Legislation

- Legislation Health Insurance Act 1973

Regulations

- Health Insurance Regulations 1975 Health Insurance (Diagnostic Imaging Services Table)
- Regulations 2012 Health Insurance (General Medical Services) Table Regulations 2012

Determinations

- Health Insurance (Diagnostic Imaging Capital Sensitivity) Determination 2011
- Health Insurance (Bone Densitometry) Determination 2012
- Health Insurance (Diagnostic Imaging Capital Sensitivity) Facilities Determination 2011
- Health Insurance (Cone Beam Computed Tomography) Determination 2011
- Health Insurance (Gippsland and South Eastern New South Wales Mobile MRI service and Rockhampton, Bundaberg and Gladstone Mobile MRI service) Determination 2013
- Health Insurance (MRI for patients 16 years and over) Determination 2013

Legislative Instruments

- Health Insurance (Diagnostic Imaging Accreditation) Instrument 2010
- Health Insurance (Diagnostic Imaging Accreditation-Approved Accreditors) Instrument 2010
- Health Insurance (Diagnostic Imaging Accreditation-Designated Persons) Instrument 2010

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SUBMISSION FEEDBACK

Definition of Diagnostic Ultrasound

Background and Terminology as communicated to DIAC since 2013

Medical ultrasound use can be divided into 3 broad categories:

- Therapeutic – such as for tissue heating (in general use by physiotherapists), coagulation (currently experimental) and to control drug delivery (also experimental).
- Diagnostic – used to contribute information to the making of a diagnosis
- Intervention imaging – used to guide interventional procedures.

ASUM recognizes that diagnostic ultrasound examinations cover a spectrum of complexity in terms of time taken to perform and interpret an examination, skill required to obtain images, skill required to interpret images, machine requirements to obtain suitable quality images, etc.

- Ø On page 20 of the RIS there are multiple mentions of "non-diagnostic imaging specialists" and "minimum training requirements in order to perform MBS-eligible ultrasound services".
  - There doesn't appear to be a clear delineation of what is meant by "non-diagnostic imaging specialists" - all ultrasound examinations are "diagnostic" by their very nature.
  - We already have minimum training standards in place within various organisations, for example ASUM CCPU, RANZCOG, ACEM. These certifications would be perfect vehicles for these purposes.

ASUM supports the principle that remuneration rates vary between examinations to reflect these differences.

- ASUM believes that any medical practice that is recognized to be of benefit to the patient and provide efficient clinical outcomes should be reimbursed via the MBS. The particular funding schedule under which it is administered should not affect the level of remuneration.
- ASUM believes that any examination should require the practitioner to be suitably knowledgeable and experienced. In practice, this is best achieved by requiring practitioners to hold current qualifications / credentialing for an examination to be rebatable (see point 2 below).

A plethora of terms has been used to try and characterize the range of examinations that are performed. The different terms are confusing, often inherently illogical and frequently based upon historical and geographical patterns of practice (which differ between countries and regions due to historical variation rather than intrinsic requirements or value). Terms have often been coined to create pejorative implications and defend traditional business models rather than viewing the spectrum of uses from the perspective of either the patient or an efficient medical system.

ASUM recommends discarding terms that create confusion. These include:

- “Non-Diagnostic”- Other than therapeutic and interventional guidance, all ultrasound is performed with the aim of progressing towards a diagnosis. The distinction is thus fundamentally flawed. To use a phrase such as “fully diagnostic” is even more confusing, as it implies these examinations will give a single, definitive diagnosis without requiring the integration of clinical information or further testing, which is incorrect.

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- "Adjunctive clinical examination" is undefined and suffers the same problems as the terms above. From a patient's perspective (and a system that is aiming for efficient, quality medical care) all tests, regardless of complexity, are adjuncts to the clinical evaluation.
- Geographically based terms such as 'bedside' and 'point of care' should be abandoned. All ultrasound is performed by an operator who is in contact with the patient. The patient's location (e.g. in an imaging suite or elsewhere) is also irrelevant as the required skill and quality of an examination does not change based upon where a patient is.
- "Clinician performed" as many specialist imaging providers also practice as 'clinicians' (for example cardiologists and obstetricians & gynaecologists) this term is confusing. The required skill and quality of a scan are determined by the patient's needs, not the background of the practitioner.

ASUM recommends the terms "comprehensive ultrasound", "limited ultrasound" and "focused ultrasound" be used to capture the differences in the range of ultrasound examinations as introduced by the American Society of Echocardiography, J Am Soc Echocardiography 2013;26:567-81).

  - Focused = used in specific clinical settings to recognize a narrow list of potential diagnoses. As such, these examinations may have lower requirements for training and equipment and can often be performed more quickly.

  - Limited = an examination performed using the skill and equipment suitable for a comprehensive examination, but not undertaking the full protocol of a comprehensive examination.

  - Comprehensive = following a recognized protocol to obtain good quality images that are interpreted by a physician who has undertaken advanced training in ultrasound. Usually would be associated with a comprehensive report.

- Unless otherwise specified, referred examinations will usually be of the comprehensive type, but the referrer may request only a limited or focused examination in appropriate clinical circumstances.

- Non-referred examinations may be of any type, depending on the clinical requirement of the patient.

Point 1

- ASUM notes that all ultrasound examinations, across the spectrum from focused to comprehensive would meet the definition of "diagnostic ultrasound."

- ASUM recognizes the difficulty in creating an administrative framework for distinguishing between the different types of examinations.

Point 2

- ASUM agrees that all providers who perform ultrasound should be appropriately trained. The level of training required will correspond to the level of ultrasound examination being performed.

  Ø On page 20 there is mention made of credentialing, "Appropriate credentialing is

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important because it impacts on the quality of the images obtained, and therefore the diagnostic potential of the images." ASUM has policies and pathways in place which demonstrate minimum standards.

- Providers should undertake appropriate continuing medical education. Credentialing bodies should maintain records of providers who meet these requirements.

- ASUM agrees that the FRANZCR and DDU are appropriate qualifications for those providing comprehensive ultrasound services, and that other equivalent specialty training programmes be recognized.

- ASUM believes that the DDU is an appropriate qualification for all specialties performing comprehensive ultrasound services (including Obstetricians and Gynaecologists)

- ASUM believes other appropriate qualifications for Obstetricians and Gynaecologists are the certification in Obstetrical and Gynaecological Ultrasound (COGU) and certification in Materno-foetal medicine (CMFM).

- ASUM believes the appropriate qualification for focused ultrasound and non-referred ultrasound is the CCPU or equivalent.

Point 3

- ASUM recognizes that equipment needs to be of a certain standard to perform accurate and reliable comprehensive scans.

Point 4

- ASUM supports the principle that any request for imaging include information to assist in the interpretation of imaging findings.

Point 5

- ASUM supports a patient centered approach to information. That is, information pertaining to a patient should be provided and available in a manner that will maximize its utility to the patient and their care.

- ASUM supports requirements for image storage and reporting that enhances appropriate information transfer between practitioners involved in the patient's care.

- ASUM supports reporting that contains details of the imaging procedure undertaken:

    - all measurements and findings relevant to diagnosis, treatment and/or monitoring of the condition and

    - the limitations and exclusions of the examination (for example noting when particular organs have not been imaged (e.g. appendix during a pelvic scan).

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- The requirements for good reporting apply to all levels of ultrasound imaging, noting that the information format may vary (e.g. stand alone report versus integrated into clinical summary).

- ASUM encourages all ultrasound users to utilize appropriate electronic image storage systems as the best currently available method to store images for clinical purposes.

- ASUM also notes that suggestions that certain findings can only be used by certain practitioners (such as described in the RANZCR document "Position statement on the provision of medical ultrasound services") are illogical and contrary to a patient's best interest whereby information that is useful for patient management must be available to both the patient and other relevant practitioners who care for the patient.

Current Context

There are a number of different diagnostic imaging modalities available in Australia, including:

- ultrasound;
- computed tomography (CT);
- diagnostic radiography (DR) (eg. x-ray, mammography);
- magnetic resonance imaging (MRI); and
- nuclear medicine (NM).

In 2013-14 there were over 22 million Medicare eligible diagnostic imaging services provided resulting in over $2.9 billion being paid by the Department of Human Services (DHS) Medicare program in patient rebates. Ultrasound items 55005-55855 resulted in 8,570,775 services (37%) and $975,834,282 expenditure.

1. General 3,443,999
2. Cardiac 1,094,636
3. Vascular 942,538
4. Urological 26,547
5. Obstetric and Gynaecological 1,134,536
6. Musculoskeletal 1,928,519

<u>This feedback from ASUM will focus solely on Diagnostic Ultrasound.</u>

The Department of Health has released a Consultation Regulation Impact Statement (RIS) on improving the quality and safety of Medicare-funded diagnostic imaging.

The Government's objective is to ensure that Medicare benefits are claimed for diagnostic imaging services that are provided by appropriately qualified staff and that patients receive quality services that are clinically appropriate and safe. Inappropriate and/or sub-optimal use of diagnostic imaging can increase the risk of patient harm and contributes to unnecessary use of resources and expenditure.

Stakeholders have raised concerns with the current supervision requirements and the ambiguity surrounding interpretation of the regulations.

Without any changes it is likely that Medicare will continue to operate inefficiently by funding inappropriate and unnecessary imaging which has no benefit to the patient. Some patients will continue

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to receive lower quality and potentially unsafe services as there will be inadequate supervision of these services by diagnostic imaging specialists.

The three policy options proposed are

- 1 –No change
- 2 –Minor changes including clarification of current requirements.
- 3 –Practice based approach

Comments on each Option outlined in the Consultation Regulation Impact Statement will consider:

- 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.

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.

Currently under the DIST

MSK Ultrasound – Currently under the DIST
"the medical practitioner responsible for the conduct and report of the examination [must] personally attend during the performance of the scan and personally examine the patient" (DIST 2.1.7)

Other Ultrasound – Currently under the DIST
"under the professional supervision of an eligible provider who is available to monitor and influence the conduct and diagnostic quality of the examination, including, if necessary, by personal attendance on the patient" (DIST 2.5.3)

"under the professional supervision of a specialist in the specialty of diagnostic radiology who is available:
(i) to monitor and influence the conduct and diagnostic quality of the examination;
and
(ii) (ii) if necessary, to attend on the patient personally" (DIST 2.2.1)

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"under the professional supervision of a specialist in the specialty of diagnostic radiology who is available:
(i) to monitor and influence the conduct and diagnostic quality of the examination; and
(ii) if necessary, to attend on the patient personally" (DIST 2.3.2)

"under the professional supervision of a specialist or a consultant physician in the practice of his or her specialty who is available:
(i) to monitor and influence the conduct and diagnostic quality of the examination; and
(ii) (ii) if necessary, to attend on the patient personally" (DIST 2.1.2)

Comment
ASUM are not in support of Option 1.
Supervision requirements are ambiguous, as the level of onsite availability by the radiologist (or other medical practitioner) is not specified.

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.

Same level of supervision for CT, MRI, Ultrasound and Mammography: "The medical specialist must be available to:

- Observe and guide the conduct and diagnostic quality and safety of the imaging; and
- If necessary and in accordance with accepted medical practice, to attend on the patient personally, within a reasonable period of time."

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Comment

ASUM do not support Option 2.

The supervision definition does not improve on the current supervision definition,

"must be available"

Requiring the specialist to be available does not ensure that they will be on-site while services are performed.

- The effect is that the specialist only needs to be able to be on-site within a reasonable period of time when it is necessary to attend on the patient – this would allow them to 'supervise' multiple practices, which means they are not meaningfully available to attend at each practice.

"if necessary and in accordance with accepted medical practice"

'If necessary…to attend' implies patient risk – this suggests that the requirement is limited to contrast administration and interventional procedures.

- Limiting the requirement for a radiologist to be on-site to circumstances when it is necessary to attend on the patient is a very low bar. It has not been interpreted to mean that that the radiologist needs to attend patients when necessary to deliver a quality diagnosis and report – or to answer patient questions.

'Accepted medical practice' does not improve the clarity of the requirement – it is limited by the words "if necessary." What is "accepted medical practice" needs clarification in the context of each modality.

- In a high percentage of ultrasound examinations the physical presence of the radiologist is not required in order to provide supervision - modern technology can provide face-to-face opportunities for discussion & questions relating to particular examinations. The experience and qualification of the sonographer needs to be appropriate to such supervisory techniques.

"within a reasonable period of time"

Attendance within a reasonable period of time is vague – for example it could allow a radiologist to cover most of metropolitan Melbourne. This broad requirement has previously been interpreted as a 20 min walk rule by some practices, and within one hour's drive or one day's drive by others.

The current wording for the supervision of most ultrasound services is ambiguous. Under the current requirements a registered sonographer can perform the service on behalf of the practitioner however this does not specify the level of supervision required. R-type services must be performed under the supervision of a specialist or consultant physician, where a specialist may be a radiologist or specialist in the particular area being scanned, such as a cardiologist. Under the supervision requirements a specialist must be available to monitor and influence the scan, and if necessary attend on the patient personally. In practice, this creates some confusion over the level of supervision required (e.g. whether the specialist needs to be in the room, on the premises, or be available by phone).The new supervision definition lacks clarity and needs to be further developed to address the issues outlined and to provide effective minimum standards for diagnostic imaging providers and patients.

While ultrasound services do not have the same safety concerns as with other modalities without appropriate supervision there is no assurance that services will be performed correctly and capture the necessary images to allow for an appropriate diagnosis and therefore treatment options for the patient. This will result in repeat imaging for the patient and potential patient harms with delaying or missing a diagnosis along with additional costs to Medicare.

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Diagnostic imaging services are provided in a mixed range of practice types – the options need to support different business models. The aim is for practices to retain flexibility within a framework of clear requirements.

It is vital that changes made to improve the quality and safety of Medicare-funded diagnostic imaging services support quality and access throughout rural and remote Australia.

Technology improves access to diagnostic imaging services in rural and remote communities, but it is important that regulations do not unintentionally undermine the good work of radiologists located in these communities.

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

MSK & Breast Ultrasound

An improved supervision rule that ensures the medical specialist or consultant physician:

- is available on-site
- provides consultative supervision
- attends on patients in accordance with accepted medical practice

Exemptions for after hours and reasonable breaks (up to three hours)

Comment

ASUM support the proposed change to MSK supervision requirements to align them with the rest of the ultrasound modality. There are many instances where the supervising radiologists do not have appropriate MSK ultrasound skills and yet "supervise" the scan. A doctor for doctor's sake does not enhance the quality and only adds cost to the consumer. Musculoskeletal (MSK) ultrasounds do not require the personal attendance of a medical practitioner to be of diagnostic quality and should be aligned with the requirements of other ultrasound services. A practice based regulatory system with clear guidelines would negate the need to separate MSK from the other applications.

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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

While ASUM support Option 3 as the closest fit with ASUM guidelines there are some areas to direct future discussion.

Practice based supervision regulation can only be effective if there are clear regulations as to the qualifications required to undertake and supervise ultrasound examinations. For example, the person under the professional supervision of the radiologist would require the appropriate qualifications, credentials, to provide the service."

There needs to be clarification of what is termed 'appropriate'. This is within ASUM's brief in respect to medical practitioners and sonographers.

The supervision definition from Option 2 and presented in Option 3 does not improve on the current supervision definition.

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- Ensure that an off-site medical specialist or consultant physician can provide consultative supervision while the service is being performed through the use of technology. Otherwise, many rural and remote practices will close and patients will lose access to vital diagnostic services.

Regarding the feature above "The person under the professional supervision of the radiologist would require the appropriate qualifications, credentials, **or training** to provide the service". What does or training mean?

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 radiologists 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
A comprehensive practice meets the conditions of the current definition.

- The radiologist provides the supervision of the services within the practice and determines the appropriate level of supervision required.
- The radiologist is responsible for ensuring quality services and establishing protocols and appropriate procedures for the practice.
- The radiologist would have flexibility to implement and supervise efficient and effective processes, by determining the particular level of supervision required for particular services, including when it was necessary to personally attend a upon patient.
- The person who is under the supervision of the radiologist would continue to have the appropriate qualifications, credentials, to provide the service.

Practices would be required to maintain records to indicate the name of the radiologist who provided the supervision in addition to the name of the radiologist who compiles the report.

- •This will ensure accountability for practices making it clear who the supervising and reporting radiologists are.
- The supervising and reporting radiologists need not be the same person.
- The reporting radiologist would not have to be located on-site, but could be located anywhere in Australia, providing the practice had an appropriate mechanism for transmitting and storing images of satisfactory quality.

Practices providing the services within a comprehensive practice are likely to face increased costs to ensure that a radiologist is present for the minimum agreed hours.

Practices will also be subject to additional regulatory impact in order to establish the new policies and procedures in line with the proposed comprehensive practice model.

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In the longer term however the impact on comprehensive practices would be a reduction in regulatory burden as the radiologist would be responsible for setting and managing the supervision requirements for their practice.

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

For many practices, a radiologist may not be available on the premises for the entire day, and may share their time between several practices located in a similar geographical location.

- The radiologist could provide remote supervision for some services, such as telephone and on-line where the appropriately qualified person seeks guidance, but the onus would be on the radiologist to be capable of making themselves available to attend to the patient personally, within the examination, where it is necessary (i.e. where the supervision regulations require it).
- In this instance, the supervision requirements as they currently exist, along with the amended clarifications in option 2 to ensure the policy intent of the legislation is clear, would apply.
- Under the current supervision requirements, when the following services are being provided, the radiologist must be available in close proximity to supervise and influence the conduct of the service:
    - mammography;
    - the administration of contrast; and
    - image guided intervention procedures / surgical interventions.
- A radiologist is required to supervise the above services due to the potential safety risks associated with the administration of contrasts and other therapeutic substances and the consequences associated with incorrect imaging and misdiagnosis of mammography services.
- Aligning the supervision requirements to the original policy intent of the current legislation will close the loop-hole for providers who have interpreted the current wording of the DIST that a radiologist only needs to be on-site when 'necessary' and thus gain a commercial competitive advantage over diagnostic imaging providers who have an on-site radiologist.
- Only services that do not require the supervision of a radiologist will be able to be performed when the radiologist is not on site.
- The person who is under the supervision of the radiologist would continue to require the appropriate qualifications, credentials, or training to provide the service (e.g. radiation license).

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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 to the local service provision?
- Should the exemption not be available for certain types of services?

Comment

Under the proposed new arrangements rural/remote exemptions will not be possible or necessary for a comprehensive practice.

For non-comprehensive practices, without a radiologist in attendance a rural/remote exemption for the supervision requirements may still remain. Where remote/rural exemptions are required remote reporting rules could be expanded to require real time access to supervising radiologists in order to recognise the workforce constraints in these areas.

The intention of having rural exemptions is to ensure patients have access to services without compromising on quality. The aim is to encourage local radiologist attendance, even if it is not full time. Exemptions should not commercially disadvantage practices that provide local services.

The current arrangements for rural exemptions vary for each of the modalities, creating confusion due to an inconsistent approach. If a modality warrants a rural exemption, ideally the requirements for meeting this should be consistent across all modalities.

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?

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Comment
If supervision requirements are to be linked to a comprehensive practice model, there would still be need for modality specific regulation particularly with respect to diagnostic ultrasound, which is performed commonly in stand-alone settings. Future enhancements to quality standards via Sonographer Registration with AHPRA and improvements to practice accreditation would go a long way to assuring Australian consumers and government that diagnostic imaging services are safe and of high quality.

3. Any additional proposals, suggestions or comments?

Comment
As there is no requirement for diagnostic imaging specialists to meet minimum training requirements in order to perform MBS-eligible ultrasound services, practitioners without formal training are currently providing some services. In response to this concern and supported by a DI grant in 2011, ASUM have developed a broad range of Clinician Performed Diagnostic Ultrasound units which meet the current demand of Ultrasound services being provided by Point of Care Clinicians across Australia. Therefore, while
ultrasound services are currently being provided by a range of Clinicians where qualifications are not currently mandatory and quality variable, ASUM have an active framework for appropriate credentialing and request this be formalised with Medicare. Appropriate credentialing is important because it impacts on the quality of the images obtained, and therefore the diagnostic potential of the images that should be appropriately remunerated.