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27 November 2024

Diagnostic Imaging Section
Diagnostic Imaging and Pathology Branch
Medicare Benefits and Digital Health Division | Health Resourcing Group
Australian Government Department of Health and Aged Care
GPO Box 9848, Canberra ACT 2601, Australia

By email: radiology@health.gov.au

Dear Ms Warner,

Review of Select Medicare Funded Diagnostic Imaging Ultrasound Services

Thank you for the opportunity to make a submission into the Australian Government, Department of Health and Aged Care, Review of Select Medicare Funded Diagnostic Imaging Ultrasound Services.

The Australasian Sonographers Association (ASA) is the professional organisation for Australasian sonographers, who are the experts in ultrasound. With over 7,000 members, and representing more than 70% of Australasia's sonographers, the ASA's purpose is to foster a sonography profession that delivers high quality ultrasound with a vision to create a healthier world through sonographer expertise.

We acknowledge the work being undertaken by the Australian Government on this important area, to ensure equal affordability and access to the MBS for Australian women. We appreciate the opportunity to provide input.

Most importantly, we advocate for adequate funding that reflects the complexity, time, and investment in training required for imaging practices and departments to deliver affordable and accessible ultrasound examinations to all Australian women, to support their clinical needs.

As the experts in ultrasound, sonographers undertake most Medicare rebateable ultrasound examinations on behalf of the medical practitioner. Three quarters of sonographers work in a private practice setting and 11% work in obstetric and gynaecological ultrasound examinations.¹

To support our submission to this consultation, we have sought feedback from; the ASA Sonographer Policy and Advisory Committee, the ASA Women's Health Special Interest Group, and sonographer representatives with specialty experience and knowledge in ultrasound examinations for detection of endometriosis. We have provided detailed feedback in Appendix 1 attached, including general feedback and feedback in response to the consultation questions. Our response focuses on sonography clinical practice, and unless otherwise stated our response refers to the role of sonographers.

¹ Australasian Sonographers Association, 2024 Employment and Salary Survey. Available from: <https://www.sonographers.org/publicassets/f9272863-bf9b-ef11-9135-0050568796d8/2024-ASA-Employment---Salary-Industry-Report.pdf>



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In addition, as the experts in ultrasound and the highly skilled health professionals who undertake the majority of medical diagnostic ultrasound examinations, we would also like to request the opportunity to be involved in the initial stages of any future consultations where ultrasound examinations are being considered, to add to the feedback provided by other medical professionals and ensure the voice of sonographers is captured.

Thank you for the opportunity to contribute to this important discussion. We look forward to hearing the outcome of this consultation.

If you wish to discuss any aspect of our submission, please contact Elissa Campbell, General Manager Policy and Advocacy, at elissa.campbell@sonographers.org.

Yours sincerely,

A handwritten signature in black ink, appearing to be 'Tony Coles', written over a light blue horizontal line.

Dr Tony Coles
Chief Executive Officer



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Appendix 1 – ASA Feedback to the Review of Select Medicare Funded Diagnostic Imaging Ultrasound Services.

General Feedback

We acknowledge the significance of this review, and believe it is timely given the importance of medical diagnostic ultrasound examinations in supporting women's health and the need to rectify some clear challenges which include:

- Historical fee inequalities
- Poor affordability due to lack of indexation, increasing out of pocket costs, and low bulk billing rates
- MBS funding that does not reflect the complexity of the examinations and the time required for the procedure
- The need to review items relating to specific conditions such as endometriosis and multiple pregnancies
- Training requirements for practitioners performing complex ultrasound assessments.

Overall, we advocate for increased MBS funding in obstetric ultrasound to ensure it reflects the complexity, time, and expertise required to provide these services, and recognises sonographer time, reporting time, and facility fee. We also advocate for appropriate indexation to ensure funding continues to remain sufficient. Currently, the insufficient funding means service providers are strongly de-incentivised to provide obstetric ultrasound service, limiting services to women with clinical need.

It is notable that obstetric ultrasound has a very low rate of bulk billing, with feedback from sonographer members stating that whole sections of the country that are absent of bulk billing obstetric ultrasound services, for example the South-Eastern corridor in Melbourne, Victoria. For some private imaging clinics, this is the only suite of examinations not bulk-billed. This presents a significant risk to women who are not able to pay for services.



Feedback in response to the consultation questions

1. General Ultrasound Subgroup

1.1 Ultrasound of the Scrotum

What should the ultrasound of the scrotum fee relative be compared to that of the 17-22 weeks pregnancy scan? Please provide advice in the table found in Appendix C.

In response to this question, members agree that the fee for the 17–22 weeks pregnancy scan should be double that of an ultrasound of the scrotum, as it is more than twice the work and complexity. The 17-22 weeks ultrasound examination assesses the entire fetal body and includes colour and pulsed doppler assessment, incorporating an in-depth assessment of the fetal heart and brain. It also includes an assessment of the maternal uterus, cervix and placenta.

Additional comments include:

- We currently allow at least double the time for a 17-22 weeks pregnancy scan. In practice, an exam of an able-bodied scrotum patient could be over in less than 10 minutes, while an anatomy exam could take up to an hour.
- At our practice we allow an average of 20 minutes (scrotum) versus one hour (pregnancy).
- There are an average of 25 images per scan for scrotal protocol, versus 80 images for a 17–22 weeks pregnancy scan plus the additional transvaginal element.
- The pregnancy scan has a higher medicolegal risk for both the sonographer and radiologist and requires more extensive training due to the more complex knowledge and pathologies compared to a scrotum scan.

In addition to the comments about higher rates for the pregnancy scan, there was feedback about the scrotum scan:

- We do not support simply reducing the rebate for an ultrasound of the scrotum, as this is also currently not that generous. A scrotum ultrasound involves somewhat complex imaging including both colour and pulsed doppler ultrasound involving two organs within the body - the testicle and the epididymis.

1.2 Ultrasound of the Pelvis

Should the ultrasound scan of the pelvis be separated into items based on time and/or complexity?

Member feedback to this question was mixed. Comments include:

- While it's important to acknowledge the time and complexity of a pelvic exam, it's not always possible to know at the time of the booking or initial presentation how complex a case is.
- Applying 'expected complexity' alone could also lead to inefficiencies if patients are mistakenly considered lower complexity and allocated reduced (and insufficient) time, meaning they require another scan.
- It may be hard to determine what complex means, and a time-based approach may be too arbitrary and will vary between practices.



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- There was no such thing as a simple pelvic scan; every patient, other than the very young or those who decline, should have a transabdominal (TA) and transvaginal (TV) scan to gather the optimal information and answer their clinical question. It's not possible to know in advance if a scan for pelvic pain, for example, could become a more complex study to look for endometriosis. Therefore, adequate time should be allocated for every pelvic scan. Factors that could influence the study might include whether it is an initial scan, or a follow up of known pathology.
- It is important that the pelvic rebate covers the complexity of a gynaecological ultrasound – which contrary to popular belief is not a basic examination.
- The rebate should reflect a scan that uses transabdominal (TA) only; versus one that requires transvaginal (TV) with or without the addition of a TA also. This reflects that a TV examination is more complex, riskier, and requires additional time for consent and high-level disinfection (HLD) for probes. A chaperone may also be involved. If a TV scan is not remunerated at a higher rate than a TA scan, it will discourage providers from offering it – despite it being the gold standard in gynaecological imaging. It is common to see patients for a 'second opinion' purely because a TV scan was never offered during the initial examination.
- Recognition of complexity for indications such as endometriosis is important. A separate item is needed for deep infiltrating endometriosis assessment due to the increased complexity and experience required.
- Pelvic floor imaging could be a separate item number with a higher rebate given it requires extra knowledge, training and is a specialised examination.

In contrast, other comments include:

- Ideally all sonographers examining a woman's pelvis should be capable of assessing higher complex cases.
- Table 6 of the consultation document, that separates common exams into complexity levels, appears reasonable.

If the item should be split, should it be split into general time-based items or condition-specific items? Should there be a combination of both approaches?

Feedback to this question was mixed. Comments include:

- Support for the approach of splitting the item to reflect if it involves only a transabdominal scan, in contrast to a transvaginal with or without a transabdominal scan.
- Endometriosis is a very complex scan. Research demonstrates it takes longer to perform a thorough pelvic scan when endometriosis is present, even when it is undertaken by trained operators.²

In contrast, other comments include:

- A combination of approaches would be useful, as the time taken for a scan will depend on a variety of factors – such as severity of the condition, patient habitus, operator expertise, and equipment capabilities.

² Deslandes A, et al. Australasian Journal of Ultrasound in Medicine. How long does a transvaginal ultrasound examination for endometriosis take in comparison to a routine transvaginal ultrasound examination? Dec 2021. Available from: <https://doi.org/10.1002/ajum.12288>



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- In many cases condition-specific items would typically be appropriate, and 30 minutes is typically enough time for most conditions.

1.3 Endometriosis

Should an endometriosis-specific ultrasound item be introduced?

The ASA provided feedback to the Parliament of South Australia – Select Committee on Endometriosis (May 2024),³ where we highlighted the need for an endometriosis-specific ultrasound item to be introduced; with a MBS fee that reflects the complexity and time required to undertake the examination, and the additional training required for sonographers to become skilled in this area. Doing so would provide incentive to private practices to upskill staff and schedule sufficient time for sonographers to undertake this extended exam, improving access for patients.

Historically, diagnosis of endometriosis has largely occurred via key-hole surgery. However technological advances mean international guidelines now recommend an endometriosis ultrasound to support the diagnosis^{4 5} and enable appropriate preparation for complex surgical cases. In some cases, it can replace the need for surgery altogether.

Current guidelines for gynaecological ultrasound in Australia suggests that only the uterus and ovaries should be assessed as part of a routine transvaginal ultrasound exam.⁶ In order for endometriosis to be detected sonographically however, the examination must be extended beyond this to include an assessment of the anterior and posterior pelvic compartments.⁷ A 2022 study revealed performing a transvaginal ultrasound to detect endometriosis (eTVUS) takes, on average, 71% longer than performing a standard transvaginal ultrasound.⁸ Currently, imaging providers need to absorb the cost of this extra time or pass it on to patients with a gap charge.

Performing an endometriosis-specific ultrasound requires training for sonographers beyond that provided in Medical Sonography Graduate Diploma courses, with scanning endometriosis considered

³ ASA Response to the Parliament of South Australia - Select Committee on Endometriosis (May 2024). Available from: https://www.sonographers.org/publicassets/5f704aca-a127-ef11-9130-0050568796d8/ASA-Response_Parliament-of-South-Australia_Select-Committee_Endometriosis_May-2024_Final.pdf

⁴ Deslandes A. and Condous. G. A Prof. Can you be diagnosed with endometriosis from an ultrasound? (Internet). Endometriosis Australia. Cited 21 May 2024. Available from: <https://endometriosisaustralia.org/diagnosed-endometriosis-ultrasound/>

⁵ Deslandes A., Panuccio, C., Avery, J., Condous, G., Leonardi, M., Knox, S., Chen, H., Hull, M. Are sonographers the future 'gold standard' in the diagnosis of endometriosis? (Internet). Sonography. 2024 Jan. Available from: <https://onlinelibrary.wiley.com/doi/full/10.1002/sono.12402>

⁶ Guidelines on the Performance of a Gynaecological Ultrasound Examination [Internet]. Australasian Society for Ultrasound in Medicine; 2020 [cited 2023 Sep 20]. Available from: <https://www.asum.com.au/files/public/SoP/curver/Obs-Gynae/Gynaecological-GL-2020.pdf>

⁷ Guerriero S, Condous G, van den Bosch T, Valentin L, Leone FPG, Van Schoubroeck D, et al. Systematic approach to sonographic evaluation of the pelvis in women with suspected endometriosis, including terms, definitions and measurements: a consensus opinion from the International Deep Endometriosis Analysis (IDEA) group. *Ultrasound Obstetrics & Gynecology*. 2016;48(3):318–32. Available from: DOI: [10.1002/uog.15955](https://doi.org/10.1002/uog.15955)

⁸ Deslandes A, Parange N, Childs JT, Osborne B, Panuccio C, Croft A, et al. How long does a transvaginal ultrasound examination for endometriosis take in comparison to a routine transvaginal ultrasound examination? *Australasia Journal of Ultrasound in Medicine*. 2022;25(1):20–7. Available from: DOI: [10.1002/ajum.12288](https://doi.org/10.1002/ajum.12288)



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an advanced skill within the Australian Sonographers Competency Framework.⁹ As such, offering eTVUS requires imaging providers to invest in further education for their staff, again presenting a cost which must be passed onto patients.

A recent study from the University of South Australia revealed that sonographers working within public hospitals and bulk-billing clinics were significantly less likely to perform eTVUS than those working within specialist women's ultrasound clinics.¹⁰ Analysis of a select private clinics in Melbourne, Sydney and Adelaide indicates out of pocket costs ranging from around \$250 to \$470. The MBS rebate is typically \$90.05. As we understand it, there is currently no bulk-billing services for patients to access a transvaginal ultrasound to detect endometriosis in private radiology services in Australia. This represents a sizeable out of pocket expense for patients, and a risk to those not able to afford this.

Most gynaecological ultrasound examinations in Australia occur within radiology clinics which often offer a wide scope of imaging across modalities, including CT and MRI. As a MRI item number exists for endometriosis investigation (63563), which currently pays significantly more than an eTVUS (schedule fee of \$441.45 vs \$110.20 for 55065), radiology providers are currently incentivised not to offer eTVUS in favour of offering MRI to investigate endometriosis. Ultimately, not having an MBS item specific to eTVUS could result in greater costs to the MBS in the long term with additional MRI examination being performed, which would not be necessary if the ultrasound were extended where possible.

In contrast, we received limited feedback to suggest:

- Endometriosis assessment should be a part of a standard pelvic ultrasound in this current clinical environment, however, a specialised code that could be used in a specialist setting could be introduced.

Should there be two items distinguishing between initial diagnosis and a high complexity mapping of all relevant structures when clinically relevant?

Member feedback to this question was mixed, influenced by several factors. Comments include:

- Yes, and no. We advocate for one code for endometriosis ultrasound and one for routine pelvic ultrasound which remunerate enough for a basic assessment for endometriosis to be performed - which the current rebate does not. To elaborate:
 - Currently, international best practice for endometriosis transvaginal ultrasound (eTVUS) suggests performing the ultrasound in line with the recommendations of the

⁹ Childs J, Thoires K, Osborne B, Halligan T, Stoodley P, Quinton A, et al. Professional Competency Framework for Sonographers [Internet]. Australia: Australian Sonographer Accreditation Registry; 2021 [cited 2022 Dec 11]. Available from: https://figshare.com/articles/online_resource/Professional_Competency_Framework_for_Sonographers/171480

¹⁰ Yang X, Deslandes A, Cross T, Childs JT. Transvaginal Ultrasound for the Diagnosis of Endometriosis: Current Practices and Barriers in Australian Sonographers. AJUM. Under Review.



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International Deep Endometriosis Analysis (IDEA) consensus.^{11,12} This means, an eTVUS should be comprehensive enough to cover both an initial diagnosis and comprehensive mapping prior to surgery. However, a recent study from the University of South Australia¹³ revealed that although many Australian sonographers self-report performing eTVUS, this is only performed in line with the recommendation of the IDEA consensus approximately 25% of the time, with the rest of the time in effect being a 'partial eTVUS'.¹³

- Performing an eTVUS to map severe endometriosis presents one of the most challenging ultrasound exams across any organ system, as anatomy typically becomes distorted. Accurate mapping will be difficult to achieve for those working in setting without high exposure to complex gynaecological cases (such as suburban radiology clinics).
- Recently, two protocols involving less complexity than the IDEA consensus have been proposed for the initial diagnosis of endometriosis with transvaginal ultrasound.^{14,15} The Society of Radiologists in Ultrasound (SRU), based in the United States, proposed an Augmented Pelvic Ultrasound, which adds organ mobility and the collection of several standardised cine clips of the posterior compartment for off-line review by a Radiologist to the rTVUS.¹⁵ They suggest this could add no more than 5 minutes to an rTVUS. Similarly, Deslandes & Leonardi¹⁴ proposed a simplified protocol of the IDEA consensus (rTVUS plus assessment of uterine mobility, the uterosacral ligaments, pouch of Douglas and upper rectum) to reduce complexity whilst focusing on the areas most affected by endometriosis. They suggest this could likely be achieved within a 30-minute appointment time (or approximately 15 minutes less allocated time than the IDEA protocol). While both these methods are in the literature, and potentially are being adopted into clinical practice, several things need to be considered in relation to creating MBS items for them.
 1. Neither of these methods have been tested in diagnostic accuracies studies to date; meaning the diagnostic value of these is currently unknown.
 2. The SRU consensus¹⁵ aims to act as a screening test for signs of endometriosis (both direct and indirect) which would then lead onto further imaging (either comprehensive eTVUS or MRI). As such, it is questionable whether having a

¹¹ Guerriero S, Condous G, van den Bosch T, Valentin L, Leone FPG, Van Schoubroeck D, et al. Systematic approach to sonographic evaluation of the pelvis in women with suspected endometriosis, including terms, definitions and measurements: a consensus opinion from the International Deep Endometriosis Analysis (IDEA) group. *Ultrasound in Obstetrics & Gynecology*. 2016;48(3):318–32.

¹² Guerriero S, Condous G, Rolla M, Hudelist G, Ferrero S, Alcazar JL, et al. Addendum to the consensus opinion from the International Deep Endometriosis Analysis (IDEA) group: sonographic evaluation of the parametrium. *Ultrasound in Obstetrics & Gynecology* [Internet]. [cited 2023 Dec 9]. Available from: <https://onlinelibrary.wiley.com/doi/abs/10.1002/uog.27558>

¹³ Yang X, Deslandes A, Cross T, Childs JT. Transvaginal Ultrasound for the Diagnosis of Endometriosis: Current Practices and Barriers in Australian Sonographers. *AJUM*. Under Review.

¹⁴ Deslandes A, Leonardi M. Proposed simplified protocol for the initial assessment of endometriosis with Transvaginal Ultrasound. *Ultrasound in Obstetrics & Gynecology*. 2024.

¹⁵ Young SW, Jha P, Chamié L, Rodgers S, Kho RM, Horrow MM, et al. Society of Radiologists in Ultrasound Consensus on Routine Pelvic US for Endometriosis. *Radiology*. 2024 Apr;311(1):e232191.



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separate billable item for this would be economically beneficial to the MBS or result in higher spending.

3. The proposal by Deslandes & Leonardi¹⁴ aims to result in an initial diagnosis of endometriosis with direct visualisation of lesions. As this opinion was led by an Australian sonographer, its design is very suited to ultrasound practice in Australia. However, as was outlined by the authors in this paper, given the prevalence of endometriosis, and the high prevalence of people presenting for TVUS with symptoms of endometriosis,¹⁶ consideration needs to be given as to whether this, or a similar protocol incorporating a basic assessment for endometriosis should be the routine standard of care TVUS.

Further comments include:

- Yes, there should be two items; an initial examination that is suspicious of endometriosis and an endometriosis specific item should be available for the detection / mapping of deep endometriosis. The mapping items should not be available only after the initial diagnosis, as some women will go directly to specialist centres for deep endometriosis assessment.
- Yes, there should be two items, but there is uncertainty over how it would work in rural settings. As patient often need to travel significant distances to attend appointments, sonographers may only see the patient once and so will extend the initial exam to include the deep endo assessment to avoid the patient needing to travel for another scan, which may or may not be before they see the specialist. This way the specialist can receive scans before they see the patient to understand the severity and plan telehealth appointments before surgery dates. If there were two items, which one they would use and asks how it would be determined by Medicare?

In contrast, feedback received that did not support having two MBS items include:

- Research has demonstrated that endometriosis can be diagnosed on ultrasound in the general imaging setting as well, as long the sonographers are adequately trained in the procedure and more time allocation is provided.
- If the rebate remains the same, then having two items could cause confusion as what is considered complex is subjective.

What training should be required for this scan?

Feedback in response to this question highlighted some challenges and recommendations in relation to training required to undertake an ultrasound examination of endometriosis. Comments include:

- Sonographers appropriately trained in endometriosis pelvic ultrasound examinations can greatly assist in earlier diagnosis and enable appropriate preparation for complex surgical cases. This can provide significant benefits for patients and enables improved efficiency and potential cost savings across the healthcare system.
- Specialist endometriosis ultrasound exams, which are distinct from routine pelvic ultrasound exams, are relatively new and require specific skills. Undertaking one is considered an

¹⁶ Young SW, Jha P, Chamié L, Rodgers S, Kho RM, Horrow MM, et al. Society of Radiologists in Ultrasound Consensus on Routine Pelvic US for Endometriosis. *Radiology*. 2024 Apr;311(1):e232191.



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advanced scope of sonography practice. Gynaecologists, and appropriately trained and credentialed radiologists and sonologists, may also undertake these exams.

- Currently there is no specific training program for this exam. Training should involve both theoretical and practical components, with input ideally from a specialist sonographer and gynecologist. Along with ASAR sonographer ultrasound training, members mentioned other ultrasound training programs suited to other practitioners such as the ASAR Diploma of Diagnostic Ultrasound (DDU), Maternal Fetal Medicine (MFM), or the RANZCOG Certificate of Obstetrical and Gynaecological Ultrasound (COGU). In all cases, it is essential the practitioner has undertaken sufficient endometriosis specific training / experience; and not be limited to general gynaecological imaging.
- In terms of sonographers, while 11% identify obstetrics and gynaecology as their primary area of ultrasound practice¹⁷, only a limited number are confident performing these exams; most of whom work in private specialist imaging clinics. As such, most of these exams are currently undertaken in private, specialty clinics; few are performed in public hospitals or clinics.
- Research shows most sonographers currently undertake self-directed learning through online events (e.g. webinars), self-directed reading or attending conferences; combined with mentoring and supervision of a specialist sonographer or gynecologist.

Member feedback highlights the importance for the relevant MBS item to be linked to adequate training of staff to maintain high standards for patients and reduce the risk of misuse by providers who may bill for this higher paying item, yet providing an insufficient service. For sonographers, this would involve:

- A minimum amount of quality theoretical training beyond GradDip level.
- A minimum number of logbook cases performed with supervision. Some evidence suggests competency can be achieved after about 50 cases,^{18 19 20} however, in lower prevalence settings (like general radiology) the number is likely greater given the lower exposure to disease people will have which will make gaining the pattern recognition needed longer.
- However, it's noted there are significant challenges with this in relation to having appropriate supervisors – for which there is no easy answer.

As reflected in the ASA response to the South Australia - Select Committee on Endometriosis,²¹ to support improved care and outcomes for patients, the ASA recommends:

- Expanding training and support for sonographers to undertake endometriosis pelvic ultrasound exams.

¹⁷ Australasian Sonographers Association. Australasian Sonographer Employment and Salary Industry Report. 2022.

¹⁸ Menakaya U, Infante F, Lu C, Phua C, Model A, Messyne F, et al. Interpreting the real-time dynamic 'sliding sign' and predicting pouch of Douglas obliteration: an interobserver, intraobserver, diagnostic-accuracy and learning-curve study. *Ultrasound in Obstetrics & Gynecology*. 2016;48(1):113–20.

¹⁹ Guerriero S, Pascual M, Ajossa S, Rodriguez I, Zajicek M, Rolla M, et al. Learning curve for ultrasonographic diagnosis of deep infiltrating endometriosis using structured offline training program. *Ultrasound in Obstetrics & Gynecology*. 2019 Aug;54(2):262–9.

²⁰ Aas-Eng M, Salama M, Sevelde U, Ruesch C, Nemeth Z, Hudelist G. Learning curve for detection of pelvic parts of ureters by transvaginal sonography: feasibility study. *Ultrasound in Obstetrics & Gynecology*. 2020 Feb;55(2):264–8.

²¹ ASA Response to the Parliament of South Australia - Select Committee on Endometriosis (May 2024). Available from: <https://www.sonographers.org/publicassets/5f704aca-a127-ef11-9130-0050568796d8/ASA-Response-Parliament-of-South-Australia-Select-Committee-Endometriosis-May-2024-Final.pdf>



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- Increasing funding and support for training in the public sector to upskill sonographers and other relevant health care practitioners to better understand and utilise ultrasound to support non-invasive diagnosis and improved triaging of necessary surgeries.
- Additional training for radiologists and referring GPs to understand the advancing capabilities of ultrasound, to ensure efficient referring and accurate reporting to support timely diagnosis and management for patients.
- Ongoing education for the public regarding the role of specialist endometriosis ultrasound examinations in diagnosis and management.

2 Vascular Ultrasound Subgroup

2.1 Duplex Scanning of the Penis

What should the ultrasound of the penis fee relativity be compared to that of the 17-22 week pregnancy scan? Please provide advice in the table found in Appendix C.

Overall, members thought that the inequality of the MBS fees for these two types of ultrasounds were significant and believe the fee relatively should be significantly less for the penis ultrasound. Members suggested from 0.2 to 0.8. Additional comments include:

- Although there is an injection involved, the complexity of the ultrasound component is notably less than the 17-22 week pregnancy ultrasound - where the subject (the baby) is complex in itself, and must be interrogated in its entirety while inside another human being (the mother) while also being mindful of any relevant pathology relating to the mother.
- One member noted that duplex scanning of cavernosal artery of the penis for ED is often performed in a specialist area. While penile ultrasound for fibrosis/Peroni's disease is the more usual scan requested in general practice. This is a relatively quick and straightforward study as the single organ in question is external to the body, easily accessible, and easy to image.

Should items 55282 and 55284 be merged into a single item covering both services?

We received limited feedback on this question. Comments include:

- Combining the two items seems appropriate.

3 Urological Ultrasound Subgroup

3.1 Ultrasound of the Prostate, Bladder Base and Urethra

What should the relative fee of a prostate ultrasound be compared to the 17-22 weeks' pregnancy scan? Please provide advice in the table found in Appendix C.



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Member feedback to this question supports a higher fee for the 17-22 weeks' pregnancy exam compared to a prostrate ultrasound. Comments include:

- That the 17-22 weeks' pregnancy scan rebate should be about \$250.
- The fee for a prostrate ultrasound should be less than 17-22 weeks' pregnancy scan, with a relative fee of 0.5 to 0.7.
- The fee for 17-22 weeks' pregnancy scan should be higher than a male renal scan as the pregnancy scan:
 - Involves a higher number of average images (80 plus additional transvaginal component in most), compared to 30 for a renal scan.
 - Has a higher medicolegal risk for sonographer and radiologist.
 - Requires more extensive training for both practitioners.
 - Involves more complex knowledge and complex pathologies.
 - Typically take more than double the length of time.

Should items 55600 and 55603 be merged into a single item?

Member feedback to this question were mixed, however most thought merging seemed appropriate.

In contrast, other feedback suggested that no 55603 could remain its own item number specific to invasive transrectal ultrasounds.

4 Obstetric and Gynaecological Ultrasound Subgroup

4.1 Multiple Pregnancy Items

Should the multiple pregnancy items be removed, and the singleton items billed once per foetus?

Member feedback to this question was mixed, but all respondents support the need for any related items to (in total) reflect the complexities of a multiple pregnancy that encompass the individual needs of each foetus plus additional interrelated factors.

Those who do not support removing the multiple pregnancy item (and using the singleton item once per foetus) highlight that:

- Multiples are nuanced and should be treated separately.
- The pregnancy should be identified and billed as a multiple pregnancy as they on their own have their own complex nature.

Those who do support the recommendation highlight:

- Removing the multiples and charging per fetus is appropriate as the same amount of time is spent on each fetus, and sometimes more imaging is required than in single pregnancies. This change would also allow the reflection of time spent on for example a triplet morphology examination which is currently not reflect by the item numbers. It may also prevent accidental



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errors of not billing as a multiple by one provider, that means subsequent billing for multiples being rejected.

- All babies in a multiple pregnancy need to be assessed independently in their entirety and can take longer than singletons due to their complex relationships.
- In addition, there should be specific support for *monochorionic* multiples as the number of scans performed per pregnancy are at least doubled due to close monitoring of their pregnancies. These women are out of pocket substantially in the private sector. This may lead to skipping important ultrasound examinations to save money, or moving to fetal maternal units increasing the burden on the hospital system.

Should the items not requiring a request (NR items) be limited to Maternal Foetal Medicine (MFM) subspecialists?

Member feedback was mixed but in general did not support this recommendation. Comments include:

- Yes, in general the NR item should be limited to Maternal fetal medicine specialists
- If this is limited to MFM, how is this not rebateable?
- No. Item numbers need to be available in the rural setting where a radiologist may not be available to provide a request form and a scan is required (e.g. ED presentation, reduced movement)
- No. About 1 in 20 morphology scans cannot be completed in one session due to fetal positioning and need to be recalled on another day to complete the examination. Currently, the NR MBS item is the only remuneration available for this second attendance unless a second referral can be sourced from the referring doctor (which is often not possible without delaying care for the patient). Removing this may discourage reporting practitioners from recalling patients to complete examinations.
- No. Given the shortage of sonographers, it is helpful to enable obstetricians and GP obstetricians for example, to able to perform bedside scans for limited things (like checking heart beats for anxious mothers).

Should there be specific items for monochorionic multiple pregnancy assessment?

Feedback was largely in support of a specific item for *monochorionic multiple pregnancy assessment* but also noted due to their complexity they are often managed through tertiary care. Comments include:

- Monochorionic multiple pregnancy need a unique approach with far more Doppler assessment which takes more time and needs more skill.
- This is highly complex and often requires tertiary management so item number could be separated from dichorionic diamniotic twin pregnancy (DCDA).
- Not necessarily, but they need to be rebated at an appropriate level.

4.2 First trimester scans



Should the nuchal translucency assessment be able to be claimed on the same day as the development and anatomy item? How should the differing clinical windows be managed?

Feedback from members in response to this question is summarised below:

- The item for *nuchal translucency assessment (NT) and 12-16 weeks* should be combined. There's little/no difference between them from a scanning POV. Guidelines from ISUOG say anatomy should be assessed in the first trimester screening (FTS) so doing a "one stop shop" makes sense. The combined first trimester screening (cFTS) calculation is an additional bit of work, but this is often done for pre-eclampsia (PE) screening even when non-invasive perinatal testing (NIPT) is performed. The optimal time to assess anatomy is 12+0-14+0 weeks which can align with cFTS if needed.
- The NT and development and anatomy scan should be able to be claimed on the same day, as they are currently performed on the same day. There would be a vast increase in the number of scans performed if these had to be performed separately. Although NIPT is available, there are an increasing number returning to NT scan due to the economy and the exorbitant cost of NIPT. Screening for PE, which is performed at the same time as NT examinations is becoming more readily available and many women are requesting it.
- Ultrasound performed at 12-16 weeks is more difficult to perform due to the size of the fetus and the position of the uterus. NT and PE screening are only available to those accredited to perform this assessment and therefore the examination of development and anatomy should be equivalent to the 17-22 weeks examination. If screening is performed, then an additional item number should be available for this that can be billed on the same day. Screening should also include a counselling item number for the counselling and consent that must accompany the screening process.
- If performing a risk assessment and an anatomy scan, then yes, both should be able to be claimed, as the process of cFTS is complex and requires multiple resources to be able to complete.
- Now PET screening is becoming more common, these cases are often being extended out in time and more is expected to be done within the time frame of a normal nuchal screen.

What should the relative fee of first trimester ultrasound examinations be compared to the 17-22 weeks' pregnancy scan? Please provide advice in the table found in Appendix C.

In response to this question, members indicated:

- It should be almost 1.0, as a FT scan with PE screening is a similar amount of work to a 17-22 weeks' pregnancy (morphology) scan.
- It should be equal to the morphology scan, as the combined first trimester screening ultrasound requires a lot of resources and extra costs involved. While the time scan is less, there are more behind the scenes work and resources required, e.g. fetal medicine foundation (FMF) software, staff member to calculate the risks, sonographer to scan, radiologists to report and interpret, and the cost of licensing to both sonographer and the practice.



What training should be required to conduct these examinations?

In response to this question, members suggested:

- All general entry level sonographers should be able to conduct a first trimester scan. Additional training/experience may be required for the 17-22 weeks' scan.
- This is in the core competency for sonographers so it should be within an ASAR accredited Graduate Diploma ultrasound qualification. The ASAR Professional Competency Framework for Sonographers²² lists NT as an advanced skill, but the established FMF certification process could be linked to the MBS if a separate number for Combined First Trimester Screen (cFTS) was adopted. (However, the member also noted in practice, it's not difficult, as the NT should be measured as per ISUOG guidelines in any FT anatomy assessment).
- Possible courses include: a recognised ultrasound training program such as COGU, MFM, DDU and accredited sonographer ultrasound training with the ASAR for anatomy examinations and RANZCOG accreditation for nuchal translucency / pre-eclampsia screening.

4.3 Cervical Length

Should transabdominal cervical length be included as part of the 20-week foetal morphology scan, with an additional item claimable if transvaginal screening is indicated?

Members agree, yes to both questions. Comments include:

- Guidelines indicate the cervix should be measured at every 20-week foetal morphology scan. Accepted practice (depending on local guidelines) is that cervical length will be assessed transabdominal (TA), and if not seen adequately (e.g. measured < 35mm), then transvaginal (TV) is indicated as an expected part of the study.
- An additional item to claim for transvaginal (TV) assessment of the cervix on the same day is appropriate and this is clinically appropriate. Performing a TV assessment of the cervix adds 5-10 minutes to the examination and uses extra resources, which should be remunerated.^{23,24}

Is it clinically appropriate to perform a transvaginal assessment of cervical length at the same time as a morphological assessment?

Members agree that this is clinically appropriate, commenting that:

²² Australian Sonographer Accreditation Registry (ASAR). Professional Competency Framework For Sonographers: Available from: <https://www.asar.com.au/public/90/files/Professional%20Competency%20Framework%20for%20Sonographers.pdf>

²³ Masters HR, Warshak C, Sinclair S, Rountree S, DeFranco E. Time required to complete transvaginal cervical length in women receiving universal cervical length screening for preterm birth prevention. J Matern Fetal Neonatal Med. 2022 Aug;35(16):3114-3118. doi: 10.1080/14767058.2020.1811666. Epub 2020 Aug 30. PMID: 32862742.

²⁴ Westerway SC, Pedersen LH, Hyett J. Cervical length measurement: Comparison of transabdominal and transvaginal approach. Australasian Journal of Ultrasound in Medicine. 2015 Feb;18(1):19-26. doi: 10.1002/j.2205-0140.2015.tb00019.x. Epub 2015 Dec 31. PMID: 28191237; PMCID: PMC5024954.



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- ASA²⁵ and RANZCOG²⁶ guidelines say this should be done via transvaginal (TV) if the cervix is <35mm transabdominal (TA) or a risk factor is present. TV is the gold standard in the assessment of the cervix. It would disadvantage patients if they could not access this at the time of their morphology scan.
- It's clinically appropriate as 15% of cervixes are shortened at the morph and detection of this can prevent pre-term labour.
- Yes, often it is to confidently assess length and proximity of placenta to *internal os*, especially if the placenta is on the posterior uterine wall.

Should cervical length assessment training be required to claim the relevant item?

Members agree that for sonographers this is standard clinical practice and within their core competencies, and therefore specific training is not required. Further comments include:

- This is within a sonographer's core competency; it should be assessed in their accredited ultrasound Graduate Diploma course.
- For non-sonographer health practitioners, a recognised ultrasound training program such as RANZCOG's Certificate of Obstetrical and Gynaecological Ultrasound, ASUM's Diploma of Diagnostic Ultrasound, or Maternal Fetal Medicine is appropriate.

What indicators should be present before a cervical length assessment can be claimed?

Most members agree that there should be no restrictions placed on this item, in terms of indicators. Additional feedback includes:

- No indicators are required. ASUM guidelines²⁷ say the cervix should be measured routinely. TV is the gold standard for this (subject to patient consent) as per international guidelines;²⁸ most preterm births occur in low-risk women without any risk factors.²⁹ We should not set benchmarks which discourage offering people the best test available.
- Refer to the ASA guidelines on cervical screening.³⁰

²⁵ Australasian Sonographers Association. Ultrasound Assessment of the Gravid Cervix to Assess for Risk of Preterm Birth: Evidence-based guideline for Sonographers. 2023. Available from: <https://www.sonographers.org/publicassets/96994633-f14d-ee11-9127-0050568796d8/Guideline-Ultrasound-assessment-of-the-gravid-cervix.pdf>

²⁶ Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG). Best Practice Statement. Measurement of cervical length for prediction of preterm birth. 2021. Available from: <https://ranzocg.edu.au/wp-content/uploads/Measurement-Cervical-Length-Preterm-Birth.pdf>

²⁷ Australasian Society for Ultrasound in Medicine. Guidelines on the Performance of a Gynaecological Ultrasound Examination. 2020. Available from: <https://www.asum.com.au/files/public/SoP/curver/Obs-Gynae/Gynaecological-GL-2020.pdf>

²⁸ International Society of Ultrasound in Obstetrics and Gynecology. ISUOG Practice Guidelines: role of ultrasound in the prediction of spontaneous preterm birth. 2022. Available from: <https://www.isuog.org/static/d88e5dff-ced3-43ee-aa2229c2679b9484/ISUOG-Practice-Guidelines-ultrasound-in-preterm-birth.pdf>

²⁹ Hui SY. Screening for women at risk of spontaneous preterm birth, include mg cervical incompetence. Best Practice & Research Clinical Obstetrics & Gynaecology. 2024 Jun 14:102519.

³⁰ Australasian Sonographers Association. Ultrasound Assessment of the Gravid Cervix to Assess for Risk of Preterm Birth: Evidence-based guideline for Sonographers. 2023. Available from: <https://www.sonographers.org/publicassets/96994633-f14d-ee11-9127-0050568796d8/Guideline-Ultrasound-assessment-of-the-gravid-cervix.pdf>



In contrast, other feedback stated the following may be relevant:

- Unable to adequately see/measure cervix trans abdominally at 17-22 weeks scan.
- Scan in 3rd Trimester if short cervix identified at 17-22 weeks scan.
- History of short cervix in previous pregnancy. Monitor early, 12-14 weeks, to enable treatment if necessary.

4.4 Pelvic scan with saline infusion of the endometrial cavity

Should the MBS items distinguish between different uses of this item? For example, saline infusion of endometrial cavity and tubal patency exams require different processes and equipment including catheters and contrast.

We received limited feedback on this question. However, members generally thought that yes, there should be two different item numbers for these examinations as the complexity and equipment is different. They also noted that if contrast agents are being used for HyCoSy (or HyFoSy), these are much more expensive than saline.

Are there appropriate circumstances for non-requested sonohysterography?

We received limited feedback to this question. Comments include:

- Yes, when there is suspicion of polyps/fibroids or synechiae in the endometrium it is appropriate to perform a NR at the time of a pelvic examination to further elucidate the cause of symptoms.

What training should be required to claim this item?

We received limited feedback to this question. Comments include:

- A recognised ultrasound training program such as COGU, MFM, or DDU.

4.5 Foetal Wellbeing

Does the current item align with best practice ultrasound assessment of foetal wellbeing in the third trimester?

We received limited feedback to this question. Comments include:

- No. After 32 weeks the fetal middle cerebral artery (MCA) should be assessed to screen for late onset growth restriction as per ISUOG guidelines.
- This question is confusing as the table demonstrates a pelvis MBS number.
- Members not aware of anyone who uses the 55729 code as the growth scan which includes Doppler and amniotic fluid assessment the 55718 and the 55721 are used consistently in the third trimester for all examinations.



4.6 Practitioner Requirements

Should there be items restricted to personal examination by particular specialties or sub-specialties for complex presentations, with a higher fee? Which items?

Members agreed that no, there should not be items restricted to personal examination by particular specialties or sub-specialties for complex presentations, with a higher fee. Comments include:

- No, sonographers have the expertise to perform these examinations.
- No, there is no need to complicate the list more than it is.
- No, definitely not. Personal attendance rules significantly limit accessibility to patients and would be unsustainable for multiple pregnancy, NT assessment, and endometriosis given the commonality of these and the time required to perform these examinations. Sonographers should be performing these examinations, with images review / reported by a suitable qualified doctor. If this came into effect, it would have a significant impact on some exams.
- Historically, the personal attendance requirements for MSK ultrasound did not lead to better outcomes and was generally flouted until it was ultimately removed.

In contrast, feedback in support of possible item restrictions included:

- Saline infusions should be performed by a medical practitioner given the increased risk associated with these of infections, etc, and are not typically within the current sonographer scope except where the sonographer is performing the examination with a doctor.
- The only time this could be considered necessary is in cases of second opinion obstetric scanning where an anomaly is anticipated as this can facilitate timely counselling. This should be able to be billed as a consult by the attending specialist.

Should ultrasounds without a referral be limited to early pregnancy assessment, dating, and growth scans included in Fellowship of the Royal Australia and New Zealand College of Obstetricians and Gynaecologists (FRANZCOG) standard training?

We received limited feedback to this question. Comments include:

- Sonographers have the expertise to perform these examinations.

4.7 Scan Complexity

Should new O+G items be created to reflect the clinical need for:

- *complex anatomy scans (e.g. full morphological assessment of foetus), and*
- *less complex pregnancy complication scans (e.g. assessing vaginal bleeding in early pregnancy without a detailed foetal assessment)?*

Member comments include:

- Yes. Currently there no discrimination between a POCUS performed in rooms and a formal pregnancy ultrasound performed in an imaging setting (except the R vs NR codes). A FT



anatomy or a morphology scan should never be performed as a POCUS examination (with the exception of some rural locations where imaging services are limited).

- Concern for the welfare of the foetus (baby) is the primary focus regardless of reason for the scan so a detailed assessment is always expected and necessary.
- Response to Part A:
 - Item numbers should reflect the complexity of the examination, a fetus with a structural abnormalities or chromosome abnormality require more time spent on the anatomy assessment, more counselling, and at times multiple assessment.
 - It is interesting the third trimester examination pays more than the more complicated scans of the morphology and early anatomy/nuchal translucency assessment. Obstetrics is starting to focus more on early detection of abnormalities and screening and the MBS billing should reflect this.
- Response to Part B:
 - Less complex examinations are generally performed before 11 weeks and after 28 weeks.

Are there other clinical indicators which can predict the complexity of the scan, and should be a basis for separate complexity-related items?

Members provided mixed responses to this question. Comments include:

- Not really. But a full morphology versus a targeted examination (such as we do for cervical length screening) could be considered. However, this could be misused as people would probably bill the higher code if they could.
- Other clinical indicators may include any other diagnosis for that current pregnancy, e.g. fetal structural or chromosomal abnormalities, and additionally low Papp-A, preeclampsia, or short cervix which all need detailed further exams for assessment as that pregnancy progresses.

4.8 Safety Net Caps

We received limited comments specific to this area, however in general members emphasise that there is a bias due to insufficient relative funding to women's health items, impacting providers viability to offer services and women's ability to access affordable timely ultrasound examinations.