

X-Ray & Imaging Pty Ltd

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

We think implementation of this level of change is appropriate and potentially feasible. The removal of the personal attendance requirement for MSK ultrasound, to aligning it with all other ultrasound items, is an appropriate change as long as the person performing the examination was suitably qualified.

We agree that there needs to be clear clarification of the definition of professional supervision and what is a “reasonable period of time” to attend. We support that a Radiologist should be able to provide supervision for a number of practices in a similar geographical location.

A Radiologist does not need to be on-site to review images and to discuss and influence a case with the Radiographers / Sonographers and would only feel the need to personally attend a patient on minimal occasions.

To implement a “time to attend” requirement which requires a Radiologist to be specifically on-site would decrease a lot of practices’ ability to offer services to patients in a timely manner and significantly increase running costs. Practices would require more Radiologists to meet this requirement. Given that it is extremely difficult to get Radiologists to work in non-metropolitan regions and the wages they can command, this would make many smaller practices unviable unless rebates were significantly increased or large out of pocket gaps were applied.

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

We do not anticipate any significant cost increase or saving from removing the personal attendance requirement. It should have no impact on the number of patients referred. It would provide patients with greater access, as their appointments would not have to be booked at a time that we know the Radiologist is immediately available to attend. This currently limits

when we make MSK ultrasound appointments available.

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

Our company already works on a model where our CT's are part of comprehensive practices and our Radiologists are on site for the performance of Mammography, IV contrast administration & image guided interventional procedures/surgical interventions. For this reason, making Computed Tomography services only able to be provided in a comprehensive practice and requiring a Radiologist on site for the listed services would have no affect on our company.

However, to put a requirement on how many hours per day a Radiologist must be on site for a practice to be classified as Comprehensive would most likely affect a few of our practices. Being in a non-metropolitan region, it is not viable to have a Radiologist at some comprehensive sites all day or every day of the week. The workload is not sufficient in those towns to support a Radiologist on site every day given the availability of Radiologists and their wages.

A better method to address the concerns outlined in this RIS would be to regulate to ensure a Radiologist is on site for studies requiring the administration of IV contrast, interventional procedures and mammography. This would ensure that more complex cases are managed by the supervising Radiologist.

Routine CT studies, like spines or sinuses, do not require a supervising Radiologist on site to influence the study. The base protocols are already well established (and already a DIAS requirement) and if performed by qualified staff, quality and dose are not an issue.

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

Being a smaller company in a non metropolitan region, we do not have Radiologists at some of our comprehensive practices all day or every day. They visit on a seasonal basis or alternate days.

Radiologists are difficult to get to move to our regional centre. Wages vary depending on if they are fellows of RANZCR or they have area of need restrictions on them. The range is from \$500,000 – \$900,000+ per annum with study leave. Locum Radiologists are asking up to \$3300 per day with travel, car hire & accommodation on top of that.

Undersupply of Radiologists is definitely an issue.

Further clarification is required in regards to a comprehensive practice requiring a radiologist to be available during agreed operating hours. How would this affect a practice that only has a radiologist on alternate days? What if a locum is unavailable when a radiologist is on leave for a day? If there is no flexibility on the agreed hours, potentially existing practices that are comprehensive in regards to the modalities installed may not be able to meet the agreed radiologist hours. Linking radiologist presence on site to specific examinations, eg CT with contrast, would address many of the concerns of supervision listed in the RIS while not adversely affecting sites providing limited services un-supervised, eg non-contrast CT.

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

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

We feel the DIAS has addressed many quality issues and this is an effective way of establishing and maintaining a minimum acceptable standard. The high cost of establishing comprehensive practices and employing a Radiologist makes providing comprehensive services in rural areas very financially unviable. Tele-radiology services allow providers to deliver many essential imaging examinations to patients that would otherwise have to travel great distances or accept inferior examinations.

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

In regards to the identified problem of unnecessary or inappropriate diagnostic imaging; Radiologists are generally reluctant to over-ride or refuse a referring physician's request unless it is very obvious that the requested study is not the best choice, given the supplied patient history. The referring doctor has much more information on the patient. To allow a radiologist to substitute a requested service for a more appropriate service, without the need for consultation with the requester is not good practice. The patient may have already had other imaging at a different provider that the radiologist is unaware of and the referral & patient hasn't conveyed this.

More emphasis needs to be on better educating the referrers, as a whole, on appropriate tests than Radiologists questioning them case by case.