Submission on reports of Medicare Benefits Schedule Review Clinical Committees, released on 9 September 2016

7 October 2016

ADIA is grateful for the opportunity to provide comment on the recommendations in the Clinical Committee reports.

ADIA represents medical imaging practices throughout Australia, both in the community and in hospitals. It promotes the ongoing development of quality accreditation standards and appropriate funding settings so that Australians can have affordable access to quality medical imaging services. This supports medical imaging's central role in the diagnosis, treatment and management of a broad range of conditions in every branch of medicine.

First Report from the Diagnostic Imaging Clinical Committee - Low Back Pain

Recommendation 1

Consider GP-requested MRI of the lumbar-sacral spine, for defined indications, with strategies for ensuring appropriate requesting by clinicians.

ADIA supports recommendation 1.

Recommendation 2

Consider limiting CT requesting by GPs. In the event of a GP-requested MBS item for MRI of the lumbar-sacral spine, CT should only be used to assess low back pain where MRI is unavailable or contraindicated.

ADIA does not support recommendation 2 in its present form, because there is not sufficient capacity across Australia on existing Medicare-eligible MRI units to support patient access for appropriate use of CT for assessing low back pain.

Recommendation 3

Consider amending item descriptors to clarify the indications for low back imaging for each modality. In particular, plain x-rays of lower back could be limited to suspected fracture or inflammatory spondyloarthritis.

ADIA supports recommendation 3 in-principle, however to ensure that item descriptors do not inhibit good clinical practice, the list of indications for low back pain imaging for each modality should be comprehensive. This would ensure that patients do not miss out on essential, clinically appropriate services.

The process for agreeing indications should be transparent and involve broad consultation with referrers and providers of low back pain imaging. Indications that could be considered include:

Plain x-ray	CT	MRI
Pre-operative assessment for orthopaedic and neurosurgery operations	Multi-trauma	Disc disease
Correlation with nuclear medicine studies	MRI contra-indicated (pacemaker, cochlear implant, aneurysm clip, metallic foreign body in eye, body piercing, some tattooing)	Metastatic disease

Clinical red flag	Scoliosis	Associated neurological signs – sciatica, cord compression
Penetrating wound with potential metallic foreign body	Congenital anomaly	Congenital anomaly with associated neurological signs
Scoliosis		Spinal Infection
Assessment of medical devices (epidural catheters, stimulators)		

Recommendation 4

Limit use of multi-region radiography of the spine and, in particular, three and four region imaging on the same day. The Committee agreed that, as a first step, the requesting of these studies be limited to medical practitioners.

ADIA does not support recommendation 4, because it is likely to lead to an increase in low back pain imaging services being performed outside Medicare by allied health practitioners. This would deny patients the protection of the Medicare funding and regulatory structure, which ensures minimum safety standards are met and requires a written radiologist report with every examination.

Accordingly, while ADIA shares the Diagnostic Imaging Clinical Committee's concern about inappropriate use of imaging for low back pain, the recommended approach is not a prudent solution. Instead, item descriptors for allied health professional referrals should be amended to specify the clinical circumstances in which the service is Medicare-eligible, including restrictors

Strengthening the provision of quality Medicare-funded diagnostic radiology services (2012-13 Budget)

In response to concerns that Medicare regulations permitted diagnostic radiology services to be performed by people without appropriate qualifications, the then Government amended the *Health Insurance (Diagnostic Imaging Services Table) Regulations* on 1 November 2012 to introduce minimum formal qualifications for people performing Medicare-funded diagnostic radiology services. The changes were announced in the 2012-13 Budget, and subject to a Post-Implementation Review (PIR).[1]

Concern about self-referral and performance

The PIR noted the emergence of a business model in which allied health professionals requested imaging, performed the scans themselves, and contracted a radiologist to report the images in order for the service to be Medicare-eligible.[2] The Royal Australian and New Zealand College of Radiologists had previously expressed its concern about the convergence of requestors and providers of diagnostic imaging to the Review of Funding for Diagnostic Imaging Services, and the risk that this would create incentives to provide unnecessary services.[3]

These concerns were addressed by restricting performance of diagnostic radiology services to:

(a) a medical practitioner; or
(b) a medical radiation practitioner (person registered or licensed as a medical radiation practitioner under a law of a State or Territory) who is employed by a medical practitioner or provides the service under the supervision of a medical practitioner in accordance with accepted medical practice; or
(c) a dental practitioner (for items 57901 to 57969) who is employed by a medical practitioner or provides the service under the supervision of a medical practitioner in accordance with accepted medical practice.

[1] Department of Health (October 2015), *Post Implementation Review: Strengthening the provision of quality Medicare-funded diagnostic radiology services* (PIR).
[2] PIR, p.4.
[3] RANZCR (2010), *Detailed Review of Funding for Diagnostic Imaging Services: RANZCR Submission*, p.9.

With chiropractors no longer eligible to perform imaging services personally, the Department of Health reported that approximately 200 chiropractic practices chose to withdraw from the Diagnostic Imaging Accreditation Scheme (all providers of diagnostic imaging services under Medicare are required to be accredited under the Scheme). DoH also reported that the measure improved allied health practitioner requesting practices, with chiropractors shifting their requesting patterns to target specific areas of concern.[4]

The likely impact of the recommendation

The recommendation would undermine the intent of the 2012 changes. Allied health professionals would no longer be permitted to refer for Medicare-eligible multi-region radiography of the spine, creating the incentive to install equipment in their practices and return to performing the imaging themselves (and generate extra revenue by charge patients privately for the service).

These unregulated services may pose a safety risk to patients, and patients would no longer benefit from a radiologist report of the examination as this would not be required for the provider to bill the patient.

Alternative recommendation

ADIA recommends that item descriptors for allied health professional referrals should be amended to specify the clinical circumstances in which the service is Medicare-eligible, including restrictors.

[4] PIR, p.6-7.

Report from the Diagnostic Imaging Clinical Committee on the review of Bone Densitometry

Recommendation 1: New items for repeat testing with intervals

This recommendation refers to item number 12323.

The Working Group recommends the introduction of intervals for bone densitometry (currently MBS item 12323) for the measurement of bone mineral density, for a person aged 70 years or over. This would involve the introduction of two new items with defined intervals as follows:

- Normal or mild osteopenia (down to t score of -1.5) 1 scan every 5 years
- Moderate to marked osteopenia (T score of -1.5 to -2.5) 1 scan every 2 years

ADIA supports recommendation 1.

Recommendation 2: Proposed item descriptor DEXA

This recommendation refers to item numbers 12306, 12312, 12315, 12321 and 12323.

The Working Group recommends that, as has been usual historical practice, a radiation licence, from the relevant State or Territory jurisdiction is required to perform a dual-energy x-ray absorptiometry (DEXA) scan, under the supervision of an appropriate specialist or consultant physician.

ADIA supports recommendation 2 in-principle, and recommends that an 'appropriate specialist or consultant physician' refers to specialists in diagnostic radiology, nuclear medicine and other specialists who have completed the training provided by the Australian and New Zealand Bone Mineral Society or equivalent.

Recommendation 3: Proposed item descriptor QCT

This recommendation refers to item numbers 12309 and 12318.

The Working Group recommends medical radiation practitioners should perform QCT scans under the supervision of an appropriate specialist or consultant physician, which could be on or off site, but would include the ability to provide contemporary/real time review of images as they were produced to ensure adequacy.

ADIA supports recommendation 3 in-principle, and recommends that an 'appropriate specialist or consultant physician' refers to specialists in diagnostic radiology.

However, Medicare statistics show that quantitative CT (QCT) items (12309 and 12318) are rarely used. ADIA recommends that these items are removed from the Medicare Benefits Schedule, as DEXA is the superior test for bone mineral assessment.

Recommendation 4: Interpretation and report provided by a specialist or consultant physician

This recommendation refers to item numbers 12306, 12309, 12312, 12315, 12318, 12321 and 12323.

The Working Group recommends the interpretation and report for bone densitometry services must be provided by a specialist or consultant physician.

ADIA supports recommendation 4 in-principle, and recommends that for DEXA services, a 'specialist or consultant physician' refers to specialists in diagnostic radiology, nuclear medicine and other specialists who have completed the training provided by the Australian and New Zealand Bone Mineral Society or equivalent; and for QCT services a 'specialist or consultant physician' refers to specialists in diagnostic radiology.

Recommendation 5: Site measurements for QCT and DEXA items

The Working Group recommends the Department undertake further work to determine the most appropriate way to include the measurement of spine and hip in the item descriptor for QCT and DEXA items.

ADIA supports recommendation 5 in-principle, noting that the item descriptor should be in the form of guidance. This would allow bone density to be measured using other parts of the body where it is clinically appropriate.

In addition to the specific recommendations of the Diagnostic Imaging Clinical Committee, ADIA recommends that bone densitometry items in Subgroup 10 of the General Medical Services Table (12306, 12309, 12312, 12315, 12318, 12321 and 12323) are moved to the Diagnostic Imaging Services Table. This would reflect that the majority of bone densitometry services are provided in diagnostic imaging practices, and support quality and patient safety by requiring bone densitometry providers to participate in the Diagnostic Imaging Accreditation Scheme.

First report of the MBS Principles and Rules Committee

Recommendation 2

That benefits be paid for a maximum of three MBS items in relation to a single procedure, and that the existing multiple operation rule be applied to these MBS items.

While we understand and support the Principles and Rules Committee's objectives, ADIA does not support recommendation 2 with respect to diagnostic imaging services. The recommendation should be clarified so as there are not unintended consequences for diagnostic imaging.

Diagnostic imaging services regularly involve claiming multiple MBS items, as not all diagnostic imaging items are a 'complete medical service'. For example, there are separate items for components of a service which are claimed in conjunction with other items:

- Modifying items for MRI services for administration of contrast, intravenous or intramuscular sedation, or performance of the service on a patient under anaesthetic
- CT scans performed in conjunction with SPECT for anatomic localisation or attenuation correction
- Specialist attendance items

In addition, DI services involving four or more MBS items are regularly performed, for example:

- Angiography-guided interventional procedures
- MRI, mammography and ultrasound-guided biopsies and fine needle aspirations
- X-ray of the feet, hands and wrists and ultrasound of the ankle to diagnose rheumatoid arthritis
- A range of unrelated tests may be conducted in one visit for the benefit of the patient, particularly rural and remote patients who travel great distances for imaging

Recommendation 5

For co-claiming attendances with procedures, that the MBS regulations and explanatory notes be amended to state:

(a) Where the decision to perform a procedure is made during an attendance, that attendance and the consequent procedure can be co-claimed, whether the procedure is performed contiguously with the attendance or after some interval of time on the same day.

(b) Where an attendance occurs in relation to a procedure that has already been agreed to take place, co-claiming of an attendance item cannot occur unless another unrelated medically significant issue is dealt with during the attendance. Pre-procedure attendances should not be charged for, as they constitute an integral part of the procedure.

(c) An attendance to obtain consent immediately prior to a procedure or attendances immediately after a procedure regarding outcomes and post-procedure care cannot be claimed.

ADIA does not support recommendation 5 with respect to diagnostic imaging services, as it would preclude a wide range of circumstances in which it is clinically appropriate for a radiologist to co-claim an attendance item; for example, where a patient has made an appointment for a high-risk procedure, and the radiologist attends the patient to discuss the benefits and risks to enable a decision on whether the procedure is to be performed.

We understand that the Diagnostic Imaging Clinical Committee is currently considering how the clinical circumstances in which it is appropriate for a radiologist to co-claim an attendance item should be defined.

We are pleased that the use of attendance items for diagnostic imaging is being considered separately, because it is important that if co-claiming rules for attendance items are to change, that dedicated rules are introduced for radiologists. This would recognise that technological advances in medical imaging and growing complexity of interventional techniques means that there is increasing risk involved and a greater need to consult with patients.