
512 Limited Medical Examination
601 Sputum smears and cultures
602 TB specialist's report
603 Respiratory specialist investigation on current state of tuberculosis
604 Chest clinic investigation about radiological abnormality
607 Continued anti-tuberculosis treatment
608 Await tuberculosis culture results
610 Pulmonologist's report
703 Repeat urinalysis
704 Serum Creatinine
705 Serum Creatinine and Estimated Glomerular Filtration Rate (eGFR)
707 HIV test
708 Hepatitis B test
711 Syphilis management information
712 Syphilis Test (VDRL or RPR)
713 Gonorrhoea
714 Hansen's Disease
715 Liver functions test
716 Hepatitis C test
719 TB Screening test - TST or IGRA
722 HIV Specialist report
720 Hepatitis C RNA
901 Mini Mental Examination
902 Global Assessment of Functioning
903 Activities of Daily Living
904 Chart of Early Child Development
948 Medical Resettlement needs
949 Departure Health Check

950 Other
951 Vaccination
952 Treatment/Medication

Annexure B – MOC opinion examples

The following provides an example of the formal decision record of the MOC opinion and will be created electronically as a PDF document and stored in Content Manager. The relevant Content Manager reference will be in the HAP. They have been provided so that MOCs can see how the information provided in HAP is used by the system to generate the 884 opinion which is provided to the visa applicant.

FORM 884: OPINION OF A MEDICAL OFFICER OF THE COMMONWEALTH

THE APPLICANT DOES NOT MEET THE HEALTH REQUIREMENT

HAP Id	**12345678**
Client Surname	XXXXX
Client Given Names	XXXXXX
Birth Date	XX/XX/XXXX
Sex	X
Visa Sub Class	XXX

The applicant has been assessed against Public Interest Criterion (PIC) 4007 [see attached extract] for the period of a permanent stay in Australia.

The applicant does not satisfy sub-subparagraph PIC 4007(1)(c)(ii)(A) in Schedule 4 to the Migration Regulations.

The applicant is a <age> year old person with: - <medical condition entered by MOC>.

<Additional comments entered by a MOC>

I consider that a hypothetical person with this disease or condition, at the same severity as the applicant, would be likely to require health care or community services during the period specified above.

These services would be likely to include:

<Health care or community service entered by a MOC>

<Health care or community service entered by a MOC>

Provision of these health care and/or community services would be likely to result in a significant cost to the Australian community in the areas of health care and/or community services, or prejudice the access of an Australian citizen or permanent resident to health care or community services.

Estimated total cost Breakdown as follows:	**$731,000**
Special education services - $45,000 X 4.0 Years Special education costed ages 14-18	$180,000
Commonwealth disability services - $26,000 X 8.0 Years Carer payment and allowance costed with 2 year wait	$208,000
Commonwealth disability services - $14,000 X 1.0 Years NDIS costed for age 14	$14,000
Commonwealth disability services - $26,000 X 4.0 Years NDIS costed ages 15-18	$104,000
Commonwealth disability services - $45,000 X 5.0 Years NDIS costed ages 19-23	$225,000

This costing is calculated on the basis of the applicant's specific condition, and guided by the information contained within the Department of Home Affairs' *Notes for Guidance*.

A visa applicant cannot be found to satisfy the sub paragraph referred to above if they have a disease or condition that is likely to:

- result in a significant cost to the Australian community in the areas of health care or community services, or
- prejudice the access of an Australian citizen or permanent resident to health care or community services.

Further information on this can be found at https://immi.homeaffairs.gov.au/help-support/meeting-our-requirements/health/protecting-health-care-and-community-services.

When assessing the likely costs associated with a disease and/or condition, the cost of health care or community services for which a hypothetical person with the same form and level of the applicant's condition would be eligible is taken into account. This includes the expected duration of services likely to be required by the applicant.

In preparing this opinion, I have had regard to the information available to date concerning the applicant, including, but not limited to the immigration medical examination dated <xx/xx/xxxx>.

Medical Officer of the Commonwealth

Position Number: BUPA001

A Medical Officer of the Commonwealth for the purposes of providing an opinion on whether prescribed health criteria under the Migration Regulations 1994 are met.

Annexure C – Drug-resistant TB case identified in visa health screening

DRUG-RESISTANT TB CASE IDENTIFIED IN VISA HEALTH SCREENING

CLIENT SUMMARY

Age:	**HAP ID:**
Gender:	**Visa Class:**
Nationality:	
Case summary:	

REFERRAL REASON

We would appreciate the Expert Medical Panel's advice in respect of the following:

1. Does the Expert Medical Panel consider this treatment is adequate in view of the management outlined below?
2. What recurrence free period would the Expert Medical Panel advise is sufficient that would give confidence that this client is free of TB

INITIAL DIAGNOSIS – CURRENT EPISODE

Clinical Findings:

Initial Chest X-Ray

Findings: Initial Sputum

Test Results: HIV Status

(if known):

Treatment Regimen:

SUMMARY OF PROGRESS

Clinical Progress:

Sputum Test, Smears, Culture - Date & Results:

Chest X-Ray Date & Results (with respect to stability):

POST TREATMENT FINDINGS

OTHER COMMENTS

RESPONSE FROM EMP

DATE

Bupa Completion	
EMP Advice	
MOC to Bupa	