Australian Institute of Radiography

SUBMISSION FEEDBACK

Please provide comments on all or any of the following, particularly in relation to each Option outlined in the Consultation Regulation Impact Statement:

- The appropriateness and feasibility of the proposals.
- Whether the proposed changes will address current concerns with the regulations in the diagnostic imaging sector.
- Potential costs associated with each option.
- Potential benefits associated with each option.
- Potential workforce impacts.
- Impacts on patient access to appropriate imaging.
- Rural and remote access for patients.
- Time required to implement the potential changes.
- Impact on both smaller diagnostic imaging practices and larger practices.
- Any other comments, questions and concerns that relate to the proposed options.

In addition, you may wish to respond to questions listed against specific Options.

Submissions should include substantiating evidence, where possible.

Option 1 – No regulatory changes or deregulation (refer to page 23 of the RIS)

Features:
- The current supervision requirements remain unchanged.
- The person under the professional supervision of the radiologist would require the appropriate qualifications, credentials, or training to provide the service.
- The current substitution rules in the *Health Insurance Act 1973* remain.
- Rural and remote exemptions.

Comment

Option 2 – Minor changes including clarification of current requirements (refer to page 24-26 of the RIS)

Features
- Amendments to the current supervision requirements to clarify the circumstances under which a radiologist and/or specialist or consultant physician must provide supervision and how the supervision must be provided.
  - Professional supervision would require: the medical practitioner be available to observe and guide the conduct and diagnostic quality and safety of the examination and if necessary in accordance with accepted medical practice, attend the patient personally, within a reasonable period of time.

- The personal attendance requirement of musculoskeletal ultrasound would be amended to align with all other ultrasound items.
- The person under the professional supervision of the radiologist would require the appropriate qualifications, credentials, or training to provide the service.
- The current substitution rules in the *Health Insurance Act 1973* remain.
- Rural and remote exemptions.
- Specified qualification requirements for ultrasound providers.
- Definition of diagnostic ultrasound.

Comment
This document needs to clarify the difference between Diagnostic Mammography and Screening Mammography

If this document was followed to the letter the entire Breast Screen system would collapse. It is obviously not possible to have a radiologist stationed in every single Breast Screening unit in the country. However, given this document is in relation to Medicare funding, we assume it is only relating to services which generate a Medicare payment to the practice providing a service which is requested by a medical practitioner, for which Breast Screen is not.

Page 18
Under section Mammography

There is no supervision of mammograms for screening sites (BreastScreen) –The radiologist reviews the images after the procedure is performed.

Musculoskeletal Ultrasound (refer to page 25-26 of the RIS)
Questions:
- Are the principles as outlined satisfactory to clarify the requirements?
- What reasons, if any, are there for the personal attendance requirements for musculoskeletal ultrasound to remain?
- Would a minimum set of guidelines for 'accepted medical practice' per modality be appropriate?
- What savings are anticipated to be realised from removing the personal attendance requirements for musculoskeletal ultrasound services?
- What additional costs are anticipated to be incurred by requiring a medical practitioner (eg radiologist) to be in close proximity to attend on a patient personally within a reasonable period of time in circumstances where this is not currently the situation?
- What other costs (if any) might be associated with the proposed changes?
- What are the potential consequences of the proposed changes?

Comment
The AIR agrees with the following statements….

Ultrasound services are currently provided by a range of imaging specialists.
Where qualifications are not mandatory and hence are variable. There is no assurance that ultrasound services are always provided for diagnostic purposes.

Practices need to be able to demonstrate that providers of ultrasound services possess appropriate credentials for safe and effective ultrasound provision.

The introduction of credentialing arrangements for ultrasound would ensure that diagnostic ultrasounds will be provided by practitioners with the requisite skills and qualification.

Yes ….Is it necessary to have a modality based approach in the regulations (as a minimum) and a practice based approach in accreditation. This would encompass all U/S including Point of Care, Trauma and Consultant U/S Imaging.

Option 3 – Practice based approach (refer to page 27-34 of the RIS)

Features

- Amendments to the current supervision requirements to clarify the circumstances under which a radiologist and/or specialist or consultant physician must provide supervision and how the supervision must be provided.
  - Professional supervision would require: the medical practitioner be available to observe and guide the conduct and diagnostic quality and safety of the examination and if necessary in accordance with accepted medical practice, attend the patient personally, within a reasonable period of time.
- The personal attendance requirement of musculoskeletal ultrasound would be amended to align with all other ultrasound items.
- The person under the professional supervision of the radiologist would require the appropriate qualifications, credentials, or training to provide the service.
- Computed Tomography services would only be able to be provided in a comprehensive practice, with the exception of CT of the coronary arteries (items 57360 and 57361).
- Supervision would be tailored to the type of diagnostic imaging practice.
- A comprehensive practice would require a radiologist to be available during agreed operating hours.
- Where a radiologist is on site during ordinary operating hours, the radiologist would be allowed to determine the supervision requirements for the practice and have the flexibility to implement and supervise efficient and effective processes.
- Where a radiologist is on site during ordinary operating hours, the radiologist would be allowed to substitute a requested service for a more appropriate service, without the need for consultation with the requester, if the substituted service has a lower MBS fee than the requested service.
- The current substitution rules in the *Health Insurance Act 1973* remain.
- Where a radiologist is NOT on site during ordinary operating hours, a radiologist must be on site for the performance of the following services:
  - Mammography;
  - The administration of contrast; and

    - Image guided intervention procedures/surgical interventions.
- The reporting and supervising radiologist would not have to be the same person, but practices would be required to maintain records which indicate the name of all the radiologists involved in the service.
- Rural and remote exemptions.
- Specified qualification requirements for ultrasound providers.
- Definition of diagnostic ultrasound.

Comment
Current supervision requirements…..
Mammography – how does this impact on screening mammography unless it is referring to diagnostic mammography only.

We consider that this document relates only to services that generate a Medicare payment therefore does not apply to screening mammography via Breast Screen Australia. There is no rebate for screening outside the screening program.

The reference to the SA program relates to the need to increase supervision requirements for mammography services to address safety and quality issues which will reduce the likelihood of false positive and false negative results. The report highlights that major causes of errors can be the result of sub-optimal handling protocols, poor soft copy reading practices and image quality issues related to PACS

A Comprehensive practice (refer to page 28-29 of the RIS)
Questions:
- Are there any other types of practices which have not been identified?
- Are there comprehensive practices that do not currently have a radiologist onsite?
- What are the costs of employing a radiologist onsite during ordinary operating hours?
- What are the costs of non-comprehensive practices expanding to become comprehensive practices?
- Are there enough radiologist for this to occur? What are the barriers?
- Is there any role for standalone CT and, if so, how would current safety and quality concerns be addressed? What will be the impact of this change on providers and patients?
- What other costs (if any) might be associated with the proposed changes?
- What are the potential consequences of the proposed changes?

Comment

Non-radiologist specialist practice (refer to page 30-31 of the RIS)
Question

- Are there any other services currently performed by non-radiology specialists?

Comment
- Other specialists to be could be added include
- Breast surgeon
- Plastic Surgeon
- Breast Physician

ADDITIONAL ISSUES FOR CONSULTATION

1. Rural and remote exemptions (refer to page 31-32 of the RIS)

The intention of having rural exemptions is to ensure patients have access to services without compromising on quality. However, current arrangements for rural exemptions vary for each of the modalities, creating confusion due to an inconsistent approach. The current approach is also difficult to administer.

Questions

- Does the current rule meet its goal of increasing access for patients without comprising on quality?
- Should exemptions be geographically/distance based rather than looking at population base and local availability of specialist services?
- Are there any other mechanisms that provide incentives for local services provision in rural Australia?
- What is the role of tele-radiology? Should it be the only service, or an adjunct the local service provision?
- Should the exemption not be available for certain types of services?

Comment
With advances in Technology …… Tele medicine, Tele Health and PACS Systems.
This should ensure patients have access to services without compromising on quality.

The current arrangements for rural exemptions vary for each of the modalities, creating confusion due to an inconsistent approach.

2. Implementing any changes and the relative role of regulation and the Diagnostic Imaging Accreditation Scheme (DIAS) (refer to page 33-34 of the RIS)

The relative role of regulation and accreditation in enhancing the quality framework for MBS funded diagnostic imaging services will be determined following feedback received from stakeholders under this consultation process.

Questions

- Would changes to supervision be better placed in the DIAS or remain in the regulations?
- How would a practice based supervision approach be incorporated into regulation?

- Is it necessary to have a modality based approach in the regulations (as a minimum) and a practice based approach in accreditation?

Comment

3. Any additional proposals, suggestions or comments?

Comment

- Clarification is also required with the following Statement

Page 15
In Table 2 –

Row Group I3: Diagnostic Radiology under the notes section –

Exception to supervision:
- where a person registered as a medical radiation practitioner provides the service under the supervision of a medical practitioner, and
- mammography items (items 59300 to 59319) must be performed under the professional supervision of a radiographer.

"Must be performed under the professional supervision of a radiographer"

There needs to be definition around who is being referred here to that performs mammography under *professional supervision of a radiographer*??

- Advanced practice in radiography….. Would this Document affect and if so how the ability for the Radiographers to achieve and perform Advanced Practice.

- Page 7

Should these groups also be included?

1. Royal Australasian College of Surgeons

Who also use ultrasound in their consultation rooms as well as in theatre these days

2. Nursing and Midwifery board

As nurses are also performing ultrasound procedures.

- Dental X-Rays (Imaging)

Qualifications and credentials of these Users also need addressing.
The AIR is in agreeance with the proposed changes to the Cone Beam Dental CT.

- Bone Densitometry

Who are able to perform these?

There is also agreeance with the requirement regarding branding of request forms.

The Capital provision for CT- relies on age and not on technology. It is our belief that CT scanners should be retired when they could no longer meet current diagnostic quality. This is based on the following:

1. ARPANSA have issued a set of DRL that are regarded as maximum exposure levels for CT scanners to achieve diagnostic images. If scanners are older than 10years or cannot meet these accepted DRL's they should not be irradiating Australians- city or remote!

2. A modern CT scanner no longer costs the $1m that it used to. A new low dose CT scanner can be purchased for less than $500,000 and as well as being user friendly will provide imaging for most requested procedures at doses that are less than 50% of a scanner that was manufactured 10 years ago. Why do we accept that rural patients can be irradiated more and then require repeat imaging when they are sent or transferred to a major city or larger rural centre?

3. MRI - 20 years seems reasonable.

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6. MRI - 20 years seems reasonable.