a healthier world through sonographer expertise

27 November 2025

Ms Mary Warner
Assistant Secretary
Diagnostic Imaging and Pathology Branch
Medicare Benefits and Digital Health Division | Health Resourcing Group
Australian Government Department of Health, Disability and Ageing
Via email: radiology@health.gov.au

Dear Ms Warner,

Re: Review of Select Medicare Funded Diagnostic Imaging Ultrasound Services - Phase Two

Thank you for the opportunity to provide feedback on the second phase of consultation on Select Medicare Funded Diagnostic Imaging Ultrasound Services. The review has examined key obstetric and gynaecological ultrasound services that are critical for monitoring fetal and maternal health during pregnancy as well as women's reproductive health.

Following years of unchanged fees and sustained underinvestment in women's health, this is a timely and welcome review that presents a unique opportunity for reform. Obstetric ultrasound is a specialised area of practice that is complex and vital for healthy pregnancies yet low MBS funding has been a challenge for service provision. Introducing fees that better reflect clinical practice, and more equitably reimburse providers for these essential services will directly impact on the availability and affordability of comprehensive reproductive and pregnancy care for all Australians, especially those in remote, regional and underserviced areas.

The Australasian Sonographers Association (ASA) is the professional organisation for sonographers, and we represent over 8,000 members across Australia and New Zealand. Sonographers are the experts in ultrasound and perform the bulk of more than 12 million Medicare-funded ultrasounds each year, with 11% of the workforce employed in obstetrics and gynaecology. Our attached response draws on the clinical experience of sonographers who are ideally placed to provide expert advice and input on this review.

We welcome the genuine, ongoing efforts in these reviews to add clarity and clinical relevance to item descriptors, and to set fees that better align with the true time, cost and expertise involved in undertaking contemporary ultrasound examinations. In particular, the revised fee structure in this proposal goes some way to recognising the added complexity of examining twins and monochorionic pregnancies, which has long been out of balance. Reform in this area has been well received by the profession as is the proposal for a Medicare item for tubal patency test using contrast ultrasound.

We thank you for the opportunity to participate in this review and ask that the Department continues to prioritise input from our profession as the review is finalised.

Should you require further information or clarification, please contact Elissa Campbell, General Manager, Policy and Advocacy, at elissa.campbell@sonographers.org.

Yours sincerely,

Dr Tony Coles
Chief Executive Officer
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1.1 Requested Obstetric Items

Do the proposed item descriptors clearly distinguish between singleton, multiple, and higher-order multiple pregnancies?

The ASA welcomes the new tiers introduced to obstetric items, separating singletons and twins from more complex cases such as monochorionic twins (identical twins with a shared placenta) and higher order pregnancies of 3 or more foetuses. This goes some way to better capturing more pregnancy types and stages and provides a mechanism to apply funding more equitably. Overall, we consider the new item descriptors do sufficiently distinguish pregnancy types.

Are the clinical criteria for each item sufficiently defined to support consistent interpretation and claiming?

Screening

Feedback from sonographers suggests that there is ambiguity in relation to the use of the term 'screening' (in 55902 but absent from the multiple birth equivalent 55915) and whether this includes genetic and preeclampsia screening. Preeclampsia screening through the use of uterine artery Doppler is not specified in the current item descriptors but is recommended by the Royal Australia and New Zealand College of Gynaecologists (RANZCOG). Screening of Nuchal Translucency (NT) and preeclampsia should be recognised as clinically indicated and valid reasons to undertake pregnancy-related ultrasound rather than representing routine reassurance.

Nuchal Translucency

It is best practice for structural assessment and NT measurement to be performed together at 12 to 14 weeks of gestation and the proposed combined item (55910/55928) should be the standard approach for undertaking a comprehensive first-trimester. This approach aligns with international and Australian guidelines for early fetal assessment.

The ASA does not support separation of NT-only scans (proposed items 55908/55925) for singleton or multiple pregnancies. There is no clinical need for this type of scan independently and there are risks of fragmenting care.

Possible error in replacement Morphology item

Item 55759 (first morphology scan for multiples at 17w to 22w gestation) seems to have been replaced with item 55918. However Fetal Crown-Rump Length (FCRL) has been substituted for number of weeks in the description, including a measurement of 45mm-84mm (which suggests 11-14weeks). NT is not mentioned in the text, so presumably FCRL should be replaced with the wording of 'over 16 weeks' in the equivalents proposed for singletons (55904) and higher order pregnancies (55932).

Do the proposed fees appropriately reflect the time, complexity, and expertise required for each type of scan?

While the proposal to increase many of the fees is welcome, the ASA considers that the level needs further review for some items. In some cases, the proposed fees still do not represent the time, complexity and growing importance of obstetric examinations in earlier pregnancy, as recognised in Phase 1 of this review. Importantly, the fee for twins, and higher order pregnancies should better reflect that these examinations take an equal amount of time per foetus – there are few, if any, time savings for multiples by virtue of being in the same womb. Therefore, funding the exam of the second

twin at 60% that of a singleton is not appropriate. Women should receive similar funding for each baby to ensure their care and so that their care is not compromised due to time pressure.

While this was explored to some extent in Phase 1, fee parity issues remain for obstetric items compared to other ultrasound items. We would encourage further work to improve relativity across the ultrasound sub-groups to boost service supply and attract staff to this complex and important area of women's health.

How obstetric ultrasound has evolved

Ultrasound is used widely to evaluate and monitor fetal growth and anatomy, maternal health and to closely manage multiple gestation pregnancies. Over time, evolving capability to detect and diagnose developmental issues earlier has resulted in more complex fetal scanning, with a higher number of detailed images, measurements and screening tests now involved. Not only is the diagnostic output far greater, but clinicians require more time and expertise to perform the expected examinations. Women are also having their babies later (with almost 30% over 35 years of age) and obstetrics has shifted its focus to earlier detection of abnormalities and screening.

This shift requires increasing vigilance at younger gestation, and both the 12-16w and 17-22w ultrasound exams now form a core part of routine pregnancy care. Accordingly, MBS fees need to reflect this shift in practice. Investing in better, earlier care prevents problems later and improves pregnancy outcomes for mothers and babies.

Ongoing fee parity concerns

In the ASA's view, comparison of the relative complexity of ultrasound services must recognise that the current funding level for what is a milestone, complex assessment for all pregnant women has been chronically insufficient. The new item 55904 is proposed to start at $257.15, and while it is an improvement from $114.85 it does not go far enough to capture the time, cost, expertise and importance of the exam, nor does it reflect price parity in the context of other ultrasound items. Significant out of pocket costs are faced by patients for pregnancy scans, often in the hundreds. Bulk billing is uncommon because it is difficult to make these time-demanding obstetric exams viable with the schedule fee alone, compared with other ultrasound services. Therefore, if these services are offered in the private sector, they charge a far higher fee, and the 100% schedule fee rebate (only available if a practice bulk bills) is rarely realised. The actual rebate that most patients will benefit at this proposed fee is 85% ($218.58). The fee for the 12-16w exam (55902 at $208.80) should be reconsidered on a similar basis.

In Phase 1 of this review, some useful comparisons were made between this 17-22w exam (currently funded at $114.85) and two vascular items for which excellent ASUM guidelines are also available [1]. A standard scrotum scan (item 55048) was described as low complexity, taking between 10-20 minutes, has a fee of $122. Duplex scanning of the penis 55284 was described as moderate complexity and taking 30-45 minutes, with a fee of $194.64.

Following Phase 1, members have highlighted other items that provide good context for the relative complexity and time variability of different ultrasound exams, such as item 55244 and 55246 (schedule fee $194.64) which uses B-mode ultrasound imaging and doppler flow measurements to assess lower

[1] ASUM Guidelines for Penile Colour Duplex Ultrasound available at www.asum.com.au/files/public/SoP/curver/Small-Parts/Guidelines-for-Penile-Colour-Duplex-Ultrasound-Examination.pdf
ASUM Guidelines for the Performance of Scrotal Ultrasound available at www.asum.com.au/files/public/SoP/curver/Small-Parts/Guidelines-for-the-Performance-of-Scrotal-Ultrasound.pdf

limbs for venous disease, such as Deep Vein Thrombosis (DVT)[2] which can vary in time and complexity depending on a patient's presentation.

Further articulating the complexity of early pregnancy exams

The key fetal exams are described in the MBS using fairly broad terms. For example, the description proposed for both the 12-16w and 17-22w exams are "*Pregnancy-related ultrasound, by any or all approaches, to assess fetal development and wellbeing"*. This is an improvement on the previous descriptor, and we do not propose more technical approach, but the general descriptor does obscure the true complexity of these services, which is relevant when considering fee parity against other MBS items.

ASA sonographer members describe these exams as physically and technically challenging. 60 minute appointments are typical, with the latter requiring upwards of 80 images to be recorded.

Australian and international guidelines outline the purpose and detailed requirements for *assessing fetal development and wellbeing* at both stages[3] and the list of equipment requirements, anatomical landmarks, views, positions and measurements that need to be captured real-time in a standardised manner is significant. Unlike some other more targeted ultrasound exams where the patient's presenting pathology or response may materially influence the approach and time taken, in earlier fetal examinations there is little flexibility or opportunity for time savings. It is a case of working methodically through a series of established checks, some of which may not even be possible (due to fetal position for example), requiring a further follow-up exam.

By way of example, the 17-22w exam entails:

- Establishing the number of foetuses, confirming fetal cardiac activity, and establishing gestational age through bi-parietal diameter, head circumference and femur length
- a full examination of fetal anatomy including detection of malformation and other abnormalities
- identifying and examining key structural features, including specific features of the head, brain and nuchal thickness, facial features, structure and function of the heart and diaphragm, great vessels, parts of the abdomen, the spine, extremities of limbs, hands, fingers, feet and toes.
- The exam also looks at factors supporting the foetus: umbilical cord, volume of amniotic fluid, placenta structure and placement, and maternal anatomy, including assessing the cervical length and uterus.
- Issues that can be detected through these earlier pregnancy checks includes congenital heart abnormalities, congenital syndromes and malformation of the spinal cord.

The process involves a variety of ultrasound techniques and approaches, including B-mode, M-mode, colour, power and spectral Doppler, and key features and abnormalities must all be noted for

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[2] ASUM Guidelines for Peripheral Venous Ultrasound www.asum.com.au/files/public/SoP/curver/Vasc/Peripheral-Venous-Ultrasound.pdf

[3]ASUM Guidelines for the performance of First Trimester Ultrasound available at **www.asum.com.au/files/public/SoP/curver/Obs-Gynae/Guidelines-for-the-Performance-of-First-Trimester-Ultrasound.pdf**

ASUM Guidelines for the performance of Second (Mid) Trimester Ultrasound available at https://www.asum.com.au/files/public/SoP/curver/Obs-Gynae/Guidelines-for-the-Performance-of-Second-Mid-Trimester-Ultrasound.pdf

ISUOG Practice Guidelines (updated 2022): Performance of the routine mid-trimester fetal ultrasound scan, available at https://www.isuog.org/resource/isuog-practice-guidelines-updated-performance-of-the-routine-mid-trimester-fetal-ultrasound-scan.html

ISUOG Practice Guidelines (updated 2023): Performance of 11-14 week ultrasound scan, available at https://www.isuog.org/resource/updated-isuog-practice-guidelines-performance-of-11-14-week-ultrasound-scan.html

reporting. For twins and other higher order pregnancies, the number and challenge of performing this list multiplies, as the sonographer must access suitable view windows while the foetuses move and interact, and keep track of which they are examining.

This description is useful to emphasise the complexity of early obstetric exams for comparison with other services.

Ultrasounds under 12 weeks

The proposed schedule fee for the Dating Scan item 55900 (replacing item 55700) is unchanged at $68.85 and remains well-below the cost of delivering quality early pregnancy scans. Failure to address this will see continued high gap fees for patients, and pressure on clinics to make shorter appointment times. Rushed examinations may result, leading to diagnostic mistakes and potential workplace injury to sonographers.

While the modality of ultrasound is not specified in the descriptors, we also note that internal Transvaginal ultrasound (TV) is considered best practice for pregnancies under 8 weeks of gestation. As recognised in the design of the new complex gynaecological item, TV is more time-consuming and costly to deliver than transabdominal (TA). TA is generally appropriate for wellbeing checks undertaken between 8 and 12 weeks of gestation.

To encourage best practice use of TV, it would be appropriate to introduce a new gestational age and viability exam for under 8 weeks of gestation using TV ultrasound (with consent). Item 55900 could still be used for under 12 weeks to undertake wellbeing checks using TA ultrasound, or for gestational age and viability where TV consent not available (55900). The first item using TV would attract a higher rebate, ensuring that the cost of undertaking the scan is reflected and that best practice approaches are incentivised.

False time savings for multiples

Imaging services must be funded appropriately to offer critical pregnancy monitoring to all patients regardless of how many babies they are carrying, to ensure these higher risk pregnancies are supported, rather than discriminated against through lack of service provision or excessive out of pocket fees. It is particularly important for rural and regional patients where tertiary services may not be a local option and private imaging practices are relied upon.

As noted in our 2024 submission, designing an appropriate fee structure that properly captures the nuance, flexibility and appropriate fee for multiples is challenging. There are benefits to separating singleton, multiple and complex or higher order pregnancies under the MBS, especially for data purposes, and the proposed design is a significant improvement. However, by applying anything below parity for fetal scanning, this suggest that multiples offer time savings, which is not the case. Every baby needs to be assessed independently with a complete exam - the steps cannot be abbreviated.

For twins or higher orders, the examination of the fetus takes the same time per baby than for a single foetus. Multiples present unique medical risks and have complex relationships and interactions which can extend the length of the examination depending on presentation.

The proposed fee loading for a second twin is only 60 percent (item 55915). This reduces to 56% for a triplet (55930). This diminishing fee approach fails to recognise that the time, complexity, physical demands and specialised expertise required to comprehensively examine each baby in the womb is essentially the same. While a portion of the examination pertains to patient consult and examining maternal structures, the larger portion of the exam relates to the fetus. The MBS fee must provide sufficient loading to acknowledge that a thorough and equal examination is conducted for each baby.

1.2 Obstetric Further Examination Items

Do the proposed item descriptors clearly define when a further examination is clinically indicated?

Clarification is needed on how these items will be used, with further guidance about when an examination is clinically indicated, and how current patient needs can be met with the new items and limits.

Sonographers have sought further information about the purpose of the new further examination items, suggesting that they are not sufficiently defined in the current item descriptors. This may lead to ambiguity about their use.

The proposal includes some changes to the way ultrasound exams subsequent to the fetal development and wellbeing ultrasounds are structured. It seems that 55945 and the NR equivalents are intended to be used more flexibly (anytime over 12 weeks) yet with a new limitation of 2 per pregnancy and deletion of 55712/55715 (with no 559XX equivalent) the effect may be that ultrasounds available after 16 weeks (excluding the 17-22w morphology) is being reduced from 3 to 2 items.

It is also not clear whether the intention is for these items to be used by tertiary or specialist centres performing second-opinion ultrasound examinations at greater than 16 weeks of gestation or whether it is intended that they can be claimed in conjunction with routine ultrasound examinations (e.g., proposed item 55904) in cases where abnormality is identified.

Further examination items should be able to be claimed in conjunction with the routine examination items where appropriate, and a sufficient number should be available (with clinical necessity) to accommodate the nuances and complexity of every pregnancy, to ensure that out of pocket costs for important follow ups do not deter patients from proper monitoring, which can increase the cost and risk later in pregnancy.

Are the safeguards (e.g. limit of two services per pregnancy, documented clinical concern) appropriate and practical?

The ASA has received consistent feedback from practitioners that the proposed limit of two 'further examination' ultrasounds per pregnancy is inappropriate and not in line with current practice or flexible to patient need. Sonographers have noted that high risk patients and multiples pregnancies are routinely scanned on at least a monthly basis, with some cases requiring far more frequent Doppler and amniotic fluid index (AFI) ultrasound to be undertaken. Complex twins are usually scanned every two weeks from 16 weeks onwards to ensure the pregnancy is monitored closely and risks averted.

The limit on extra scans should be raised to at least five scans or removed entirely. Similarly, the limit on growth scans (55981) should be extended from 5 to 6 and kept more flexible for multiples and higher order pregnancies (55984).

More appropriate and targeted safeguards could be put in place, such as clearer definitions for which clinical concerns are appropriate triggers for the use of further examination items.

The International Society of Ultrasound in Obstetrics and Gynaecology (ISUOG) Practice Guidelines on ultrasound in twin pregnancy[4] provide excellent detail on these matters. An excerpt of the ultrasound monitoring pathways for uncomplicated twin pregnancies is provided below. These pathways reflect requirements for normal pregnancies, and flexibility for further ultrasounds should be provided in the MBS to ensure vital monitoring is supported for pregnancy complications.

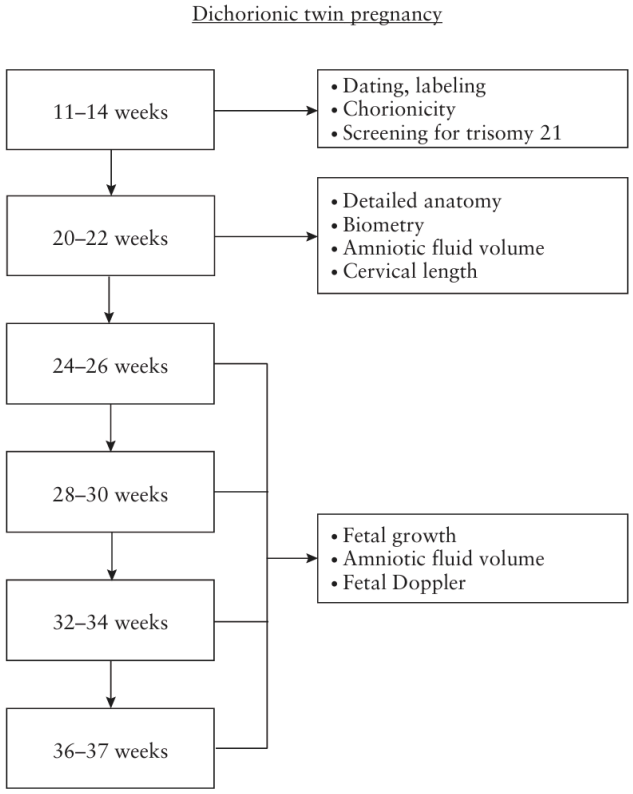

Figure 2 Ultrasound monitoring pathway in uncomplicated dichorionic twin pregnancy.

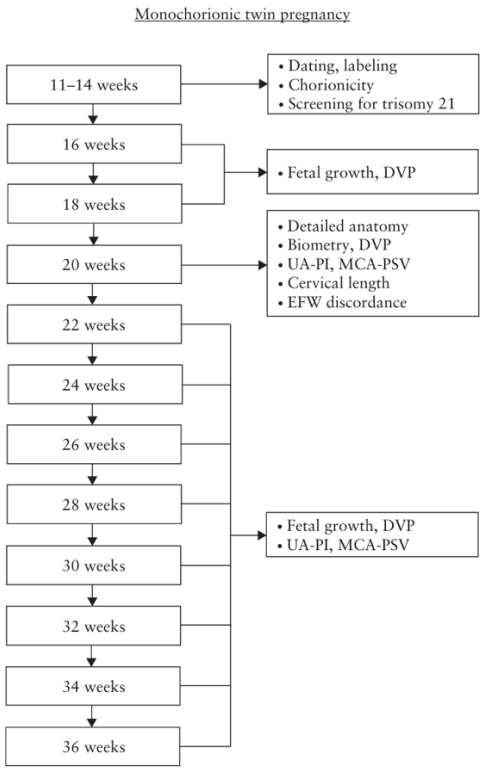

Figure 3 Ultrasound monitoring pathway in uncomplicated monochorionic twin pregnancy. DVP, deepest vertical pocket; EFW, estimated fetal weight; MCA, middle cerebral artery; PI, pulsatility index; PSV, peak systolic velocity; UA, umbilical artery.

Do the proposed fees reflect the time, expertise and complexity involved in conducting further obstetric ultrasound examinations?

If further obstetric ultrasound examinations can be claimed in conjunction with routine examinations where clinically indicated, then the rebate is appropriate.

However, if this is not the case, then we note significant concerns that routine community screening scan attracts a higher reimbursement than a complex tertiary scan for suspected abnormality.

1.3 Non-Requested Obstetric Items

Are the clinical criteria for non-requested scans sufficiently defined to support appropriate use?

The ASA notes a misalignment between the description of non-requested obstetric items in the consultation paper - which refers to their use in urgent or follow-up scenarios to assess fetal

[4] ISUOG Guidelines: Role of Ultrasound in Twin Pregnancies – available at www.isuog.org/static/89db40d1-928b-49bc-be5ea200fd41130c/ISUOG-Practice-Guidelines-role-of-ultrasound-in-twin-pregnancy.pdf

development, viability, and complications - and the proposed item descriptors which reference the same routine elements as the requested items.

While the item descriptors reference the need for a documented clinical concern, it is our view that clearer guidance should be provided, aligned with clinical practice standards, to guide practitioners in relation to when non-requested items are to be used to prevent misuse overuse or confusion.

Are there specific clinical scenarios where the proposed fees may not adequately cover service delivery costs?

The ASA reiterates our concern about the rebates for multiple pregnancy ultrasound examinations being reimbursed at 60 percent higher than singleton pregnancy ultrasound examination, rather than double or close to double the latter rate. This lower rate assumes efficiencies or time savings that are not reflected in practice and impact the practitioner's ability to take a full ultrasound examination without either increasing costs to the consumer or being pushed to rush the examination.

1.4 Other Obstetric Items

Do the proposed fees reflect the time, expertise and complexity involved in delivering these targeted assessments?

Cervical Length

The ASA has received feedback with significant concerns about the significant discrepancy between the fee for referred item 55975 ($83.90) and NR item 55978 ($31.85). Overall, we note that the schedule fee for most NR items under review is around 50% of the equivalent R item, however the fee for 55978 (NR) represents just 37.96% of the equivalent R item.

Cervical length can be a critical determinant in pre-term labour, and monitoring is vital for preventative care. Sometimes the need for this exam is not obvious at the time of referral, but the need for full cervical measurement is detected later during an ultrasound.

Sonographers have indicated that for this particular service, the rebate for both referred and non-referred services should be the same. The clinical need and process for both examinations is the same regardless of referral type, and the current fee does not reflect the time, skill and responsibility involved or the risk and importance of this exam for the safety of the expectant mother and her baby.

Abdominal Circumference

The ASA received feedback with concerns about the fee for singleton fetal growth monitoring (proposed item 55981), indicating that a third trimester abdominal circumference when performed correctly, takes significant time that is not well-reflected in the proposed schedule fee of ($68.50). Sonographer members highlight that current practice requires that third trimester exams involve review of additional anatomy screens including four chamber cardiac view, three vessel and trachea view, interventricular septum, cleft lip, cerebral ventricular diameters, as well as bladder, stomach, and kidneys. Additional Doppler ultrasound may be needed including Middle Cerebral Artery Pulsatility Index and ductus venosus.

Do the proposed item descriptors clearly define the clinical indications for cervical length and Doppler-based assessments?

Feedback from ASA members suggest that referrers may omit clinical indications when requesting ultrasound examinations and that sonographers often identify risk factors when undertaking

ultrasound examinations. Sonographers also note that if the cervix is poorly visualised or less than 35 mm when undertaking a transabdominal (TA) scan, a transvaginal (TV) scan should be performed regardless of other indications.

2.1 General pelvic ultrasound

Do the proposed item descriptors accurately reflect the complexity and clinical requirements of these services?

Transvaginal (TV) ultrasound is now considered gold standard in gynaecological examinations, including for endometriosis, and we welcome the introduction of the new item 55080 this month.

Practitioners continue to emphasise that there is no simple pelvic scan, and for best results, all patients, other than the very young or those who decline, should have both a transabdominal and TV scan to gather the diagnostic information required to address clinical questions for the referring practitioner. Feedback suggests that it is common to see patients for a 'second opinion' purely because a transvaginal scan was not undertaken during the initial examination. The ASA considers that it is important to incentivise this best practice not just to improve diagnostic results but also to improve the experience and efficiency for patients.

Remunerating a TV at a higher rate than 55065 will be important to encourage providers to offer the more comprehensive exam. TV examinations add complexity and risk, requiring additional time to seek consent and complete high-level disinfection for probes. A chaperone may also be involved.

The wording in the descriptor for 55080 may also need to be more explicit in requiring TV examination (along with traditional Transabdominal scanning) to incentivise best practice and justify the higher schedule fee.

Does the proposed fee for item 55065 appropriately reflect the time, expertise and consumables required to deliver these services?

The ASA received feedback from practitioners expressing concern about the level of difference between the proposed fee for 55065 and standard fees currently charged by providers for these examinations of around $260. Members advise that the procedure is complex, involving multiple procedures with high-level disinfection required for the probes used during examinations.

While the introduction of item 55080 may alleviate some of this pressure, it is likely that some patients who are billed under item 55065 will continue to face barriers to access and significant gap fees. Further review of these two items will be needed at some stage to see how clinics are responding, to ensure both that 55080 is working as an effective MBS item to incentivise provision of complex gynaecological exams at affordable prices, and that 55065 offers a suitable alternative when TV is not appropriate or possible.