

SUBMISSION

Friday, 28 November 2025

AMA submission to the Review of Requesting and Access Pathways for Magnetic Resonance Imaging Services (MRI)

By email: mri@health.gov.au

Due: 28 November 2025

Summary position

The Australian Medical Association (AMA) welcomes the opportunity to comment on the Department of Health, Disability and Ageing's review of MRI requesting and access pathways. Our submission focuses on principles-based guidance rather than item-by-item commentary, drawing on our 2025 position statement on diagnostic imaging (2025) as the foundation for safe, evidence-based, patient-centred reform.

Diagnostic imaging is not a simple transactional service; it is a critical component of comprehensive care that requires clinical reasoning, interpretation, and integration into a patient-centred management plan. For this reason, radiologist-led oversight of imaging protocols, interpretation, and reporting must remain central. Any expansion of requesting rights should be strictly evidence-based and limited to scenarios where MRI is demonstrably superior and supported by national guidelines (e.g., ACSQHC Low Back Pain Clinical Care Standard, ACR Appropriateness Criteria).

The AMA strongly supports expanding the scope for general practitioners (GPs) to request MRI where clinically appropriate. Current restrictions create unnecessary delays, costs, and inconvenience for patients, often requiring specialist referrals for imaging services that GPs are well placed to initiate. Allowing GPs to access MRI for defined indications will improve timeliness, reduce out-of-pocket costs, and enhance continuity of care — without compromising safety — when supported by clear guidelines and radiologist-led governance.

The AMA does not support independent MRI requesting by nurse practitioners or physiotherapists due to the risks of fragmented care, increased costs, and patient safety concerns. International evidence shows greater utilisation and unnecessary imaging when non-medical practitioners order tests, while MRI interpretation and follow-up require medical expertise. In one study, emergency department visits managed by nurse practitioners or physician assistants were associated with 5.3 per cent more imaging overall, including 14.2 per cent more MRI/ultrasound, compared to physician-only visits. That equates to more than one million additional imaging studies annually for Medicare

patients,¹ an increased resource utilisation that negates any cost advantages to expanding the scope of requesting and access pathways.

Equity in rural and regional access should be achieved through workforce and infrastructure solutions, not by lowering referral thresholds or substituting medical expertise. Above all, reforms must avoid incentivising low-value imaging and ensure every MRI request improves patient outcomes and reduces unnecessary radiation exposure and duplication. Changes in requesting services and access pathways should incorporate mandatory decision support and documentation into e-referral systems to ensure appropriateness and facilitate auditing.

The AMA supports reforms that improve timely access to MRI where clinically justified, but changes must uphold safety, quality, and radiologist-led governance.

AMA principles to guide reform

Radiologist-led, team-based care

Clinical radiologists must lead medical imaging, including protocol design, contrast use, interpretation, reporting, and escalation of urgent or unexpected findings. Quality, safety, and legal accountability sit with medical practitioners. The AMA supports appropriate delegation within scope under radiologist oversight but does not support independent substitution of medical decision-making roles. This distinction ensures collaborative care without compromising clinical governance. Reforms should reinforce radiologist leadership across all settings.

Evidence-based appropriateness and stewardship

Referral pathways must minimise ionising radiation and duplication, reserve imaging for suspected specific pathology, and ensure clinical information is sufficient to guide appropriate MRI. The AMA supports tools and standards (e.g., ACSQHC clinical care standards, ACR appropriateness criteria, RANZCR diagnostic pathways) and education-first audit models to improve practice.

Decision support and documentation

Mandatory e-referral decision support (CDS) should capture red flags, neurological findings, prior imaging results, clinical questions, and relevant examination details, enabling audit and reducing low-value care. This is consistent with the AMA's endorsement of nationally consistent standards and structured clinical handover.

Access and equity without compromising standards

Address inequities — especially rural and regional — through workforce, infrastructure, sustainable funding, and interoperable digital systems — rather than by lowering referral thresholds or substituting medical expertise. The AMA does not support equipment licensing that restricts rebates;

¹ Christensen EW et al., JAMA Network Open (2022) Association of state share of nonphysician practitioners with diagnostic imaging ordering among emergency department visits for Medicare beneficiaries; <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2798248>

the transition to practice-based licensing and eventual deregulation should improve access while maintaining quality.

Non-medical referrer access

The AMA does not support extending Medicare benefits to MRI services requested by non-medical health practitioners unless operating under formal collaborative arrangements with medical practitioners and within clearly bounded protocols. Independent requesting by nurse practitioners or physiotherapists risks fragmentation, cost escalation, and patient safety issues in complex MRI interpretation and follow-up.

Appropriateness and safeguards

The AMA supports Stage 1 reforms as a positive step toward modernising MRI access. While item descriptors are highly specific, they represent progress beyond the current arrangements. We recommend targeted consultation with the Royal Australian College of General Practitioners (RACGP), Royal Australian and New Zealand College of Radiologists (RANZCR), and sports medicine craft groups to refine descriptors and ensure alignment with clinical practice. The AMA is willing to facilitate engagement with these groups to strengthen implementation.

Do the proposed clinical indications appropriately balance diagnostic value with safeguards against overuse?

The AMA supports tightly defined clinical indications for GP-requested MRI where MRI is demonstrably superior (e.g., lumbar radiculopathy with objective neurological deficit; occult fractures after negative radiography), provided items explicitly exclude non-specific musculoskeletal pain without red flags. Embedding ACSQHC and ACR guidance into e-referral CDS will reinforce appropriate use and reduce unnecessary radiation exposure and duplication. This approach accords with the AMA's principles on safety, quality, and evidence-based care.

What safeguards should be in place to ensure compliance and clinical justification?

Safeguards should centre on mandatory documentation (history, examination findings, red flags, prior imaging, clinical question), e-referral CDS prompts, and education-first audit with peer feedback. Radiologist-led protocol selection must be preserved, and structured clinical handover (e.g., ISBAR) should be required for urgent or unexpected findings. This aligns with the AMA-endorsed standards and governance and avoids punitive measures which may inadvertently restrict access.

To ensure MRI requests are clinically appropriate and auditable, the AMA recommends embedding national decision-support tools within e-referral systems. These tools should integrate ACSQHC and ACR pathways and require structured fields for clinical history, examination findings, red flags, and prior imaging results. Mandatory attachments of relevant reports will support radiologists in protocol selection and reduce duplication of imaging.

The AMA supports nationally consistent imaging standards that reflect best clinical practice and prioritise patient safety. Compliance should be monitored through education-first audit models and peer feedback rather than punitive measures. Clear protocols for urgent and critical result reporting,

including structured clinical handover, must be embedded to maintain continuity of care and minimise risk.

Stage 2: GP access and safeguards

The AMA supports further consultation on expanding GP access to knee MRI for patients aged 50 and over and additional musculoskeletal indications where MRI is clinically superior. These changes will address gaps currently leading to unnecessary specialist referrals and delays. However, we reiterate early concerns about proposals to broaden the referrer workforce to non-medical practitioners. Any consideration of such changes must involve rigorous consultation and evidence review, and the AMA stands ready to contribute.

Stage 3: Follow-up imaging

The AMA supports in-principle GP involvement in follow-up imaging for chronic or complex conditions under clear clinical guidelines and shared-care arrangements with treating specialists. Conditions such as chronic pelvic pain, where guidelines recommend MRI, should be prioritised to reduce financial and geographic barriers to care. We do not support allied health professionals initiating MRI requests, as this risks fragmentation and undermines clinical governance.

Non-medical referrer access

Radiologist leadership should remain the cornerstone of MRI service delivery. Protocol selection, contrast administration, and final clinical responsibility for reporting must rest with a radiologist. Delegation of tasks, including reporting, is appropriate where supported by structured governance arrangements that maintain quality and accountability. This ensures flexibility without compromising patient safety and clinical integrity.

What clinical indications should be included for nurse practitioner and physiotherapist-requestable MRI items?

As outlined above, the AMA does not support extending independent MRI requesting rights to nurse practitioners or physiotherapists. MRI is a complex modality where clinical decision-making, protocol optimisation, interpretation, and follow-up are medical responsibilities. Extending independent access risks fragmentation, over-utilisation, and patient harm; international experience indicates higher utilisation when non-medical practitioners order imaging.

How can the department ensure consistent acceptance of NP/physio MRI requests across providers?

Given the AMA's opposition to independent non-medical requesting, "acceptance" should not be assumed. If pilots are pursued, acceptance must be conditional on: (i) formal medical collaboration, (ii) radiologist-led governance for protocol/contrast decisions and reporting, (iii) access to shared records and prior imaging, and (iv) structured handover back to a medical practitioner responsible for

diagnosis and management. These conditions align with AMA standards, however, we emphasise the department should not implement non-medical requesting in order to maintain safety and quality.

Continuity, equity and system design

Do the proposed reforms appropriately support continuity of care and reduce unnecessary specialist referrals?

Continuity of care is welcome where it does not dilute clinical governance. All members of the care team should consult with the patient's regular GP regarding investigations, recognising the GP's central role in coordinating care and maintaining continuity. For surveillance MRI (e.g., MS, sarcoma, prostate), GP requesting should occur only under documented specialist plans and shared-care arrangements, with radiologist-led reporting and defined frequency limits. Improving rural access should prioritise workforce and infrastructure solutions (including radiologist presence, teleradiology as supplementary, digital interoperability, sustainable rebates, and travel support for patients), not scope changes that risk lower standards. This approach is consistent with the AMA's positions on access, affordability, and maintaining quality irrespective of location.

Licensing Reform and Access

The AMA supports the staged transition from machine-specific licensing to practice-based licensing and the planned full deregulation of MRI equipment from July 2027, provided these changes are accompanied by robust safeguards. Historically, restrictive licensing has limited patient access and created geographic inequities, particularly in rural and regional areas. Removing these barriers is a positive step toward improving equity; however, deregulation must not compromise quality or safety. All practices offering Medicare-eligible MRI services should continue to meet nationally consistent accreditation standards, maintain radiologist-led governance, and ensure protocols align with evidence-based clinical guidelines. The AMA also cautions against incentives which could encourage investment in lower-quality equipment or unsupervised service models. Licensing reform should be paired with sustainable funding arrangements and workforce strategies to support radiologist availability across all settings. In short, access improvements must be accompanied by measures preserving clinical integrity and patient safety.

Equity and cost efficiency

Expanding GP access to MRI is not only clinically appropriate but also cost-efficient and time efficient. Current restrictions often force patients to choose between paying hundreds of dollars out-of-pocket for an MRI or incurring the cost and delay of a specialist referral. GPs act as responsible stewards of patient investigations and are uniquely positioned to coordinate care, leveraging their knowledge of local resources and patient history to ensure investigations are timely, appropriate, and aligned with patient goals. Allowing GPs to request MRI for defined indications will streamline patient pathways and reduce unnecessary duplication of consultations and imaging.

Improving digital interoperability is essential to reduce unnecessary repeat scans and enhance reporting quality. Practices should have secure access to prior images and reports, and systems should support seamless uploads to shared electronic health records. This will enable radiologists to provide accurate, context-rich interpretations and improve patient outcomes. Integration of referral, follow-up, and reporting within GP clinical information systems will further reduce fragmentation and

ensure the GP record remains the most accurate and comprehensive account of the patient's health journey.

Sustainable funding arrangements are critical to maintaining access and quality. Rebates must reflect the true cost of service provision, and additional support should be provided for rural and remote practices through grants or loadings. GPs must be fully supported, both financially and through policy settings that enable them to make Medicare-rebatable referrals for MRI, ensuring equitable access for patients and supporting the GP's role as care coordinator. Where local capacity is constrained, patients should receive assistance for travel and accommodation. Policies must avoid creating perverse incentives which may encourage investment in lower-quality equipment or unsupervised service models.

Contact

president@ama.com.au