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Health Insurance Amendment (Diagnostic Imaging, Radiation Oncology and Other Measures) Bill 2002

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Health Insurance Amendment (Diagnostic Imaging, Radiation Oncology and Other Measures) Bill 2002

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Law and Bills Digest and Social Policy Groups
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Health Insurance Amendment (Diagnostic Imaging, Radiation Oncology and Other Measures) Bill 2002

Date Introduced: 11 December 2002

House: House of Representatives

Portfolio: Health and Ageing

Commencement: Schedule 2, which establishes the Radiation Oncology Register commences immediately after Royal Assent. The remainder of the Bill commences on the day of Royal Assent.

Purpose

To amend the *Health Insurance Act 1973* to:

- require registration of premises that offer diagnostic imaging and radiation oncology services before Medicare benefits are payable for such services
- make changes in patient referral procedures in relation to diagnostic imaging services, and
- allow all osteopaths to refer patients for diagnostic imaging services.

Background

The growth in the diagnostic imaging and radiation oncology sectors

Diagnostic imaging refers to a variety of services including diagnostic radiology, ultrasound, computed tomography, magnetic resonance imaging and nuclear medicine imaging. Diagnostic imaging services consist of two distinct parts: the procedure, which is the capturing of the images (for example, the x-ray film); and reading of, and reporting on, those images by a medical practitioner. For many diagnostic imaging services, these two components need not necessarily be done at the same time or at the same location. . Radiation oncology is the study and discipline of treating malignant disease with radiation. The treatment is referred to as radiotherapy or radiation therapy.

Diagnostic imaging accounts for approximately 15.5 per cent of Medicare Benefits paid in 2001-02.[1] Advances in technology and more widespread use of magnetic resonance imaging, ultrasound and computerised tomography scanning have made diagnostic imaging a significant area of growth within the health sector.[2] In 2001-02 radiation oncology accounted for 0.9 per cent of Medicare benefits paid, an increase of over 50 per cent.[3] The growth in radiation oncology is partly attributable to the increase in the incidence and detection of cancer in Australia.[4] Together, diagnostic imaging and radiation oncology account for 16.4 per cent (or approximately $1.3 billion) of Medicare benefits paid.

The number of health professionals entering medical imaging as an occupation rose by 27.6 per cent between 1996-97 and 2000-01.[5] However, a recent report on radiation oncology in Australia indicates that as the need for radiotherapy increases there will be significant workforce shortages in this area.[6] The Commonwealth has taken steps to increase the number of radiation therapist students, increase retention of qualified radiation oncology staff and improve access to radiation oncology services in rural and regional Australia. In the 2002-2003 budget, $72.7 million was provided for the development and funding of new radiation oncology facilities in rural and regional areas.

The problem of high costs and limited information

Despite the high costs associated with the provision of diagnostic imaging and radiation oncology services, little is known about the nature of the practices that provide these services. Some information about service delivery is currently collected through Medicare provider numbers and patient identifiers; this provides insight into the size of the workforce and number of patient services. However, information about the practices and equipment used to deliver diagnostic imaging services is not collected.

The lack of data about premises and mobile facilities that provide diagnostic imaging services has in the past compromised the capacity of the Commonwealth, the medical profession and health researchers to:

- examine and ensure equity of access to such services (for example by examining the geographic distribution of services)
- target education and information campaigns, and
- assess compliance with legislation and regulation and ensure that equipment meets the eligibility requirements for Medicare benefits.

While more information is currently collected about radiation oncology services, radiation oncology has been included under the 'location specific practice number' (LSPN) registration arrangements (Schedule 2) in order to standardise the information collected across public and private radiation oncology practices and consolidate registration processes.

Corporatisation

The corporatisation of general practice medicine, particularly the trend towards vertical integration, has provided added impetus to the need for more information about the premises and facilities that provide diagnostic imaging and radiation oncology services. Vertical integration is a form of corportisation that refers to the co-location of different practitioners and services, such as GPs, specialists, pathology and diagnostic imaging services. Often a third party (not directly involved with the provision of health care) owns and receives the profit generated by such services. Diagnostic imaging and radiation oncology are two services where there have been significant movements in ownership from individual practitioners to corporate practices.[7]

The impact of corporatisation has become a significant issue within the health sector. In particular professional associations and governments have become concerned with the potential for professional and clinically rigorous practice to be compromised in favour of corporate profits.[8]

There is Australian and overseas evidence to suggest that the co-ownership and co-location of GP and diagnostic imaging services results in higher rates of ordering diagnostic tests.[9] It is widely believed that there are a number of corporate practices that have encouraged practitioners to increase their requests for diagnostic imaging services.[10] This is not to suggest that all increases in the rates of ordering of diagnostic tests in these circumstances are clinically unsound, however such evidence does encourage caution about the level of servicing within practices where there is co-ownership and / or co-location of GPs and diagnostic imaging services.[11]

As noted, professional organisations have been concerned with the potential for corporatisation to compromise professional practice. These concerns have been magnified since the introduction of capped funding for diagnostic imaging.[12] Because there is an upper limit on funding under the current arrangements, the costs of over-servicing and associated practices are re-distributed amongst the entire industry. This has provided a further prompt for increased regulation in the area.

Currently the Health Insurance Commission (HIC) is unable to collect detailed information about whether a practice is part of a corporate structure or about the ownership of a practice. This means that neither the Commonwealth nor professional associations in the field can identify corporate (or individual) practices that are over-servicing.

Access to more extensive information about the location of practices and equipment will enable the Commonwealth, the diagnostic imaging profession and the health sector to better monitor the location and use of diagnostic imaging services. More specifically, one of the key objectives of the legislation is to:

> Monitor the impact of corporatisation of diagnostic imaging and radiation oncology services.[13]

Referral Arrangements for Diagnostic Imaging Services

In response to the concerns of the Commonwealth and various professional bodies, legislation regulating the relationship between referring practitioners and service providers was introduced in 1991. Referred to as 'arms length' legislation in the Explanatory Memorandum for this Bill, the 1991 legislation meant that referring practitioners and service providers could not be operating in such a way where a financial or other inducement exists for them to perform or refer a service. 'Arms length' relationships are intended to limit inappropriate servicing by ensuring that no financial or other gain could be obtained through referral practices.

The 1991 legislation was reviewed in 2000. The outcome of this review, conducted by the Diagnostic Imaging Arrangements Review Committee (DIARC) considered the current legislation to be an adequate framework for regulating the relationship between referring practitioners and service providers.[14] Despite the acceptability of the current legislative framework, the DIARC recommended a number of measures designed to enhance the operation of 'arms length' legislation. These measures are included in the Bill.

Main Provisions

Schedule 1 - Diagnostic Imaging Register

Items 1-9 insert various definitions relating to the proposed Diagnostic Imaging Register into the *Health Insurance Act 1973* ('the Act').

Item 10 inserts **new sections 16D-16E,** which restrict the circumstances in which Medicare benefits are payable for the provision of diagnostic imaging services.[15] In particular, **new subsection 16D(1)** contains three requirements that must, unless the Minister directs otherwise, be satisfied before Medicare benefits become payable. These requirements are:

- the premises that provide the service, or in the case of mobile imaging equipment, their usual storage location ('base'), must be registered
- the equipment used in the diagnostic imaging procedure must be ordinarily located at the registered premises or base, and
- the register must have recorded on it at least one item of the same type[16] of equipment as was used in the procedure.

There is no guidance in the Bill about the circumstances in which the Minister's power to direct payment of a Medicare benefit (that is, where one or more of the above requirements are not satisfied) can be exercised. The *Explanatory Memorandum* to the Bill comments that:[17]

> The intention…is so that the Minister can give consideration as to whether the patient has been disadvantaged in a particular case through no fault of their own. Examples of when it would be envisaged that this power would be exercised include:
>
> – where there was a delay in the processing of the registration; or
>
> – when the patient was unable to use a registered practice to have the diagnostic imaging procedure, which in similar circumstances would be eligible for a Medicare benefit.
>
> Where the Minister does direct a benefit to be paid in accordance with this provision and the proprietor has failed to notify the patient that the premises or base was not registered, the benefit paid is a debt recoverable from the proprietor of the premises or mobile base.

New section 16E deals with the situation where premises or base have been suspended from the Register under **new section 23DZX**. Medicare benefits become payable again once the suspension is lifted, provided that suspension is not replaced by cancellation of registration under **new section 23DZY.**

Item 11 inserts **new Division 4** (**new sections 23DZK-23DZZI**). Division 4 covers the 'nuts and bolts' of the establishment and operation of the Diagnostic Imaging Register.

New section 23DZK establishes a statutory obligation on the Minister to keep a diagnostic imaging services Register and sets out the purposes for which it is kept. To paraphrase them, these purposes are:

- the gathering of information on the provision of diagnostic imaging services, including (but not limited to) the structure of medical practices connected with the provision of those services, for the purposes of planning and developing the Commonwealth Medicare benefits program;
- identifying whether a Medicare benefit is payable for a particular diagnostic imaging service rendered to a person
- assisting in identifying whether any inappropriate practices[18] are taking place, and
- assisting in identifying whether prohibited diagnostic imaging practices[19] are taking place.

The register may be maintained in an electronic form: **new section 23DZS.**

New section 23DZO defines a 'proprietor' of a diagnostic imaging premise or base. These are the only entities that may apply for registration of a premise or base. Essentially, a proprietor is the person or government agency who has *effective control*[20] of:

- the relevant premises or base

- the use of the relevant diagnostic imaging equipment, and
- the employment of staff (including medical practitioners) connected with the premises.

Proprietors may also be partnerships, in which case *each* partner is equally responsible for the various obligations under the Bill: **new paragraph 23DZZI(3)(a)** and see discussion of **new sections 23DZZF-G.** As noted in the *Explanatory Memorandum*, this statutory obligation regarding responsibility overrides anything contained in the relevant partnership agreement.[21] However, no more than one partner may be fined for the one offence: **new paragraph 23DZZI(3)(c)**.

Under **new section 23DZP**, applications for registration must contain certain information listed in **new subsection 23DZR(1)** ('primary information'[22]) plus any prescribed information,[23] provided that the latter is 'relevant' to the purposes of the Register mentioned in **new section 23DZK**. The Minister may require further information even after registration, again providing it is 'relevant' to the purposes of the Register: **new section 23DZW**. A failure to provide this information will result in suspension or cancellation of registration: **new sections 23DZX-Y.**

Upon registration, a premise or base is given a unique location specific practice number (LSPN): **new subsection 23DZQ(1)**.

New section 23DZT provides that an extract of the Register be made available to any person who requests it, providing the 'purpose' of the request is to 'determin[e] whether [a] Medicare benefit is likely to be payable in respect of a particular diagnostic imaging service'. It is not clear how the purpose of the request is to be determined by whoever is responsible for issuing extracts. The *Explanatory Memorandum* comments:[24]

> This provision will allow anyone, including the referring doctor, to check the registration status (including whether the registration is currently suspended or cancelled) of a premises or mobile base

The Minister has the power to publish an extract on the Internet for any purpose: **new section 23DZU.**

The Minister may cancel a registration under **new section 23DZZA** where:

- a registration was obtained improperly, or
- the proprietor fails to notify changes to the *primary* information under new section 23DZR within 28 days of the information changing.

Before cancelling a registration, the Minister must invite the proprietor to provide reasons within 28 days[25] why the registration should not be cancelled: **new section 23DZZD**. There is no obligation on the Minister to give the reasons why he / she is considering a cancellation. Note also there is no requirement in the Bill for the Minister to take any submission of reasons into account: indeed there is no requirement for the Minister to wait

until the proprietor's submission is received before acting. However, a decision by the Minister to cancel a registration is reviewable by the Administrative Appeals Tribunal (AAT): **new section 23DZZE.** A failure to take into account submissions may well lead to an overturning of a decision by the AAT. Formal cancellation of registration must be in writing and this notice must set out the reasons for the cancellation: **new subsections 23DZZA(2)-(3)**.

There are restrictions on the proprietor's ability to apply for re-registration of a premise or base where registration was cancelled under **new section 23DZY or DZZA**. Specifically a proprietor must have the Minister's permission to apply if they are doing so within 12 months of the cancellation. In considering whether to grant permission, the Minister must take into account whether:

- the act or omission that gave rise to the cancellation was inadvertent, and
- it is reasonable to conclude, in all the circumstances, that the proprietor will comply with this Division in making the application and after registration of the premises or base.

A proprietor of an *unregistered* premises or mobile base commits an offence if the patient is not informed before undertaking the diagnostic imaging procedure that a Medicare benefit is not payable: **new sections 23DZZF-G.** A person is deemed to have informed the patient if either they have given a written notice to the patient or 'prominently' displayed a notice where the procedure is being performed. The offence is one of strict liability - the prosecution does not need to prove any 'fault' (eg recklessness, negligence etc) but the defence of reasonable mistake is available to an accused person. As mentioned earlier, if the proprietor is a partnership, any one of the partners can be prosecuted, even if they have no direct involvement in the failure to inform the patient. The offence carries a maximum penalty of 10 units ($1 100).

Should the Minister direct that a patient be paid a Medicare benefit for a service done in an unregistered premises where the patient was not informed as required under **new sections 23DZZF-G**, the relevant proprietor is liable for this amount: **new section 23DZZH.**

Schedule 2 - Radiation Oncology Register

Schedule 2 establishes the Radiation Oncology Register. Schedule 2 is virtually identical to Schedule 1 in terms of the requirement for registration in order for Medicare benefits to be payable, registration and cancellation processes, liability of radiation oncology proprietors' etc.

Schedule 3 - Referral arrangements for diagnostic imaging services

As mentioned in the background to this Digest, the Act is designed to ensure an 'arms length' situation between the providers of diagnostic imaging services and the practioners who refer patients to these providers. The policy objective behind this is to prevent inappropriate or unnecessary imaging being done. This objective is achieved by (i) prohibiting a provider from offering any inducement or other form of encouragement to practitioners to refer patients to them (existing section 23DZG) and (ii) generally making the service ineligible for Medicare benefits unless it was done by a person acting on the written request (referral) of a practitioner (existing subsection 16B(1)).

However, there are number of exceptions to the rule outlined in (ii). For example, a follow-up ('additional') service is eligible for Medicare if an initial service - which was duly requested by a practitioner - indicates the need for a follow-up: existing subsection 16B(10). Under current subsection 16B(10), there is no specific limit on what this service might be. **New subsection 16B(10)** will limit such additional services to diagnostic imaging services (**item 2**).

New subsection 16B(10A) will insert another exception. This covers the situation where a diagnostic imaging service provider considers that a service different from that requested is more appropriate in diagnosing the patient's condition. This exception requires both that the provider take 'all reasonable steps to consult' with the requesting practitioner *and* that the planned different service must be one that would be accepted by the 'general body' of practitioners / consultants as being the more appropriate service than the one originally requested.

Existing sections 23DT-DZE collectively form another exception to the subsection 16B(1) restriction on Medicare payments. They allow a person in specified remote areas[26] to apply for an exemption from subsection 16B(1) if the referral requirement would result in 'patients in the area…suffer[ing] physical or financial hardship'.

Items 3-19 make a number of amendments to existing sections dealing with the remote area exemption issue. The most significant change is to allow, in certain situations, a prohibited practice to be undertaken in remote areas via the granting of an exemption: **new section 23DXA (Item 5)**. Currently, a person is prohibited from stationing equipment and /or employees at the place of a second person for the purpose of that person providing imaging services on behalf of the first person. The proposed amendments will allow a specialist to apply for an exemption to this rule. The Minister may restrict the exemption to certain equipment or employees. The applicant may ask the Minister to review any such a decision. The Minister's decisions (including review decisions) are reviewable by the AAT: **item 15, new subsection 23DZD**.

Schedule 4 - Osteopaths

Osteopaths are practitioners who specialise in treatment of bones and related skeletal issues.

Currently, osteopaths are not included in the existing subsection 16B(1) list of practitioners who may request a service to be done so that a Medicare benefit is payable for the service. In contrast, registered chiropractors are listed. According to the Second Reading speech,[27] many osteopaths have historically also been registered as chiropractors under State legislation, thus enabling them participate in the Medicare benefit arrangements for diagnostic imaging services. However, it seems that some States now have separate legislation for the registration of the two types of practitioners with the effect that osteopaths may no longer by registered as chiropractors. Under the current Act, this means some osteopaths are no longer able to request a service covered by Medicare.

Items 2-7 amend existing section 16B to add osteopaths to the subsection 16B(1) list and make various related changes. **Items 8-14** make other consequential amendments to the Act to bring them into line vis-à-vis the rights and responsibilities of other classes of practitioners currently listed in subsection 16B(1).

Endnotes

1 Commonwealth Department of Health and Ageing, Medicare Statistics 2002.

2 Australian Institute of Health and Welfare, Australia's Health 2002, p. 268. Medicare benefits paid for radiation oncology have increased by approximately 52 per cent since 1996–97. In the same period Medicare benefits paid for diagnostic imaging have increased by approximately 28 per cent (Health Insurance Commission, Medicare Statistics).

3 Medicare benefits paid for radiation oncology have increased by approximately 52 per cent since 1996–97, Medicare Statistics.

4 Report of the Radiation Oncology Inquiry 2002.

5 Ibid., p. 268.

6 Report of the Radiation Oncology Inquiry 2002.

7 Ian Porter, 'Mayne buys 10 radiology practices', *Sydney Morning Herald*, Tuesday, 3 December 2002.

8 Amanda Elliot, The Decline in Bulk Billing: Explanations and Implications, *Current Issues Brief No. 3 2002-03*, Department of the Parliamentary Library, 24 November 2002, http://www.aph.gov.au/library/pubs/cib/2002-03/03CIB03.htm.

9 Nicola Ballenden, Doctors in the house, *Consuming Interest*, Autumn 2002, Volume: no.91, pp. 18–19.

10 Professional Services Review, *Annual Report 1999-2000*, p. 9.

11 Recent research by the Australian Institute of Health and Welfare indicates that there is also evidence of a significant relationship between practice size and high image ordering rates. Large practice sizes (ie: 11 or more GPs) are most associated with corporatised practices, see Australian Institute of Health and Welfare, Imaging Orders by General Practitioners in Australia 1999-00 General Practice Series No. 7.

12 The funding arrangements for diagnostic imaging services are outlined in an agreement between the Commonwealth, the Royal Australian and New Zealand College of Radiologists, and the Australian Diagnostic Imaging Association. The main purpose of this agreement is to ensure predictable Commonwealth outlays for diagnostic imaging services, consequently within the agreement are agreed annual targets for growth in the number of scans provided per year and Medicare outlays.

13 Explanatory Memorandum, Health Insurance Amendment (Diagnostic Imaging, Radiation Oncology and Other Measures) Bill 2002, p. 9.

14 Diagnostic Imaging Referral Arrangements Review Committee - Final report 2002.

15 Note that these new provisions are to come into effect for services rendered on or after 1 May 2003. However, it is understood that an amendment to the Bill may be introduced to push this date back a little.

16 It is not necessary for the actual piece of equipment used in the procedure to be listed on the Register for the premises or base at the time the procedure is carried out

17 Explanatory Memorandum, p. 27.

18 'Inappropriate practice' is defined in section 82 of the Act. The concept centres on practice that would be 'unacceptable to the general body' of practitioners or specialists in the relevant field.

19 Such prohibited practices are defined in section 23DZG of the Act.

20 This term is not defined, but is currently used elsewhere in the Act.

21 p. 36.

22 This is basic information such as the relevant proprietor's name(s), Australian Business Number, address of premises or base, listing of types of equipment etc.

23 It is unknown whether what is required under new subsection 23DZP(2) 'prescribed information' would be specified by the Government through administrative means or by passing regulations.

24 At: p. 31.

25 A longer period for a response may be given.

26 Generally speaking, this is normally regarded as a location that is at least 30 kilometres by road to the nearest radiology practice at which the services are provided. See Medicare Benefits Schedule, March 1999 Update, Category 5, diagnostic imaging services: http://www.health.gov.au/pubs/mbs/mbs3/categor4.htm#Notes-SectionDIC

27 The Hon Kevin Andrews MP, House of Representatives, *Debates*, 11 December 2002 p. 10078.