**Submission on Consultation Regulation Impact Statement –**

**Options for improving the quality and safety of Medicare-funded diagnostic imaging**

1. The Australian Diagnostic Imaging Association (ADIA) thanks the Department of Health (DoH) for the opportunity to comment on the Consultation Regulation Impact Statement (RIS). We look forward to working with DoH to fine-tune the options which will be presented in the revised Consultation RIS.

2. The Consultation RIS is the culmination of several years of policy development and advocacy by ADIA and the Royal Australian and New Zealand College of Radiologists (RANZCR), including the *Quality Framework to underpin sustainable, quality medical imaging* (2012). ADIA was given the opportunity to provide feedback on RANZCR's submission, and broadly supports it.

3. The proposals presented by DoH need to support access to diagnostic imaging services and promote service quality, while enabling diagnostic imaging to be delivered in a range of practice types. The aim is for practices to retain flexibility within a framework of clear requirements.

4. ADIA supports Option 3, which involves implementing the proposals in Option 2 as well as additional practice-based requirements, and makes the following specific comments:

**The definition of professional supervision needs to be clear and enforceable**

5. Option 2 is the building block of the RIS, with the effectiveness of the Option 3 model dependent on a clear and enforceable supervision rule being introduced.

6. ADIA considers that the proposed definition of professional supervision (page 24) does not improve on the current definition, because it does not address the problems identified in the RIS of ambiguity and enforceability:

   (a) <u>must be available</u>
   - Requiring the specialist to be available does not ensure that they will be on-site while services are performed.
   - The effect is that the specialist only needs to be able to be on-site within a reasonable period of time when it is necessary to attend on the patient – this would allow them to 'supervise' multiple practices, which means they are not meaningfully available to attend at each practice.

   (b) <u>if necessary and in accordance with accepted medical practice</u>
   - 'If necessary…to attend' implies patient risk – this suggests that the requirement is limited to contrast administration and interventional procedures.
   - Limiting the requirement for a radiologist to be on-site to circumstances when it is necessary to attend on the patient is a very low bar. It has not been interpreted to mean that that the radiologist needs to attend patients when necessary to deliver a quality diagnosis and report – or to answer patient questions.

- 'Accepted medical practice' does not improve the clarity of the requirement – it is limited by the words "if necessary".

(c) within a reasonable period of time

- Attendance within a reasonable period of time is vague – for example it could allow a radiologist to cover most of metropolitan Melbourne. This broad requirement has previously been interpreted as a 20 minute walk rule by some providers, and within one hour's drive or one day's drive by others

7. ADIA recommends that the proposed supervision definition be refined, primarily to address the need for a medical specialist or consultant physician to be on-site for particular modalities, using the following framework:

   - A strict on-site rule for mammography, image-guided interventional procedures or surgical interventions and contrast administration, which requires the medical specialist or consultant physician to be on-site while the service is being performed.

     The rule would include an exemption for practices subject to a rural and remote exemption, to enable a medical practitioner to supervise the administration of contrast.

   - A generally on-site rule for MRI, CT, MSK and selected Ultrasound, which requires the medical specialist or consultant physician to be available on-site, provide consultative supervision, and attend on patients in accordance with accepted medical practice.

     'Consultative supervision' is where the radiologist exercises his or her professional judgement with full regard to accepted medical practice, and participates in the examination as required to provide quality imaging, a diagnosis that supports the referrer in determining the most appropriate treatment options, and a comprehensive report.

     The rule would include exemptions for outside ordinary working hours (9am-5pm on weekdays, excluding public holidays) and reasonable breaks (including meals and other breaks) and clinical meetings to a maximum of three hours per day.

8. ADIA is a strong supporter of medical specialists and consultant physicians being on-site while ultrasound services are being performed. This should be encouraged because medical specialists and consultant physicians offer significant value in the provision of clinical input and attendance on patients when required. However, it is important to recognise that current accepted medical practice has evolved to a significant volume of ultrasound services being performed without a radiologist on-site. There is a significant risk that if the supervision requirement for CT is the same as for ultrasound, practice standards in CT will evolve to reflect practice standards in ultrasound, resulting in an increase in unsupervised CT.

9. Finding the appropriate balance when setting supervision rules for ultrasound is difficult. ADIA recommends that DoH engage with the various specialist groups to clarify which ultrasound services:

    - should require a medical specialist or consultant physician to be available on-site to provide consultative supervision while the service is being performed;
    - should require an off-site medical specialist or consultant physician to be available to provide consultative supervision through the use of technology while the service is being performed; and
    - should not require a medical specialist or consultant physician to provide consultative supervision while the service is being performed.

10. ADIA would like to work with DoH to further develop these proposals for inclusion in the revised Consultation RIS.

**Practice-based requirements in Option 3**

11. ADIA supports the practice-based requirements for comprehensive practices set out in Option 3, including:

    - CT services must be provided as part of a comprehensive practice.
    - A radiologist must be on-site for an agreed minimum number of hours.
    - Practices would maintain records to indicate the name of the supervising and reporting radiologist, who need not be the same person (this would enable the service would be billed in the name of the supervising radiologist). It is important that the prevailing practice of 'figurehead billing' is expressly approved as part of these arrangements.

12. ADIA considers that SPECT and PET/CT equipment should not be included in comprehensive practice arrangements, except where the equipment is used for diagnostic CT services under the DIST.

13. ADIA supports the proposal to permit radiologists to substitute a more appropriate imaging service in place of the requested imaging service, without the need for consultation with the requester. However, in many cases the more appropriate service has a higher MBS fee than the requested service – the radiologist should not be restricted from substituting this service. There is a natural check and balance in the nature of referrer-radiologist arrangements – if a radiologist substitutes services beyond what the referrer considers appropriate, that referrer would be discouraged from referring to that radiologist again in future. Concerns about abuse of this rule could also be addressed by auditing radiologists' substitution patterns.

**Option 3 needs to include rural and remote exemptions**

14. ADIA shares RANZCR's aspiration that all diagnostic imaging services be supervised by an on-site radiologist, regardless of where in Australia the service takes place. However, this aspiration is not achievable in the short to medium-term due to workforce constraints.

15. To maintain access to diagnostic imaging for rural and remote communities, it is critical that the revised Consultation RIS include rural and remote exemptions in both Options 2 and 3. Rural and remote exemptions underpin access to a limited range of diagnostic imaging services for patients in these communities where employing a radiologist is not viable. Access would be lost if a radiologist is required to be on-site for a minimum number of hours each day in comprehensive practices.

16. As well as in private practices, many CT services that operate under the rural and remote exemption are located in the local public hospital, and are an essential component of clinical services delivered in those communities. In particular, CT is a critical service for urgent cases such as head trauma or appendicitis, as it enables local clinicians to determine whether to transport the patient to a tertiary hospital.

17. In rural and remote areas, there may need to be a flexible approach to comprehensive practice requirements and how the mix of CT, Ultrasound and X-Ray services is provided between practices. This will ensure that patients have access to a full range of services.

18. The 30km rule is the current basis for rural and remote exemption eligibility. The rule has shortcomings, however the key policy objective needs to continue to support radiologists who make themselves available on-site in rural and remote communities – particularly if the aspiration is to increase the numbers of radiologists on-site in these communities. ADIA supports the consideration of changes to this exemption as a separate item of work for DoH, however this should be through improvements to the 30km rule rather than the AGSC-RA classification or the Mixed Monash Model, which would discourage radiologists from relocating to these communities.

19. As an interim measure, the current 30km rule should remain.

20. Area of Need arrangements are a major inhibitor to bringing radiologists to rural and remote communities, as the application process has broken down. ADIA has been making representations to the Department of Health on this issue for many years. We recommend that these arrangements are improved as an essential first step, to support the aspiration to give patients access to on-site radiologists in rural and remote communities.

21. ADIA considers that in locations where it is not currently viable to mandate an on-site radiologist, access and service quality can be balanced by putting appropriate service standards in place. This would include a requirement that an off-site radiologist supervise services while the service is being performed through the use of technology.

22. However, ADIA does not support rural and remote exemptions for MRI, mammography, and image-guided interventional procedures or surgical interventions. These are services for which it is important that a radiologist is on-site and available to attend the patient.

23. While not currently within the scope of this RIS, ADIA supports the Australasian Association of Nuclear Medicine Specialists recommendation that a partial rural and remote exemption to the performance and supervision requirements for nuclear medicine services be developed.

**The RIS needs to reflect on whether the changes will be enforceable**

24. The diagnostic imaging sector is unlikely to support changes to supervision rules unless it can be satisfied that the new rules will be enforceable by the Department of Human Services (DHS). The new supervision rules should set clear expectations of diagnostic imaging providers, and be coupled with a commitment by DHS to an ongoing programme of compliance and audit.

**ADIA supports changes to ultrasound requirements**

25. ADIA supports the introduction of credentialing arrangements and minimum equipment standards for ultrasound services.

26. ADIA also supports introducing a definition of diagnostic ultrasound, to reflect the evolution of ultrasound into a broad range of clinical settings for different clinical purposes. ADIA is currently working with other stakeholders on defining the components of 'comprehensive' and 'focused' ultrasound. We look forward to working with DoH to progress this work.

2 July 2015

## Framework for improving the RIS proposals

<table>
<tr><th></th><th>Option 2 – clarification of current supervision arrangements</th><th>Option 3 – additional practice based requirements</th><th>Rules for services where rural and remote exemption applies</th></tr>
<tr><td>Contrast administration<br>Surgical and interventional procedures<br>Mammography</td><td colspan="2">Strict on-site rule which requires the medical specialist or consultant physician to be on-site while the service is being performed<br>+<br>Generally on-site rule</td><td>No rural and remote exemption for surgical and interventional procedures and mammography<br><br>Contrast should only be administered under the supervision of a medical practitioner</td></tr>
<tr><td>MRI</td><td rowspan="2">Generally on-site rule that ensures the medical specialist or consultant physician:<br>• is available on-site<br>• provides consultative supervision<br>• attends on patients in accordance with accepted medical practice<br><br>Exemptions for after hours and reasonable breaks (up to three hours)</td><td rowspan="2">Generally on-site rule<br>+<br>Practice-based requirements</td><td>No rural and remote exemption</td></tr>
<tr><td>CT<br>MSK Ultrasound<br>Selected Ultrasound</td><td>Ensure that an off-site medical specialist or consultant physician can provide consultative supervision while the service is being performed through the use of technology<br><br>Exemptions for emergencies and after hours</td></tr>
<tr><td>Ultrasound</td><td colspan="3">The Department of Heath should engage with the various specialist groups to clarify appropriate supervision requirements for the range of ultrasound services in the DIST</td></tr>
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