

CONSULTATION SUBMISSION

The Royal Australian and New Zealand College of Radiologists

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.

Please note: RANZCR has used a lettering system for the comment boxes and numbering for each feature to allow us to cross reference different aspects of our response and to avoid repetition wherever possible. The order of the paragraphs also reflects the bullet points featured under each question.

Introductory Comments from RANZCR

The Royal Australian and New Zealand College of Radiologist (RANZCR) is the peak body for setting, promoting and continuously improving the standards of training and practice in diagnostic and interventional radiology. This includes supporting the training, assessment and accreditation of trainees; the development of standards of practice; and workforce planning to ensure adequate access to appropriate radiology services for the entire community.

Since the [2010 Review of Funding for Diagnostic Imaging Services¹](#), RANZCR has actively advocated full implementation of the Quality Framework, which emphasises the importance of increasing the role of the clinical radiologist in determining the most appropriate imaging test by providing direct on site radiologist supervision in a comprehensive practice.

In its submission to the 2010 Review of Funding for Diagnostic Imaging Services, RANZCR advocated the provision of diagnostic imaging (DI) services in comprehensive practices, which provide a minimum of plain X-ray, CT and ultrasound. Such practices would have a radiologist on site during their normal business hours to provide professional supervision of services.

RANZCR advocates the comprehensive practice model, with an on site radiologist as the keystone to delivering safe, high quality imaging services. As noted in the 2012 [ADIA/RANZCR Diagnostic Imaging Quality Framework Proposal²](#) medical imaging has advanced beyond diagnosis and into medical assessment and treatment, and non-surgical treatment via interventional procedures; therefore it is important that patients are able to access these advanced services in supervised,

¹ The Royal Australian and New Zealand College of Radiologists. Detailed Review of Funding for Diagnostic Imaging Services. 2010, May. Available from: <http://www.ranzcr.edu.au/documents-download/document-library-1/751-ranzcr-submission-to-di-review>

² Australian Diagnostic Imaging Association and the Royal Australian and New Zealand College of Radiologists. The ADIA/ RANZCR Diagnostic Imaging Quality Framework Proposal. 2012, October 2. Available from: http://www.ranzcr.edu.au/component/docman/?task=doc_download&gid=2236

quality, comprehensive practices and receive the most appropriate examination for their clinical presentation considering both the body system³ that requires imaging and the most appropriate modality to answer the clinical question.

RANZCR's [*The Role and Value of the Clinical Radiologist*](#)⁴ position paper further explains that contemporary patient-centred care requires a new and more collaborative radiology practice model – with radiologists as key members of multi-disciplinary teams, taking a greater role in clinical decision-making and patient management. This results in an optimised outcome for the patient through higher quality, appropriate and timely imaging-based care.

In summary, RANZCR strongly supports Option 3 with minor amendments, most notably a revised and tighter definition of professional supervision. The package of measures proposed in the Quality Framework needs to be implemented in its entirety to realise its full and true benefits for patient care. We believe that all patients, regardless of where they live, should have access to diagnostic imaging provided in a comprehensive practice model. We are committed to the comprehensive practice model also being available in rural and remote areas, however we acknowledge there will be difficulties fulfilling this in the short term due to uneven distribution of the current radiologist workforce. RANZCR is available to support the Department of Health and other stakeholders to develop these key reform proposals further and throughout implementation.

³ The Royal Australian and New Zealand College of Radiologists. The Body Systems Framework. Available from: <http://netinteractive.com.au/projects/live/ranzcr/bsf/>

⁴ The Royal Australian and New Zealand College of Radiologists. The Role and Value of the Clinical Radiologist, Version 1.0. 2014, November 5. Available from: http://www.ranzcr.edu.au/component/docman/?task=doc_download&gid=3469%60

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.

RANZCR's comments are below.

Comment Box A

1. RANZCR would like to state that we warmly welcome the publication of the RIS and look forward to working with the Department of Health and diagnostic imaging (DI) stakeholders to progress these important reforms.
2. RANZCR does not support Option 1.
3. DI supports clinical decision-making across the breadth of the healthcare system and is central to high quality patient care. This opportunity for overdue reforms must be seized. As the RIS clearly outlines on pages 12-21, there is a range of issues and inconsistencies in the current DI regulatory framework which need to be addressed.
4. We feel it would be remiss of the Department and stakeholders not to clarify the Medicare rules and thereby deliver improvements in the quality, appropriateness and sustainability of DI services under Medicare.

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.

RANZCR's comments are below.

Comment Box B

1. Although several of the features contained in Option 2 would improve the delivery of DI services under Medicare, RANZCR does not favour this option.
2. Regarding supervision, RANZCR would prefer to have a specific requirement for the radiologist to be on site in a comprehensive (also referred to as a multi-modality) practice which allows her or him to influence directly the conduct of examinations and to be available to attend and manage patients whenever required. There should be an explicit requirement for the radiologist to be on site during the practice's normal business hours on ordinary working days with an allowance for reasonable breaks.
3. RANZCR is worried that the proposed definition of supervision (page 24 of the RIS) has loosely defined criteria which would allow a medical specialist to supervise a number of practices in a similar geographical region. We cannot see how there can be appropriate clinical supervision of patients at a number of practices by a single medical practitioner. The proposed definition therefore leaves too much room for local and variable interpretation, making it difficult to enforce.
4. Quality and patient safety in DI are significantly enhanced by a radiologist on site. We are concerned that loose criteria for professional supervision such as attending 'within a reasonable period of time' allows avoidance of the intention to provide meaningful and timely radiologist clinical input into the imaging examination or life threatening emergencies. It would also permit practices not to have a radiologist or other medical specialist present thereby reducing clinical oversight of DI services and the opportunities for communication with patients and referring clinicians. Patients and the quality of their care suffer as a result. Furthermore, adopting loose criteria would also provide an unfair competitive advantage to unsupervised practices over practices which have a radiologist on site, thus, 'a reasonable period of time' must be specified and defined or preferably replaced with a requirement to be on site and in the practice. The two proposed definitions of 'a reasonable period of time' on page 25 of the RIS have very different clinical implications. 'Within the same day' creates an even greater loophole than that which exists in current regulation. Almost any location in Australia can be reached in a day by the means of driving and/or taking a flight. We recommend that rather than 'a reasonable period of time' the appropriate definition should be 'during the conduct of the examination'.

5. Professional supervision means that the medical specialist is providing consultative supervision i.e. is physically present, immediately accessible and able to personally attend the patient to observe and influence the conduct of the examination when required. This enables the medical specialist to provide advice, direction and clarification to the medical imaging professionals working under his/her supervision. It also allows the medical specialist to review the referral/request and clinical circumstances of the patient, if necessary take a history and examine the patient and/or to communicate with the referrer, and determine the most appropriate imaging examination for the patient. (Please note that this definition describes normal operating procedures during a practice's normal business hours. Arrangements for after-hours and emergency services are many and varied and are outside the scope of this discussion).

For the purpose of regulation, professional supervision should be defined as follows:
The medical specialist or consultant physician must be available to:

- a. Supervise and guide the conduct and diagnostic quality and safety of the examination, and
 - b. In accordance with established medical practice, to attend the patient personally during the conduct of the examination.
6. RANZCR agrees with the proposal on page 14 of the RIS to remove the wording 'or a person employed by a medical practitioner' from the definition of supervision.
 7. RANZCR also supports strengthening requirements for administration of contrast media, mammography and interventional procedures which should only be provided when the medical specialist or consultant physician is strictly on site. For CT, MRI and ultrasound, the medical specialist or consultant physician should be on site in line with paragraphs 2 and 5 above. A key property of professional supervision is the ability to attend the patient while the examination is still being performed.
 8. RANZCR supports amending the personal attendance requirements for MSK ultrasound to align with other ultrasound items. Although the personal attendance requirement for MSK ultrasound was consistent with best practice when it was originally drafted in Nov 2000, the provision of MSK ultrasound services has evolved since then (most especially the skills of sonographers) which negates the need to personally attend every examination. Notwithstanding this, RANZCR expects that in most instances the radiologist would still need to personally attend an MSK ultrasound examination and she or he would use their professional judgement to determine when this is necessary. RANZCR strongly believes that there should be a requirement for the radiologist to be on site to enable personal attendance on MSK ultrasound when required. (For details please refer to Comment Box B, paragraph 2).
 9. RANZCR understood that there is already a requirement for staff working under the supervision of the radiologist to hold appropriate qualifications, credentials or training under DIAS Standard 1.2. RANZCR supports maintaining this requirement.
 10. RANZCR strongly believes that the current substitution rules are an impediment to the provision of appropriate imaging. Radiologists have specialist expertise in determining the most appropriate clinical test and are currently restricted from providing this expertise to benefit the patient. The range and complexity of DI modalities is ever increasing and the radiologist is in the best position to know when it would be better to substitute for a more appropriate examination for a patient. Moreover, having a radiologist on site greatly facilitates communication and collaboration between patients, radiologists and referring clinicians.
 11. As previously stated, RANZCR strongly believes that all patients should have access to DI that is provided in a comprehensive practice with a radiologist on site, regardless of geographical location. We are committed to this practice model also being available in regional and remote areas, however we acknowledge there will be difficulties in reaching this objective in the short-term due to the uneven distribution of the current radiologist workforce. RANZCR is keen to work with the Department to develop and implement

strategies to address the uneven distribution of the radiology workforce and enable a transition over time so that all patients in Australia have access to DI services provided in a comprehensive practice with on site supervision.

12. We wish to discuss the best model for rural and remote service provision further with the Department once we have a clear understanding of how the complete package of reforms is taking form in metropolitan areas. The impact on rural and remote areas needs to be better understood before an appropriate, improved exemption model can be established. The current 30km rule is a crude method to try to grant patients in rural and remote areas access to quality DI services and we are aware that it has proven very difficult to enforce. RANZCR would like to engage with the Department to explore more appropriate criteria for rural and remote exemptions. (For details please also refer to Comment Box G.)
13. RANZCR believes that two clearly distinct models of delivery of ultrasound care have emerged: comprehensive ultrasound and focused ultrasound (also known as point-of-care ultrasound).
14. For comprehensive diagnostic ultrasound, the required qualification for a sonologist (i.e. the providing and reporting medical practitioner) should be one of: FRANZCR, Diploma in Diagnostic Ultrasound (DDU), Certificate in Obstetrics and Gynaecological Ultrasound (COGU) or Certificate in Maternal and Fetal Medicine (CMFM). This would allow a range of appropriately trained medical practitioners to be credentialed as having the correct level of expertise to capture and review the ultrasound images resulting in a report to the original referring clinician i.e. to provide comprehensive diagnostic ultrasound under the DIST. More importantly, setting these qualifications as a minimum would ensure that ultrasound funded under the DIST is provided to a consistently high standard with reports produced which are available to clinicians involved in subsequent care.
15. Given that all ultrasound services are arguably 'diagnostic' in some capacity i.e. a 'point-of-care' test is intended to answer a rudimentary clinical question, RANZCR favours the terms 'comprehensive diagnostic ultrasound' and 'focused diagnostic ultrasound'. A comprehensive diagnostic ultrasound should include the following components as a minimum:
 - The service should be initiated following a referral/request, and involve interpretation of a full range of anatomy relevant to the patient's symptoms, signs and other test results.
 - The providing sonologist holds minimum qualifications (see paragraph 14 above) and the ultrasound equipment meets minimum quality and safety standards.
 - Standard protocols are in place for the range of ultrasound services provided.
 - The sonologist and sonographer act as a team.
 - The sonologist provides a comprehensive written report.
 - The captured images are stored and available to the referring clinician and if appropriate other clinicians involved in the patient's care.

For clarity, the professional supervision definition outlined in Comment Box B, paragraph 5 would also apply.

16. RANZCR sees the following benefits from the introduction of a clear definition of comprehensive diagnostic ultrasound:
 - Patients having Medicare funded examinations would benefit from defined appropriate qualifications for practitioners and consistent standards of care
 - Minimum qualifications are broadly defined, allowing suitably skilled medical specialists to continue to access training and Medicare rebates
 - Reports would be consistently provided which benefit the original referring doctors and inform patients about the care they receive
 - Images would be consistently captured and stored for subsequent use by clinicians involved in a patient's care.

Musculoskeletal Ultrasound (refer to page 25-26 of the RIS)

RANZCR's comments are below.

Comment Box C

1. [Are the principles as outlined satisfactory to clarify the requirements?](#)

Yes. RANZCR supports the removal of the personal attendance requirement for MSK ultrasound as this is not required for every MSK ultrasound scan. RANZCR Standards require the radiologist to be available to personally attend the patient to discuss and influence the conduct of the examination, if required. As noted above, the Quality Framework proposal is a package of measures and this change would need to be coupled with a requirement for a radiologist or other suitably qualified medical practitioner (see Box B, Paragraph 14) to be on site. This would ensure clinical oversight and allow the radiologist to attend the patient when required. RANZCR expects that the radiologist would continue to personally attend a large proportion of MSK ultrasound scans. (Please refer to Comment Box B, paragraph 2 for further information.)

Please note: A clinical radiologist would still need to perform MSK-guided injections and other ultrasound-guided interventional procedures which are highly targeted interventional techniques requiring medical training.

2. [What reasons, if any, are there for the personal attendance requirements for MSK ultrasound to remain?](#)

We do not believe there are reasons for this requirement to remain, however it is important that the change be coupled with a radiologist on site to enable attendance where clinically appropriate. We would like to add that the vast majority of MSK ultrasound scans are provided by radiologists so we do not anticipate any problems for other specialists.

3. [Would a minimum set of guidelines for 'accepted medical practice' per modality be appropriate?](#)

RANZCR's Standards of Practice cover guidelines for accepted medical practice in the provision of ultrasound scans, which already have significant influence over the provision of such services. They specify in Standard 15.3.4 Performance of Ultrasound Examinations that: *"the radiologist shall be available to personally attend the patient to discuss and influence the conduct of the examination. When the ultrasound scan reveals specified significant or unexpected findings the sonographer will communicate with the radiologist while the patient is on site to facilitate review of the patient by the radiologist and allow patient triage."* RANZCR would be happy to work with the Department and other stakeholders to incorporate this to the DIAS or provide other guidance materials as appropriate.

4. [What savings are anticipated to be realised from removing the personal attendance requirements for MSK ultrasound services?](#)

Any savings would be minimal. The radiologist would still personally attend a large proportion of MSK ultrasound scans and would be on site when the scan is provided. RANZCR considers on site supervision to be a central component of a package of measures therefore any savings would be offset by a higher cost of providing services elsewhere (e.g. to have a radiologist on site during normal business hours with reasonable allowances for breaks).

5. [What additional costs are anticipated to be incurred by requiring a medical practitioner \(e.g. Radiologist\) 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?](#)

If there is a requirement for a radiologist to be on site in a comprehensive/multi-modality practice, which we strongly advocate for, and given the vast majority of MSK ultrasound scans are provided by radiologists, we do not anticipate any increase in costs that specifically relate to the requirement to be in close proximity to attend a patient personally during the conduct of the examination.

6. **What other costs (if any) associated with the proposed changes?**

We do not anticipate any other costs associated with this change.

7. **What are the potential consequences of the proposed changes?**

We do not foresee any negative implications for the quality of care since the radiologist will still personally attend the patient during the scan when required i.e. where there is a clinical benefit from doing so. On the contrary, we believe this proposal will lead to a quality improvement by helping make best use of radiologists' time e.g. allowing them to communicate more effectively with referring clinicians.

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.

RANZCR's comments are below.

Comment Box D

1. RANZCR supports Option 3, however we have made some specific comments and propose minor revisions below.
2. RANZCR strongly supports the proposal for a comprehensive practice to have a radiologist on site. The major benefits of this include:
 - allowing radiologist supervision of the appropriateness of imaging referrals/requests and achieving the most appropriate way of performing the study and lowest possible radiation exposure for patients
 - ensuring a radiologist is available to supervise all activities including treating a patient in the event of an emergency or adverse reaction
 - improving access to DI services that require on site supervision
 - facilitating communication between radiologists and referring clinicians, and
 - the radiologist personally attending procedures when required and in line with best clinical practice.

3. As noted above, we feel the definition of supervision proposed on page 24 of the RIS is too loose and will not achieve the intended outcomes. Please refer to our alternative definition of supervision under Comment Box B paragraph 5.
4. We agree with amending the personal attendance requirements for MSK ultrasound. Please refer to Comment Box C for details.
5. RANZCR understood that there is already a requirement for staff working under the supervision of the radiologist to hold appropriate qualifications, credentials or training under DIAS Standard 1.2. RANZCR supports maintaining this requirement.
6. RANZCR strongly supports the proposal that CT services only be provided in comprehensive practices with a radiologist on site. As outlined in Comment Box B paragraph 11 and 12 and Comment Box G, we would wish to do further work with the Department on how services would be provided in rural and remote areas.
7. RANZCR does not agree with the Department's suggestion that CTCA services should be exempt from the comprehensive practice model. We agree with the Department that the vast majority of locations where CTCA services are provided would comply with the proposed comprehensive practice model. The credentialing system which is in place does not require an exemption from the comprehensive practice model. That system has supported collaborative care models allowing CTCA-accredited cardiologists and nuclear medicine physicians to report on CTCA services and should endure. Furthermore, since CTCA services require the injection of contrast agents, in the interests of patient safety strict on site supervision by an appropriately qualified medical practitioner should also apply to CTCA services (see Comment Box B, paragraph 7). In addition, all CTCA studies reported by a cardiologist should also be co-reported by a radiologist to exclude non-cardiac conditions. We would be happy to work with the Department and others to transition any locations providing CTCA services that cannot easily meet the requirements of a comprehensive practice.
8. Under our alternative definition of supervision (Comment Box B paragraph 5), there is scope for the radiologist to vary the type of on site supervision in accordance with their clinical judgement e.g. to personally attend when clinically beneficial.
9. We believe that a radiologist should be on site in a comprehensive practice during its normal business hours on ordinary working days with an allowance for reasonable breaks.
10. The on site radiologist (in a comprehensive practice) should determine the supervision requirements for that practice and have the flexibility to implement and supervise efficient and effective processes in line with clinical best practice.
11. RANZCR has for many years advocated for improved capacity for radiologists to substitute a more appropriate service. Radiologists are best placed to determine the most appropriate imaging modality for any particular clinical presentation and the existing regulations make this too cumbersome. In many instances a more appropriate service will be one with a lower radiation dose and lower MBS fee, for example an ultrasound examination rather than CT.
12. We urge the Department to consider that in certain clinical circumstances, it may be appropriate to substitute the requested service for a more expensive alternative without first discussing it with the referring clinician. This need is particularly pertinent where the radiologist is acting to minimise radiation exposure, and especially so for vulnerable patient populations (e.g. children and pregnant women). In a number of such circumstances substitution of a clinically appropriate, non-irradiating service for an irradiating service may lead to a higher cost to the MBS (for example, substitution of MRI instead of CT, substitution of ultrasound instead of radiography). We would welcome the opportunity to discuss this further with the Department of Health.

13. Should the Department have any concerns regarding substitution of services for more expensive alternatives, we believe this can be addressed through robust audit mechanisms.
14. The Department has proposed retaining Section 16B (10A) of the current Health Insurance Act which specifies that the radiologist must consult the person who made the request or take all reasonable steps to do so. We would like reassurance from the Department that this would not conflict with the ability of a radiologist to substitute for a service with a lower MBS fee, without the need for consultation with the referring/requesting clinician.
15. In addition to changes to the substitution rules, RANZCR would like to propose changes to the information that must be included on the referral/request form. The College notes that Section 23DQ (1) of the Health Insurance Act provides for the regulations to specify the form in which a subsection 16B (1) referral/request must be made; and the information that must be included on the referral/request. Under the current regulations, there is no firm requirement for the referring/requesting practitioner to put relevant clinical information on the referral/request form although the DIST regulations encourage it. Additionally, certain clinical guidelines advise referring doctors to do so for example for MRI referral/requests. RANZCR believes that a firm requirement should be included in the regulations outlining what information must be included on the referral letter/request form, in order to assist radiologists to assess the appropriateness of the procedure requested. This change would further enhance the process for ensuring that patients receive the most appropriate imaging for their clinical indication and that resources are used appropriately. Currently many referrals/requests do not include sufficient accurate clinical information for radiologists to determine the appropriateness of the referral/request without discussion with the patient and/or referrer. Moreover the quality of the imaging test performed and the report is enhanced by allowing the radiologist to tailor the performance of the imaging procedure and the clinical interpretation of the findings by using the additional information. RANZCR appreciates that this would mean changes to current referral processes, and the proposal should also be discussed with referring clinicians.
16. We agree that a radiologist must be on site for the performance of the following services:
 - a. mammography;
 - b. the administration of contrast media; and
 - c. image-guided interventional procedures/surgical interventions.
17. RANZCR agrees that it will be necessary for practices to maintain records of the on-site radiologist and reporting radiologist so it is possible to audit compliance with the new rules when necessary. In the overwhelming majority of practices this information is already captured by practices for other purposes (typically in work rosters) and this will not be a major imposition.
18. We also believe such records would assist to make it easier to assess compliance with a revised model for rural and remote locations. For our position on rural and remote exemptions, please refer to Comment Box B, paragraph 11 and 12 and Comment Box G.
19. For our position on the definition of and qualifications for comprehensive diagnostic ultrasound, please refer to Comment Box B, paragraphs 13-16.
- 20.

A Comprehensive Practice (refer to page 28-29 of the RIS)

RANZCR's comments are below.

Comment Box E

1. **Are there any other types of practices which have not been identified?**

The four categories outlined in the RIS (p.29-30) cover the other models. Cone Beam CT (CBCT) is included as a type of CT in the DIST. We believe this merits another category (or if that is not possible be listed as an exemption to the requirement for radiologist supervision of CT services). CBCT delivers significantly lower radiation doses (in the order of 20-50 micro Sieverts) compared to medical CT (with doses averaging approximately 500 micro Sieverts) and intravenous contrast media are not used. We understand there are at least 100 dental focused practices providing CBCT services (but not other types of CT services).

2. **Are there comprehensive practices that do not currently have a radiologist onsite?**

RANZCR does not know how many comprehensive practices currently operate without a radiologist on site. However, as previously stated we believe that on site supervision is essential to delivering safe, high quality imaging services. See Introduction (p.2).

3. **What are the costs of employing a radiologist onsite during ordinary operating hours?**

The costs for those practices who do not have a radiologist on site would be the costs related to employing a radiologist, however we feel that the benefits for patient safety and appropriate imaging outweigh these costs. This would include the radiologist's salary and related on costs. They may also need to invest in reporting equipment if they did not previously have this on site. Presumably there would be a significant mitigating saving as they would no longer need to pay the off-site medical practitioner previously reporting images.

4. **What are the costs of non-comprehensive practices expanding to become comprehensive practices?**

This would depend on their starting point:

- If CT only, they would need to invest in ultrasound equipment and X-ray. They would need to hire a sonographer and potentially other additional staff holding a radiation safety licence to operate the X-ray.
- If CT and ultrasound, they would need to invest in X-ray equipment. Presumably the staff who operate the CT machines could also do X-ray.
- If CT and X-ray, they would need to invest in ultrasound equipment and hire a sonographer.

Such practices would of course then be in a position to offer other services for which they would take in revenues.

Dedicated CBCT practices can be located in buildings or precincts with large numbers of dental specialists who are eligible to refer for CBCT services. CBCT may be the only modality provided and the addition of new modalities would be costly. Given the nature of their work and provided they only carry out dental work, we do not believe these practices should be included in the comprehensive practice model (by reallocating CBCT to another category – see paragraph 1 above).

5. **Are there enough radiologists for this to occur? What are the barriers?**

We believe this would be sufficient to cover an estimated 700 comprehensive practices (excluding rural and remote areas). Despite sufficient numbers of radiologists in Australia, their distribution does not match that of the Australian population. There are currently 1,902 radiologists in Australia which has increased by 66 radiologists per year over the past five years. Please note this figure is the overall number of radiologists within RANZCR's Australian based membership and does not translate directly to full time equivalents. We have included a table below illustrating the ASGC-RA distribution of radiologists by residential postcode compared with the Australian population.

	Population (millions) ^[1]	Resident clinical radiologists (per 100,000 population)
Australia	23.5	7.7
RA1 (major cities)	16.6	9.5
RA2 (inner regional)	4.3	4.6
RA3 (outer regional)	2.1	1.8
RA4 (remote)	0.3	0.3
RA5 (very remote)	0.2	0.0

Table 1: Distribution of clinical radiologists by residential post code (Dec 2014) based on RANZCR data

6. We agree it would be sensible for practices that need to adapt to have an appropriate lead time to transition across to the new criteria i.e. for a comprehensive practice with a radiologist on site. Any comprehensive practices that currently operate without a radiologist on site should anticipate changes following from this RIS.
7. We favour waiting until we know more about the likely outcomes of the DI reform package before exploring appropriate criteria for rural and remote exemptions. RANZCR will monitor the workforce implications of these policies closely and will keep the Department informed should any problems arise.
8. Due to the uneven distribution of the radiology workforce, there is currently not an adequate number of radiologists located in rural and remote areas to provide on site supervision. RANZCR would like to engage with the Department to explore appropriate criteria for rural and remote exemption to ensure that rural and remote communities continue to have access to DI services. We would like to see this as an interim measure until we can progress to having a radiologist on site for comprehensive practices in rural and remote areas.
9. **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?**
We do not believe that CBCT should be included in the comprehensive practice model. To avoid potential for confusion, CBCT should be placed in a separate category (see paragraph 1 above). We see no other role for standalone CT services.
10. **What other costs (if any) might be associated with the proposed changes?**
We do not anticipate any further costs (beyond those set out in Comment Box E, paragraph 3) and as noted above, there will be potential for new revenue streams through providing those services.
11. **What are the potential consequences of the proposed changes?**
Please refer to the list of benefits from having a radiologist on site in a comprehensive practice model (Comment Box D, paragraphs 2).

^[1] Australian Bureau of Statistics, information as at June 2014 <http://www.abs.gov.au/>

Non-Radiologist Specialist Practice (refer to page 30-31 of the RIS)

RANZCR's comments are below.

Comment Box F

1. [Are there any other services currently performed by non-radiology specialists?](#)
The other non-radiologist specialist practices are those providing ultrasound as part of their routine practice (i.e. focused ultrasound). We note that nuclear medicine is covered elsewhere in the RIS document.

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.

RANZCR's comments are below.

Comment Box G

1. **Does the current rule meet its goal of increasing access for patients without comprising on quality?**
RANZCR believes that although the current rule is crude, in principle it should: prevent practices with an on site radiologist from being undercut by a nearby practice without one; and allow some flexibility in the provision of services in rural and remote locations. We appreciate that the current rule has been difficult to enforce.
2. **Should exemptions be geographically/distance based rather than looking at population base and local availability of specialist services?**
Ideally there would be a tailored approach to exemptions based on criteria such as: population base and local availability of specialist services; and striking a balance between access to services and quality for those locations. As noted in Comment Box B, paragraphs 10-11, we wish to see how this overall package of reforms is shaping up and then work with the Department and other stakeholders to establish clear criteria for the provision of services in these locations. In the short term, we would suggest retaining the 30km rule, however there should be no rural and remote exemptions for MRI, mammography and image guided interventional procedures.
3. **Are there any other mechanisms that provide incentives for local services provision in rural Australia?**
RANZCR has adopted networked training to provide trainee radiologists with an opportunity to practise in a regional or rural area during their five-year program. We hope that in time this will help to address the uneven distribution of radiologists in Australia.
4. There would be merit in exploring whether a financial incentive could be provided to comprehensive practices located in rural and remote areas to have a radiologist on site.
5. **What is the role of teleradiology? Should it be the only service, or an adjunct to the local service provision?**
RANZCR considers that the diagnostic imaging service represents a continuum that begins before the image acquisition and extends beyond the clinical interpretation of the imaging findings and rendering of the report and that radiologists should be engaged at all points in the continuum. Teleradiology is now embedded into the workflow of many radiology practices, driven largely by technology and an expanding model of networked practices. It can offer a number of benefits to patients and their healthcare providers regardless of location, including access to second or sub-specialist opinions and cost-effective after-hours reporting, but it also has some limitations. We believe that the role of teleradiology needs to be set into the context of the radiologist's broader responsibilities so that patient care is not compromised by barriers to radiologists' clinical input into their care.
6. We are currently reviewing our position on teleradiology and will be seeking further discussions with the Department about the role of teleradiology under the proposed new arrangements.
2. **Should the exemption not be available for certain types of services?**
We do not believe there should be any rural or remote exemptions for MRI, nuclear medicine, PET.

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.

RANZCR's comments are below.

Comment Box H

- 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?
1. RANZCR believes that an effective process for assessing and enforcing compliance with all regulations and practice requirements is an essential aspect of the proposed reform package. The current arrangements for assessing and enforcing compliance with professional supervision regulations have had mixed success and a more robust approach is required. This should be achieved through clearer regulations in the DIST and a more robust DIAS.
 2. We believe there should be specified rules which outline the requirements for a radiologist to be on site in a comprehensive practice during its normal business hours on ordinary days with reasonable allowance for breaks. The strict on site requirements for mammography, administration of contrast media and image guided interventional procedures should also remain in the DIST.
 3. We believe there is greater flexibility with respect to ultrasound, however the requirement for an appropriate ultrasound qualification (or credential) should feature in the DIST regulations. The other requirements for the provision of comprehensive diagnostic ultrasound (e.g. provision of a report or image storage) can be included in the DIAS.
- RANZCR would be happy to work with the Department and other stakeholders on the draft regulations.

3. Any additional proposals, suggestions or comments?

RANZCR's comments are below.

Comment Box I

1. With respect to ultrasound, the RIS notes on page 33 that the introduction of a requirement for a minimum of DDU qualification 'is not expected [to] impact a significant number of ultrasound providers'. We do not believe this to be the case since there is a range of medical practitioners who provide ultrasound services. Many of these will not hold a DDU, FRANZCR, COGU or CMFH which must become the minimum required to provide comprehensive diagnostic ultrasound. These practitioners will have adequate time to complete the required qualification if they wish to do so.
2. We would like the Department to work with those practitioners who perform focused (or point of care) ultrasound to provide them with appropriate recompense (outside of the DIST) for the work they do.
3. Regarding the timeframes, we support the timeframes outlined on page 11 of the RIS and will work with the Department to progress them.
4. RANZCR would like to add that we have initiated a major project to develop imaging guidelines for referring/requesting practitioners which we feel would dovetail well with the ANAO recommendation 'to progress key initiatives not yet implemented such as appropriate requesting of diagnostic imaging services', quoted on page 19 of the RIS. We will follow this up with the Department of Health in due course.
5. Finally, RANZCR would also wish to use this opportunity to amend the regulations to specify 'referral' for DI services, rather than 'request'.