AUSTRALIAN MEDICAL ASSOCIATION
ABN 37 008 426 793
T I 61 2 6270 5400
F I 61 2 6270 5499
E I ama@ama.com.au
W I www.ama.com.au
39 Brisbane Ave Barton ACT 2600
PO Box 6090 Kingston ACT 2604

SUBMISSION

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MBS Review Taskforce — vascular recommendations

By email: anna.waddington@health.gov.au

Introduction

The AMA welcomes the opportunity to provide comments on the three outstanding recommendations from the MBS Review Taskforce's final report on vascular services items. Our core position is to support clinician-led improvements that align item descriptors and fees with contemporary evidence and practice, simplify claiming, and improve patient access and affordability.

We caution against blunt restrictions or administrative hurdles that inadvertently displace appropriate low-risk care, increase out-of-pocket costs, or create barriers to timely diagnosis and management — particularly for people in rural and regional communities.

The AMA's previous commentary and recommendations on similar amendments have been consistent with our long-standing advocacy on MBS reform and diagnostic imaging policy. We are pleased to note this approach is reflected in the taskforce's intent to modernise items while maintaining access to clinically appropriate services.

Summary of position

The AMA broadly supports the recommendations with updated descriptors and fee relativity, supported by pre-implementation AskMBS advisory and worked examples (Recommendation 1).

Recommendation 2 should be adopted with clear exception notes for symptomatic and peri-procedural indications, along with concise decision support for referrers to maintain access where clinically justified while discouraging asymptomatic screening, drawing on Australian guidance such as RACGP/Choosing Wisely.

However, we do not support Recommendation 3 in its current form. General practitioner (GP) access should be retained with strengthened clinical indications, but without introducing additional documentation burdens. The AMA also opposes excluding Obstetrics and Gynaecology specialists from requesting item 55278, given ultrasound is the appropriate first-line modality in pregnancy and the puerperium for suspected pelvic or ovarian venous thrombosis, or for renovascular indications. We support retaining O&G access with strengthened clinical indications.

Specific requesting concerns should first be addressed through education, audit/feedback, and AskMBS guidance rather than categorical exclusion.

As always, the Department of Health, Disability and Ageing must provide adequate lead time and comprehensive communication to practices and insurers to support informed financial consent and smooth implementation, applying lessons from previous MBS tranche rollouts. Finally, the government should commit to a 12-month post-implementation review of co-claiming and split-day patterns to ensure the changes operate as intended and to identify/assess any unintentional system impacts.

Key priorities (cross-cutting considerations)

Further to our input to the three recommendations, the AMA emphasises that major MBS changes require appropriate implementation lead time, transparent guidance, and clear mapping to prevent confusion for patients, practices and private health insurers, and to protect informed financial consent. The AMA has consistently warned that compressed implementation windows cause operational disruption and lead to increased out-of-pocket costs for patients. These vascular changes must be supported by AskMBS advisories and worked examples clarifying co-claiming, split-day rules, and exceptions.

Medicare compliance problems often stem from system complexity rather than intent. The AMA supports the department's emphasis on education and simplification ahead of punitive or blunt restrictions. The independent compliance review in 2023 reinforced high practitioner integrity and the need for better guidance and systems to support correct claiming.[1]

As per the AMA's 2019 advice and broader AMA policy on diagnostic imaging,[2] fee relativity and private sector viability should be supported. Changes that combine or redefine services must be matched with robust fee modelling that reflects clinical time and complexity, ensuring providers are not disincentivised from offering necessary services and that the private sector remains viable.

The final consideration is equity of access — particularly for rural and regional communities. Referral restrictions that remove GP pathways can exacerbate inequity. Retaining GP access with clear indications preserves timely investigation while supporting coordinated care with specialists when required.

Recommendation 1 — Improve diagnostic options for duplex of aorto-iliac and lower limb vasculature (items 55238 and 55276)

The taskforce proposes amending MBS item 55238 to explicitly include examination "with or without the aorto-iliac segment," and amending item 55276 to restrict co-claiming with item 55238 unless examination of the inferior vena cava and iliac veins is warranted. This would be accompanied by fee recalibration to reflect the combined service and reduce incentives for split-day billing.

The AMA supports these changes. They reflect the principle of a complete service, address historically high co-claiming rates and split-day claiming influenced by the Multiple Services Rule, and are likely to reduce patient inconvenience by minimising multiple visits for closely related examinations. Information provided by the department as part of the consultation indicates co-claiming has fallen

[1] AMA media release: Medicare compliance review stands by doctor integrity (4 April 2023); https://www.ama.com.au/media/medicare-compliance-review-stands-doctor-integrity-and-calls-future-proofing-medicare
[2] AMA Diagnostic Imaging Position Statement 2025; https://www.ama.com.au/articles/ama-position-statement-diagnostic-imaging-2025

from ~51 per cent to ~35 per cent but remains substantive, supporting the case for continued investment with improved descriptor clarity and fee relativity.

Throughout the MBS review feedback provided, the AMA has supported this simplification approach[3] while urging robust fee-modelling and stakeholder consultation to avoid unanticipated increases in out-of-pocket costs and to protect the viability of private provision of imaging services. The AMA's diagnostic imaging policy similarly emphasises funding and regulation should support clinically appropriate, evidence-based services delivered by qualified practitioners in accredited facilities.

Concerning implementation, the AMA recommends AskMBS advisory resources with worked examples before changes go live. Adequate lead time must be provided for insurers and practices to update schedules, enabling doctors to provide informed financial consent without confusion. The AMA has previously highlighted the operational risks and out-of-pocket harm arising from compressed implementation windows; those lessons should inform this rollout.

A 12-month post-implementation review of co-claiming and split-day patterns will help confirm whether fee relativity and descriptor changes have achieved the intended effect.

Recommendation 2 — Prevent low-value over-servicing of carotid duplex examinations (item 55274)

The AMA supports the taskforce's proposal to amend item 55274 to exclude screening of asymptomatic patients, except when referred by a specialist, and to limit claiming to two services per 12 months. The evidence base does not support population screening for asymptomatic carotid disease; false positives and downstream harm from unnecessary confirmatory testing and interventions are well recognised. Specialist triage for selected higher-risk groups is appropriate, as is discouraging repeat use without a clear clinical indication. The department's utilisation analysis suggests the cap will affect a small number of patients — 1,226 patients were recorded as having accessed more than two services under item 55274 in 2024 — indicating a proportionate, targeted intervention rather than a broad disinvestment.

In our 2019 submission, the AMA endorsed this recommendation. The recommendation also aligns with the AMA's principled approach to diagnostic imaging policy, which prioritises clinical appropriateness, safety and access. To ensure patients with genuine clinical need are not disadvantaged, the final explanatory notes should include clear exception wording for symptomatic or peri-procedural contexts (e.g., recent transient ischaemic attack-operative evaluation), along with concise decision support for referrers to distinguish symptomatic indications from screening. Australian general practice guidance also underscores the primacy of clinical assessment and targeted imaging in symptomatic or high-risk scenarios.[4]

The AMA notes Australian guidance advises against screening asymptomatic adults for carotid stenosis. The Royal Australian College of General Practitioner's Choosing Wisely recommendation states, "Don't screen asymptomatic, low-risk patients (<10% absolute 5-year cardiovascular risk)

[3] MBS Review Clinical Committee reports — Colorectal, General, Plastic and Reconstructive, Vascular and Thoracic surgery AMA submission to the MBS Review Taskforce; chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.ama.com.au/sites/default/files/documents/AMA_submission_MBS_Review_surgical_reports.pdf

[4] Carotid artery stenosis: An approach to its diagnosis and management; https://www1.racgp.org.au/ajgp/2021/november/carotid-artery-stenosis

using … carotid artery ultrasound," reflecting the balance of harms and the minimal benefit from population screening.[5] This is consistent with the Stroke Foundation's Living Clinical Guidelines,[6] which focus carotid imaging and intervention on symptomatic disease and secondary prevention rather than screening. Australian clinical commentary in the *Australian Journal of General Practice* similarly emphasises best medical therapy and risk-factor modification for asymptomatic disease and questions the benefit of intervention, further undermining any case for routine screening.

The AMA notes recent trends show a fall in bulk-billing for carotid duplex and rising out-of-pocket costs. Reducing low-value screening while preserving access for symptomatic patients should help limit unnecessary expenditure and patient costs.

Recommendation 3 — Prevent low-value over-servicing of renal duplex examinations (item 55278)

The AMA opposes restricting item 55278 requests to selected specialists (hypertension, nephrology, vascular surgery, interventional radiology, rheumatology), excluding Obstetrics and Gynaecology, and removing GP access. Removing GP referral creates a substantial access risk, particularly for patients in rural and regional areas, by introducing delays and added costs associated with specialist referral. It also risks test substitution — displacing appropriate, low-cost, no-radiation ultrasound with computed tomography angiography, which carries higher system costs and higher radiation and contrast exposure to patients — undermining both safety and value. The AMA has previously raised these concerns[7] and recommended retaining GP referral for renal duplex, with a focus on clinical indications rather than categorical referral barriers.

The AMA continues to recommend retaining GP access to item 55278 and strengthening clinical indications in the explanatory notes (e.g., refractory or atypical hypertension, suspected renovascular disease, or renal impairment with suspected vascular aetiology). This approach balances access and appropriateness without imposing additional documentation burdens on GPs.

The AMA reiterates the system must continue to support doctors' professional judgement and remains cautious about administrative requirements that seldom improve appropriateness yet often hinder timely care.

The AMA opposes excluding O&G specialists from requesting MBS 55278. Australian obstetric guidance supports the appropriate use of diagnostic ultrasound when it answers a relevant clinical question, which is precisely the case in pregnancy and the puerperium for suspected pelvic or ovarian venous thrombosis, or renovascular hypertension, where ultrasound is the safest first-line modality in maternal care.[8] State and national clinical materials used in Australian maternity services emphasise

[5] https://www.choosingwisely.org.au/recommendations/racgp4
[6] Stroke Foundation Living Guidelines; https://informme.org.au/guidelines/living-clinical-guidelines-for-stroke-management
[7] MBS Review Clinical Committee reports — Colorectal, General, Plastic and Reconstructive, Vascular and Thoracic surgery AMA submission to the MBS Review Taskforce; chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.ama.com.au/sites/default/files/documents/AMA_submission_MBS_Review_surgical_reports.pdf
[8] Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) position statement on the appropriate use of diagnostic ultrasound; chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://ranzcog.edu.au/wp-content/uploads/Position-Statement-Appropriate-Use-of-Diagnostic-Ultrasound.pdf

risk assessment and timely investigation of pregnancy-associated VTE; in suspected thrombosis,[9] ultrasound is a first-line imaging test in Australian primary and specialist practice, aligning with obstetric care pathways (Queensland Health VTE in pregnancy/puerperium; KEMH obstetric VTE guideline; RACGP clinical guidance on DVT/PE imaging).[10]

Excluding O&G risks delays and substitution to higher-risk modalities, whereas retaining access with strengthened clinical indications (e.g., postpartum fever/pelvic pain with suspected ovarian/pelvic venous thrombosis; refractory hypertension with suspected renovascular cause), supported by education, audit and AskMBS guidance, preserves timely, evidence-aligned care.[11] O&G requests are not the majority of 55278 services but remain material (~8.5 per cent of 2024 requests in the department's data), so targeted indications — not categorical exclusion — are the proportionate response.

We note GP requests account for most services for item 55278, with O&G representing a small fraction. The current requesting mix supports maintaining GP access, with clearer indications to guide appropriate use. In short, a well-targeted explanatory note will better protect patient access and system value than a blanket referral restriction. If patterns of requesting in specific specialties remain concerning to the department, education, audit/feedback, and AskMBS guidance should be employed rather than categorical exclusion.

Contact

president@ama.com.au

[9] Deep vein thrombosis risks and diagnosis; www.racgp.org.au chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.racgp.org.au/getattachment/99b1cc58-4899-48f0-a47c-b314fa24f908/Deep-vein-thrombosis-risks-and-diagnosis.aspx

[10] Queensland Clinical Guidelines, Venous thromboembolism (VTE) prophylaxis in pregnancy and the puerperium; chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.health.qld.gov.au/__data/assets/pdf_file/0011/140024/g-vte.pdf

[11] National Health and Medical Research Council, Clinical Practice Guideline For the Prevention of Venous Thromboembolism in Patients Admitted to Australian Hospital; chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://ranzcog.edu.au/wp-content/uploads/NHMRC-Prevention-Venous-Thromboembolism-Australia.pdf