

A Submission relating to
Consultation Regulation Impact Statement
on Diagnostic Imaging & Accreditation

on

Improving the quality and safety of Medicare
funded diagnostic imaging services through the
enhancement of regulatory and accreditation
requirements

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respectfully submitted

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1. Introduction

This submission is made by the Chiropractic Australia Ltd, a newly formed association of Australia chiropractors. Chiropractic Australia champions inter-professionally collaborative and evidence-based diagnosis and treatment in the health care system. This response to the call for consultation on the Regulation Impact Statement May 2015 concerns itself to areas of interest to chiropractors and their patients.

1.1 Chiropractors participate in the diagnosis and management of Australians and commonly make use of radiology in doing so. They are trained and licensed to possess and use ionising X-ray machines and this important diagnostic tool has played useful role to chiropractic patients since the introduction of radiology services. Australian chiropractors either perform their own radiography or make use of the diagnostic imaging services provided within the health care system. While the importance of plain film radiography has declined with the advent of more recent technologies, X-ray diagnosis remains a vital component of the diagnostic work-up for patients with suspected red flag conditions, fracture or bone weakening disorders.

1.2 The application of spinal manipulation and other forceful manual procedures carries with it certain risks in some classes of patients and therefore the use of radiology is a strategy to improve patient safety in such cases and where a clear indication for radiology is determined. With this service chiropractors can provide more timely and effective service to patients, especially so in areas where reliance on the immediate availability of a radiologist may be limited.

2. Justification for chiropractors providing a limited radiology service

2.1 Chiropractors provide a safe and effective treatment options for patients with musculoskeletal mechanical pain syndromes and radiculopathies. An important component contributing to safety and effectiveness is the opportunity to provide a limited radiology service which concentrates on the timely examination of the patient to screen for biomechanical instabilities or pathologies which would form immediate contraindications to treatment. this Appropriate image. These clinical decisions can be made at the time of the initial consultation and prior to the rendering of care.

2.2 Most chiropractors rely on existing full-service radiology clinics to assist them in this regard. Some prefer to offer a limited service in-house, while others are compelled to offer radiology services as they operate in remote or rural locations which make the availability of prompt radiology diagnostic support difficult.

2.3 Therefore, in keeping with the principles under which Medicare operates, chiropractic radiology services “are provided by appropriately qualified professionals, who have the training, knowledge and experience required to provide quality outcomes for patients and ... patients receive services that are clinically appropriate, safe and provide benefit” .

3. Chiropractors have appropriate qualifications, training, knowledge and experience to support radiologists

3.1 Chiropractors in Australia are university qualified, in accredited training programs in radiography, radiology and relevant associated areas such as pathology and orthopaedics in areas of importance to chiropractors.

3.2 The training of chiropractors is underpinned by the education in biomedical sciences such as anatomy, physiology and so on.

3.3 Chiropractors are trained in radiography, radiology and diagnostic radiation safety to a standard and depth not less than medical practitioners or dentists. In terms of safety procedures and in the area of spinal radiography, chiropractors receive similar training as radiographers.

3.4 Therefore, we respectfully submit that chiropractors should have similar access to the usual Medicare funded radiology diagnostic opinions from radiologists as do general practitioners and dentists. This would recognise their training in radiation safety and radiographic technique, as well as limited orthopaedic scope radiology diagnosis on the basis of their education appropriate in these areas.

4. Appropriate Radiation minimisation

4.1 Chiropractic Australia supports the ARPANSA code in relation to safety in radiology. Accordingly, the ‘as low as reasonably achievable’ (ALARA) radiation dose principles are a requirement in chiropractic radiology. Chiropractic radiology involves the optimisation of radiographic factors such as distance, kVp and mAs to ensure that this principle is adhered to.

4.2 All X-ray procedures must conform to strict justification requirement, that is, the diagnostic value of the procedure must outweigh that radiation exposure to the patient inherent in this diagnostic.

4.3 Further, dose limits must never be exceeded in accord with RPS1 standards.

4.4 The Chiropractic Board of Australia code of conduct for chiropractors provides the following -

“Chiropractors use radiography for several purposes following the identification of various history and examination findings, including: confirmation of diagnosis/pathology; determining appropriateness of care; identifying contraindications or factors that would affect or modify the type of treatment/care proposed.”

5. Supervision required to ensure high quality, safe and appropriate images

5.1 Chiropractic Australia submits that chiropractic should be accepted as a non-comprehensive practice without a radiologist in attendance for diagnostic imaging within their scope of licensing.

5.2 Chiropractic radiology has a strong reputation in terms of image quality and we see no reason to suspect that the inclusion of chiropractors in this way would have any negative impact on the quality of radiographs.

6. Access for rural and remote area patients

6.1 The availability of chiropractic services in rural and remote regions of Australia represents an important contribution to the health of citizens in these areas.

6.2 Reduction of chiropractic imaging services in these regions would increase waiting time before a diagnosis could be made, or a serious pathology excluded, or indeed before the commencement of appropriate care. Because of the tyranny of distance, it is often the case that in these regions the timely identification of a diagnosis can have profound effects on the success or otherwise of a patient's management.

6.3 Removing a Medicare funded radiologist report in rural settings from chiropractors would increased financial hardship on a number of country practices.

6.4 Chiropractic Australia supports the Health Department in strategies designed to simplify regulations or the interpretation and application of policies such as may be possible in the Rural exemption clause, short of any change which would result in creating any hardship to Rural Patients.

SUBMISSION FEEDBACK

Please provide comments on all or any of the following, particularly in relation to each Option outlined in the Consultation Regulation Impact Statement:

- 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.

In addition, you may wish to respond to questions listed against specific Options.

Submissions should include substantiating evidence, where possible.

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.

Comment

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.

Comment

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

Deregulation of MSK ultrasound is desirable with respect to relaxation of supervision requirements. The impact on the system would be minimal and availability of service increased. It is unlikely that there would be a significant increase in usage as a result of such deregulation, nor is it expected that quality of service decline substantially.

Clarification of regulations in this area is important.

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

Ultrasound providers must be able to demonstrate that they possess appropriate credentials for safe and effective provision. To assist maintenance of quality and uniformity in reviewing service provision, a definition of diagnostic ultrasound should be adopted.

Equipment standards should be established and adherence to those standards monitored.

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 radiologist 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

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

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

Comment

Rural and remote exemption should remain in place with minimal change. It is important to maintain diagnostic services in these areas recognising that the access benefit that such exemptions provide outweigh the potential loss of quality normally achievable.

Distance rules may be difficult to administer reliably but represent an appropriate means of defining remoteness.

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?

Comment

3. Any additional proposals, suggestions or comments?

Comment

Chiropractic Australia Ltd. is a new organisation that advocates safe, effective, evidence based chiropractic care in order to improve public healthcare outcomes.

www.chiropracticaustralia.org.au

Established in June 2015 Chiropractic Australia Ltd has only now become aware of this Consultation Submission, hence this submission is brief.

As a new organisation and stakeholder in chiropractic in Australia with approximately 1,100 members already joined we respectfully request to be recognized as a stakeholder with the Department of Health and in this instance the Department of Diagnostic Imaging.

As a body devoted to evidence-based care in chiropractic and emphasising the value of a multi-disciplinary team approach in the diagnosis and care of Australians, Chiropractic Australia recognises and supports the initiatives of the Department of Health.