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

Tuesday, 31 March 2026

AMA submission – Post Implementation Review of Medicare Funded Cardiac Imaging Items — Second Consultation Paper (December 2025)

Consultation closes 31 March 2026

By email: radiology@health.gov.au

The Australian Medical Association (AMA) welcomes the opportunity to respond to the Department of Health, Disability and Ageing's (the department) second consultation on Medicare-funded cardiac imaging services. The AMA supports the department's intent to ensure Medicare-funded cardiac imaging items reflect contemporary clinical practice, support equitable access, and reduce unintended barriers to timely care. We remain concerned complex item structures and prescriptive claiming requirements can impede good clinical practice and add administrative burden, particularly in regional, rural and remote settings.

The AMA supports Phase 1 measures to clarify the stress echo caveat, remove rigid myocardial perfusion studies frequency restrictions where clinically justified, and improve descriptor clarity reducing administrative uncertainty. We support Phase 2 objectives in principle, subject to careful implementation design and safeguards that preserve rural access and maintain safety and quality, particularly in relation to MPS streamlining, GP-requested computed tomography of the coronary arteries (CTCA), and CTCA credentialling requirements.

Sound clinical advice should remain the key determinant of service design and Medicare support, including where non-invasive imaging can reduce avoidable escalation to more invasive pathways.

Overarching principles and context

The AMA's position on diagnostic imaging emphasises services should reflect best clinical practice, be delivered by qualified practitioners in appropriate settings, and be supported by funding and regulation that promotes timely, affordable access, including for regional and rural patients.

The department's consultation paper recognises stakeholder feedback that the 2020 cardiac imaging changes have remained confusing and administratively complex and have created barriers to timely and equitable patient care, with particular emphasis on the stress echo caveat, MPS item complexity, and GP-requesting pathways.

The AMA has consistently warned that poorly calibrated cardiac diagnostic settings can increase out-of-pocket costs and reduce timely access to care, especially in regional and remote areas where access to non-GP specialists is limited.

Evaluation of reforms should prioritise good clinical practice and patient outcomes rather than focusing primarily on utilisation measures.

The AMA notes stakeholder feedback that several cardiac imaging item descriptors and requesting pathways reflect legacy structures rather than contemporary clinical workflows. There is a risk that incremental amendments replace one source of complexity with another. The AMA encourages the department to use this post-implementation review as a stepping stone toward a more coherent modernisation of cardiac imaging items and explanatory notes, so that clinical indications, requesting pathways, and claiming rules align with current practice and support consistent interpretation by referrers and providers.

Phase 1 — Myocardial perfusion studies

The AMA supports the department's direction in Phase 1 to reduce unintended access barriers for myocardial perfusion studies (MPS) and to improve clarity in requesting and claiming, noting the department's summary that barriers have arisen from broad application of the stress echo caveat, separation of metropolitan and rural/remote structures, and rigid frequency restrictions.

The AMA also encourages the department to consider whether separate GP-requested and specialist-requested MPS item numbers remain necessary where the clinical indication and the Medicare benefit are effectively the same, noting this split can add avoidable complexity for referrers and providers, including in regional and rural settings where GPs coordinate most cardiac care. Any simplification should preserve appropriate safeguards for low-value use while removing administrative distinctions not reflecting clinical reality.

To support appropriate use and reduce unintended substitution effects, the AMA recommends practical decision support and education for referrers on the appropriate role of stress echo, MPS, and CTCA in contemporary care pathways, consistent with previous advice that education can improve appropriateness without relying solely on restrictive claiming rules.

Stress echo caveat — exertional dyspnoea and known coronary artery disease

The AMA supports adding exertional dyspnoea as an explicit exception in relevant specialist-requested MPS items, consistent with the department's rationale dyspnoea can represent an anginal equivalent and exclusion has contributed to delayed diagnosis and avoidable invasive angiography in some circumstances.

The AMA also supports an explicit exception for known coronary artery disease (CAD), noting the department's view that broad application of the caveat has restricted access to timely non-invasive assessment for patients with established disease and evolving symptoms.

These reforms will work in practice only if the department pairs descriptor changes with concise interpretive guidance supporting consistent application and claiming. The AMA recommends the department provide short explanatory notes and clinical examples clarifying how clinicians should document "undue exertional dyspnoea of uncertain aetiology" and "known CAD with evolving/poorly

controlled symptoms" so that legitimate care is not delayed by uncertainty or inconsistent interpretation.

In designing safeguards, the AMA cautions against overly prescriptive documentation requirements adding burden without improving care; simplicity often best supports compliance and usability, and it keeps clinical time where it belongs — with patients rather than paperwork.

The AMA acknowledges risks of inappropriate use whenever access expands and supports safeguards focused on

(i) clear explanatory notes emphasising appropriate indications, and
(ii) post-implementation monitoring that considers appropriateness and outcomes, not utilisation alone.

Frequency restrictions for repeat MPS

The AMA supports removing rigid 12- and 24-month restrictions for repeat MPS where clinically justified and appropriately requested, consistent with the department's description of unintended consequences under current arrangements (delayed testing, increased out-of-pocket costs, or unnecessary invasive procedures for some patients).

The AMA considers the most practical safeguard is to require reasonable clinical justification in the request (and/or report) without creating a new compliance maze. The department should avoid replacing a rigid time-based frequency restriction with equally rigid and prescriptive documentation requirements that increase administrative burden without improving care.[1]

Item 61410 clarity

The AMA supports clarifying that item 61410 can be requested by a medical practitioner, including GPs, where this reflects original policy intent and reduces administrative uncertainty in Modified Monash (MM) 3–7 regions.

The AMA recommends short guidance examples to support consistent use and reduce disputes about referral pathways, designed with rural practice realities in mind.

Phase 2 — structural reforms that require careful implementation design

The department proposes three medium-term initiatives: streamlining MPS item architecture, expanding GP requesting pathways for Medicare-eligible CTCA, and reconsidering CTCA credentialling requirements.

The AMA supports the objectives behind these proposals — reducing complexity and improving equitable access — but emphasises implementation details will determine whether benefits are realised or whether new barriers are inadvertently created.

Streamlining MPS items

The AMA supports simplification in principle, noting the department's record of stakeholder feedback that additional items increased administrative complexity and confusion without clear benefit.

[1] By "lock-out" settings, we mean MBS time-based claiming restrictions (for example, 12/24-month frequency restrictions for repeat MPS or a 5-year claiming restriction for CTCA); When we refer to "lock-in" settings we mean prescriptive administrative or documentation requirements attached to claiming.

However, removing MM 3–7 MPS items is an equity-sensitive change. The AMA recommends the department proceed only if it can demonstrate replacement criteria will preserve (and ideally *improve*) access for rural and remote patients in practice, including through clear definitions and practical guidance on when stress echocardiography is "not reasonably accessible".

We also recommend transition support (a consolidated fact sheet, examples, and targeted education) to prevent a repeat of earlier implementation problems that left clinicians navigating confusion and administrative burden.

GP requesting pathways for CTCA

The AMA supports introducing structured GP-requested CTCA access in principle, consistent with the department's rationale that specialist-only pathways can delay diagnosis and disproportionately disadvantage patients in rural and remote areas. We support clear eligibility criteria and safeguards to prevent inappropriate use for screening or low-value indications, which the department also flags as a risk.

The AMA recommends safeguards combining clear explanatory notes, targeted education, and monitoring focused on appropriateness and outcomes. This approach aligns with the AMA's broader position that clinical advice should guide service design and reform should enable clinically prudent non-invasive diagnostics without creating unnecessary administrative friction.

The AMA also reiterates its earlier view that rigid repeat restrictions for CTCA warrant careful design to ensure Medicare settings remain responsive to evolving clinical circumstances.

CTCA credentialling requirements

The department notes that additional credentialling beyond the Fellowship of the Royal Australian and New Zealand College of Radiologists (FRANZCR) may contribute to workforce maldistribution and constrain regional access, while also noting the need to protect safety and diagnostic quality and foreshadowing further consultation and potential MSAC processes.

The AMA supports addressing inequitable access and workforce sustainability while insisting any credentialling reform include appropriate safeguards and transitional arrangements to maintain service quality and diagnostic accuracy. This stance aligns with the AMA's diagnostic imaging principles that place safety and quality at the centre of funding and regulatory settings.

Implementation, monitoring, and what "good" looks like

Across both phases, the AMA encourages the department to treat administrative simplicity as an access and safety issue.

The AMA has received advice from specialist stakeholders that Medicare billing rules and explanatory settings do not always reflect contemporary cardiac diagnostic workflows, including multi-stage services where data capture and reporting occur at different times and increasingly through virtual systems. This reinforces the need for the department to pair any item changes with clear, practical guidance and examples aligning claiming rules with real-world service delivery, rather than relying on increasingly prescriptive administrative requirements.

Stakeholder experience outlined in the department's paper demonstrate revised structures were confusing and administratively complex; reforms should not solve one problem by inventing another.

The AMA recommends implementation support that's practical for clinicians: consolidated guidance, plain-language explanatory notes, and examples that reduce interpretive disputes and support consistent claiming.

We also recommend evaluation frameworks that include patient outcomes and appropriateness of care, not only utilisation or service volumes. The AMA has previously expressed concern where reviews lacked outcome measures and focussed disproportionately on counts rather than good clinical practice. This approach better reflects how clinicians and patients experience the system: timely diagnosis, appropriate modality choice, affordability, and equitable access regardless of location.

As a final comment, the AMA also notes stakeholder advice that cost pressures in nuclear medicine supply chains may affect the ongoing viability of some private Single Photon Emission Computed Tomography (SPECT) services, which could have flow-on effects for regional access and bulk billing. The department should consider service viability impacts when finalising MPS settings and monitoring implementation outcomes.

Contact

president@ama.com.au