a healthier world through sonographer expertise

06 October 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 Medicare Funded Diagnostic Breast Imaging Services 2nd Public Consultation Paper

Thank you for the opportunity to provide feedback on the questions outlined in the second consultation paper released as part of the review of Medicare Funded Diagnostic Breast Imaging Services.

The Australasian Sonographers Association (ASA) recognises the significant work that the Department has already undertaken as part of this review and welcomes the updated proposals outlined in this second consultation paper. The increase in Medicare rebates for breast imaging outlined in the paper, and the proposals for an updated tiered item structure, reflect a welcome recognition of the cost and mode of delivering services as well as the importance of ensuring that those who most need services can access them.

While our response below provides additional feedback on the proposed service tiers and further iterative changes to the fees associated with the breast imaging items, the sector is grateful for the constructive and responsive consultation approach being taken by the Department. We also recognise the Commonwealth Government's strong commitment to improving the quality, affordability and equitability of access to diagnostic breast imaging. We particularly note the commitments made in the 2025-26 Commonwealth Budget, which will see a range of co-claiming restrictions and other rules removed or adjusted from 1 July 2026 to better support access to imaging for patients. These changes will benefit all patients, particularly those in regional and rural settings who often travel significant distances for diagnostic imaging services.

The ASA is the professional organisation for Australasian sonographers, who are the experts in ultrasound. We represent over 8,000 members and more than 70 % of sonographers across Australia and New Zealand. The feedback provided below in our response to the consultation questions draws on input provided by clinicians and focuses on sonography clinical practice. As sonographers undertake the majority of medical diagnostic ultrasound examinations in Australia, we thank you for our engagement 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
Australasian Sonographers Association

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RESPONSES TO THE CONSULTATION QUESTIONS

The responses outlined below focus on the questions and proposals associated with sonography practice and breast ultrasound outlined in sections 1 and 2.

Section 1: Breast Ultrasound Item Restructure (Items 55070, 55073, 55076 and 55079)

A. Do the tiered items (Targeted, Standard, Complex) better reflect clinical practice? Why or why not?

Feedback from practitioners consulted as part of this second phase of consultation indicates that the proposal for tiered ultrasound items based on targeted, standard and complex ultrasound procedures much more accurately reflects current ultrasound practice. While sonographers note that the volume of services delivered across each tier vary depending on the individual practice and the focus of their services, there is general support for a high-level breakdown of services across the three tiers.

Where practitioner feedback suggests that the structure may not entirely align with clinical practice is in relation to the item descriptors associated with each of the tiers. Practitioners note in particular concerns about whether the descriptor for complex ultrasound sufficiently reflects real world practice, noting for example the lack of inclusion of breast density and surgically altered breast tissue in the updated item descriptor (though the consultation document does reference these as factors leading to a need for complex scans). Additional information about how the item descriptors could be amended to better reflect clinical practice is outlined below in our response to question 1C.

B. Do the proposed fee increases better reflect the time, expertise and resources used to provide these services?

The proposed fee increases for unilateral (single) breast scans more accurately reflect the time, expertise and resources used to provide services at each level of complexity and are welcomed by the sector. However, feedback from practitioners consistently raised questions about the rebate offered for bilateral (both) breast scans, a concern shared by the ASA. It is the ASA's position that there are only very minimal time and resource benefits for providers associated with scanning both breasts when compared to scanning the individual breasts separately. We argue strongly that setting the fee at 1.5 times the revised unilateral rate does not reflect the time and resources needed to provide this service properly.

The ASA notes that the consultation paper argues that a rate of 1.5 times the unilateral fee for bilateral services is consistent with other imaging modalities. It does so without specifying which other imaging modalities or procedures are referenced. The consultation paper itself includes proposed fee rates for mammogram, which are set at 1.66x the unilateral rate while also having greater potential cost efficiencies, 3D Tomosynthesis is set at 1.77x the unilateral rate and radiographic examination during surgery is set at 1.66x the unilateral rate. This suggests that the rate of 1.5x is not being applied consistently and that there is a recognition that the cost of bilateral scans can vary based on the modality. The ASA argues strongly that the rate for bilateral ultrasound should ideally be between 1.9x and 2x that of the unilateral rate to reflect the cost of delivering a complete service, and to avoid creating disincentives to effective and timely patient care. This position reflects that which was previously put forward in our response to the first round of consultation.

While the ASA understands the need for government to manage the Commonwealth health budget prudently, we have concerns that the current proposals may drive providers to offer services in a way that reflects the cost of delivering services but negatively impacts patients. Where providers can generate significantly more income from providing only unilateral scans in a way that better reflects the true cost of delivering services, the likely impact is that patients will find it more difficult to access bilateral scans. That will drive up costs and impact how quickly care can be provided, particularly for people living in rural and remote areas who may travel significant distances and have accommodation costs associated with accessing ultrasound and other health services that rely on the findings of those diagnostic services. Some patients accessing imaging services in regional centres travel distances of up to 700 kilometres. The impact for those patients of having scans spread across multiple days is significant in terms of time, productivity, and travel and accommodation costs.

Addressing the accessibility of services for rural and remote consumers should be considered carefully when setting fees for scans and when considering any limitations on eligibility to access multiple rebates on the same day. It is common for patients having breast scans to also need biopsies, clips, and Magseed appointments, each of which can generate significant costs. The ASA submits that government should work to minimise barriers to providers being able to deliver services as efficiently as possible for patients.

C. Are the proposed item descriptions and eligibility criteria clear and easy to understand for both providers and patients? What guidance should be provided in notes?

The proposed item descriptions and eligibility criteria currently contain areas of ambiguity as well as appearing not to include some of the key factors that might lead to a scan being more complex that have been outlined in the consultation paper, namely breast density and surgically altered breast tissue. The ASA argues that there are practical adjustments that could be made to address the absence of breast density and surgically altered breast tissue and address current ambiguity by expanding the item descriptor with additional information and definitions. This in turn would provide greater clarity and better guide decision-making about the use of individual items.

The addition of high breast density and/or the presence of surgically altered breast tissue to the item descriptor for complex breast scans appears to be a straightforward correction of an omission, given that both are described as relevant factors in section 1.3. However, in addition to simply including breast density as a factor, the ASA argues that defining density requirements on the Volpara system and a Volpara Density Grade of C or D removes ambiguity and provides straightforward guidance for practitioners. While the Breast Imaging Reporting and Data System was proposed as an alternative to the Volpara system, this was considered less ideal.

The ASA also notes the need to define the term “lesion”. Practitioners noted uncertainty about whether cysts are considered lesions, highlighting that many practices only image cysts if they are within the Region of Interest (ROI), if they are the largest cyst, or if they are complex. Feedback also queried whether many simple cysts would meet the requirements for a complex scan or whether a lesion in this context refers only to atypical or solid lesions. A definition would remove this ambiguity, though practitioners cautioned about the need to also consider the presence of breast cancer, fibroadenoma, thick-walled cysts, duct papilloma, and axillary lymph nodes as factors that contribute to the complexity of the scan.

D. Should the proposed item descriptors have scan time stipulations?

The ASA does not support the inclusion of scan time stipulations, noting that these do not align well with current practice or the high degree of variability of the patient being scanned and its impact on scan times. Practitioners note that a wide range of factors impact the time taken to scan, including the number and type of lesions and/or presence of complex cysts, breast density, and the age of the patient noting that some older

patients may find scanning more difficult due to physical limitations and require additional time or adaptations to allow them to undertake a full scan. The ASA also considers that the sonographer's experience with breast scanning can impact the time taken to complete a scan as can the patient's level of comfort with the procedure.

The ASA position is that the item descriptors for the three tiers of breast ultrasound, subject to the adjustments outlined above, provide sufficient structure to ensure that they are used and billed appropriately.

E. What would you estimate the proportion of services would flow between targeted, standard and complex scans (e.g. would it be 33%:33%:33% or 20%:50%:30%)?

The ASA notes that the degree of variability between practices, and the type of patients being seen, makes a general response to this question difficult. Based on responses from members, it would generally be expected that the highest proportion of services would be balanced between standard (around 50 percent) and complex (40 – 60 percent). Generally, targeted scans would comprise a lower volume of services. However, some practices noted that they would expect to provide primarily targeted scans suggesting that caution should be applied when estimating the proportion of services likely to be billed at each tier.

2. Breast Ultrasound in Conjunction with a Surgical Procedure Questions

A. Do you have any other comments or feedback on these items?

The ASA has no further comments on these items.