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Dear Professor Robinson

Medicare Benefits Schedule (MBS) Review – Diagnostic Imaging Clinical Committee Final Report

I am writing to provide feedback on the final report of the Diagnostic Imaging Clinical Committee (DICC) that was received in September as part of the MBS Review Taskforce's targeted consultation.

The AMA commends the work of the DICC in making recommendations to update diagnostic imaging items to reflect modern, evidence-based medical practice. The AMA supports most of the recommendations including:

- the introduction of new MRI items;
- the replacement of clinical indications with general statements for some items;
- the removal of NK items, rebates on older equipment and remote area exemptions to support use of more up-to-date equipment; and
- the removal of co-claiming restrictions on several items which will provide significant benefits to patients, especially for those living in regional and rural areas, by removing the need for multiple visits.

The AMA has consulted with the Royal Australian and New Zealand College of Radiologists (RANZCR), the Royal Australian College of General Practitioners, and the National Association of Specialist Obstetricians and Gynaecologists. The AMA notes that RANZCR is responding in detail to numerous recommendations, reflecting its specialist expertise.

As always, the AMA defers to the relevant College, Association and Society on specific clinical matters, and calls on the Government to engage with the key stakeholders should any of these groups identify significant clinical concerns with the proposed changes to the MBS.

However, the AMA makes a comment regarding recommendation 13; and details its opposition to recommendations 14 and 37, and concerns regarding recommendation 15, below.

Recommendation 13: Remove the list of clinical indications from the item descriptors of >22 weeks pregnancy ultrasound items (MBS items 55718, 55722, 55723 and 55726) and allow access to these items to rely on clinical judgement.

Whilst the AMA agrees with this recommendation, we would like to take the opportunity to support RANZCR's suggestion of allowing GP's to request up to two scans per pregnancy, in line

with specialists; as many GPs undertake significant shared care.

Recommendation 14 – Prohibit claiming of items 55065, 55067, 55068, 55069 (pelvis ultrasound) for solely pregnancy related services.

The AMA cannot support this recommendation as it currently stands. It is not clear what is the definition of a 'solely pregnancy related' service. There are legitimate, important reasons why a pelvic ultrasound is required in women who may be pregnant. Radiologists still need to be able to check for ovarian torsion, uterine fibroid degeneration or infarct, or appendicitis in a pregnant patient.

Recommendation 15 – Include nuchal translucency (NT) assessment in the item descriptor for 12-16 week ultrasound items (55704, 55705, 55710 and 55711) with the addition of an explanatory note identifying NT assessment as an integral part of the examination, and remove current NT assessment items (55707, 55708, 55714 and 55716) from the MBS.

The AMA supports this recommendation in principle and agrees that nuchal translucency is an extremely important measure. However, there would need to be an increase in the MBS rebate to compensate for the extra training and certification required and for the extra time to undertake the assessment. There is additional complexity and skill required to take the measurement and not all ultrasonographers are skilled to the same level. Despite this, overall costs will still be lower because an increase in the rebate would be offset by avoiding a second scan.

Recommendation 37 – split the current item 57350 (CT spiral angiography) into three items with requesting restricted to specialists and remove the word 'spiral' from the item descriptor for CT angiography items.

The AMA opposes the restriction of requesting of this item to specialists only. Both radiologist and general practitioner AMA members consider that this part of recommendation 37 would be detrimental to patients.

There are multiple clinical examples where it is appropriate and cost-effective for a general practitioner to request a CT angiography. RANZCR has provided several examples in its submission. Additionally, if a patient has family members who have had intracranial aneurysms there is a good indication to rule out an aneurysm in the rest of the immediate family either with CT angiography or MRI angiography. CT is more readily available, and it is appropriate for a general practitioner to request it. Similar scenarios exist for general practitioners to request CT angiography for the thoracic aorta or the abdominal aorta and branches.

In urban areas there are often waiting lists to see an appropriate specialist and expensive gap payments. This restriction would be even more onerous for patients living in regional and rural areas where the appropriate specialist may not be available at all and a referral would require travel and time away from home and work.

The DICC report itself states that growth in use of this item is appropriate and reflects contemporary practise. There appears to be no indication of inappropriate use from general practitioners.

If there is indeed evidence that some general practitioner requests are inappropriate, a more effective and equitable approach would be to restrict requests to appropriate clinical situations. The use of software based clinical support tools has been recommended by the Diagnostic

Medicine Clinical Committee and should be considered rather than removing this item for general practitioners. This would ensure appropriate use while supporting access for patients.

Finally, it is not clear if the recommendation applies to a restriction to all 'specialists' or only specific specialists. If the former, there is even less logic to the proposed restriction.

Yours sincerely

Dr Tony Bartone
President