

3 December 2025

Australian Government
Department of Health, Disability and Ageing

Email: MRI@health.gov.au

Dear Secretariat,

Re: Review of Medicare Magnetic Resonance Imaging (MRI) Services: Requesting and access pathways

The Royal College of General Practitioners (RACGP) thanks the Department of Health, Disability and Ageing for the opportunity to provide feedback on the *Review of MRI Services: Requesting and access pathways*.

The RACGP supports improving access to Medicare funded MRI services by expanding general practitioner (GP) requesting rights through an evidence-based, three phased approach. This will particularly benefit areas where access to non-GP specialist services is limited, or expensive for patients, particularly in regions where over time public specialist services have been defunded.¹

The RACGP provides feedback on the specific sections in the consultation document:

1. Phase 1: Initial expansion of requesting for GPs

Currently multiparametric magnetic resonance (mpMRI) of the prostate can only be requested by urologists, radiation oncologists and medical oncologists, not GPs.² The RACGP recommends mpMRI requesting for GPs be addressed and included in Phase 1, to align with current best practice guidelines for investigation of raised PSA.³

1.1. Lumbar spine MRI

The RACGP supports the inclusion of Item 63570 - scan of body-person over the age of 16 years in Phase 1 of the expansion of requesting for GPs.

1.1.1. Do the proposed clinical indications for GP requested lumbar spine MRI appropriately balance diagnostic value with safeguards against overuse?

The RACGP position on imaging of adult patients experiencing acute low back pain is for this to be recommended only after careful clinical assessment that results in a high suspicion that there is a serious cause. Routine imaging for uncomplicated low back pain is not recommended.⁴

We question if the proposed exclusion of lumbar spine MRI in conjunction with CT lumbar spine is appropriate. For example, when MRI picks up a fracture, many of which can cause radicular symptoms including pain, numbness, etc., CT lumbar spine imaging would then be indicated to further evaluate the fracture.

1.1.2. Is the proposed service limit of two lumbar spine MRIs per patient per 12 month period appropriate?

The restriction is not unreasonable however; a caveat should be in place for suspected serious conditions and malignancy and be based on clinical need. We note a previous MRI ruling out serious conditions would make a person ineligible for repeat MRI, unless new and concerning clinical features were present. However, it makes little clinical sense to limit the new and concerning features to a minimum timeframe. This should instead be



considered based on clinical need. Consider the following examples of suspected serious conditions and malignancy:

- a patient with known prostate cancer who develops unremitting back pain in the context of raised PSA
- the need to rule out neural compressive pathology in a patient who develops additional neurological deficits.

1.1.3. Does the proposed item align effectively with national clinical guidelines (e.g. Low Back Pain Clinical Care Standard)?

The proposed item aligns with RACGP First Do No Harm guidance on *Imaging in adults with acute low back pain*.⁵

1.2. Thoracolumbar spine MRI

1.2.1. Do the proposed clinical indications for thoracolumbar spine MRI (e.g. trauma, malignancy surveillance, compression fractures) appropriately reflect the conditions commonly managed in general practice? Are there any other indications that should be considered?

The RACGP supports inclusion of thoracolumbar spine MRI in Phase 1 due to its importance in the assessment of spinal trauma, malignancy surveillance and vertebral compression fractures. However, it is unclear why an age cut-off (16 years) has been introduced for this item, as trauma can occur at younger ages. The RACGP requests clarification if this proposed new item will work in conjunction with the existing MRI rule allowing for spine imaging in the under 16 age group.

Other indications that may be considered include unexplained back pain with neurological signs such as:

- suspicion of serious pathology such as infection or tumour
- patients that are surgical candidates for conditions such as spinal / neurogenic claudication may require thoracolumbar spine MRI for pre or post operative assessment
- imaging for the management of Multiple Sclerosis patients.

1.2.2. Is the proposed service limit of two thoracolumbar spine MRIs per patient per 12 month period sufficient to ensure appropriate use while maintaining access for patients with complex or progressive spinal conditions?

The limit of two thoracolumbar spine MRIs per patient per 12 month period is not appropriate, as frequency should be determined according to the specific medical condition. Whilst unnecessary imaging can lead to additional, unnecessary interventions, it is important that the decision to conduct an MRI is based on patient need and determined by a thorough evaluation by the patient's usual GP.

1.2.3. Does the proposed item descriptor and fee structure adequately account for the complexity of imaging protocols required for trauma and malignancy related indications, including contrast-enhanced and extended scan sequences?

It is outside of the remit of the RACGP to comment on work that is not usually carried out by GPs. Importantly, the rebates should be adjusted so there is no out of pocket expense for patients to allow equitable access.



1.3. Foot, ankle, hip, and shoulder MRI

1.3.1. Do the proposed clinical indications for foot, ankle, hip, and shoulder MRI (e.g. occult fractures, ligamentous injuries, osteonecrosis) reflect the types of presentations commonly managed in general practice? Are there additional indications that should be considered?

As previously noted, it is unclear why an age cut-off (16 years) has been introduced for these items. As previously indicated, clarification is needed for why a limit of not more than twice in a 12 month period is set. The RACGP recommends the frequency should be determined by the needs of the patient, following a thorough clinical evaluation by the patient's usual GP.

Clinical indications for each of the items could be described more simply: "*where MRI scanning will exclude or confirm joint intra articular damage and the result will assist with further management of the injury*".

Other indications to consider are:

- the two indications listed for hip imaging are quite rare. The inclusion of joint surface damage is recommended e.g. osteochondral defect of the femoral head or acetabulum;
- for MRI of the shoulder, osteochondral defect of the humeral head or glenoid should be considered indications.

1.3.2. Are the safeguards, such as documentation requirements, exclusion of routine musculoskeletal pain, and limits on concurrent imaging, sufficient to ensure appropriate use of these items?

Assessing MSK conditions is part of GPs core training and is well within the scope of practice of most GPs. The primary factor determining appropriate use of these items should be the thorough clinical examination and management by the patient's GP.

1.3.3. Does the proposed fee structure appropriately reflect the complexity and diagnostic value of these musculoskeletal MRI services, particularly in cases requiring high-resolution imaging or follow-up after inconclusive radiography or CT?

The RACGP is not placed to provide comment about the rebates for radiologists. Importantly, the rebates should be adjusted so there is no out of pocket expense for patients to allow equitable access.

1.4. MRI for suspected stress or insufficiency fractures

1.4.1. Does the proposed requirement for prior radiography (negative or inconclusive) and persistent clinical concern appropriately safeguard the use of MRI for suspected stress or insufficiency fractures? Are there any other criteria that should be considered?

It is reasonable to perform a radiograph (x-ray) first because it is a low-cost and widely available option. As x-rays may be negative in the early stages of a stress or insufficiency fracture, if symptoms persist then an MRI is reasonable to perform.⁶

However, it should be noted that clinical notes and context is important to consider. For instance, a prior radiograph may not be useful in a pars stress fracture (spondylolysis) nor will a negative MRI be useful in a metatarsal stress fracture. The requirement of an ionising radiation study prior to an MRI should be discretionary. The potential harms of x-ray radiation should be weighed against an MRI, which has greater diagnostic sensitivity and is a "no harm" modality.



Other criteria to consider include the patient's clinical history and a physical examination to determine: activity level (e.g. high impact activities); pain pattern (e.g. worsening pain with activity that improves with rest); and localisation – pain that is specific and localised to a particular area is more indicative of a stress fracture than more diffuse pain.

It is not clear why there is an age cut-off for this item. If insufficiency or stress fractures are suspected, then an age cut-off is inappropriate.

1.4.2. Is the documentation requirement, specifically the need to record radiographic findings and clinical rationale, sufficient to support audit and compliance processes?

It is a reasonable and standard requirement to document in the patient's clinical record the following:

- The date and findings of the prior radiograph - these details should be known to the imaging provider and should be accessible in the patient's My Health Record. Findings of the prior radiograph may be inconsequential and not necessary to reproduce on a referral;
- A clear, concise clinical rationale for MRI, including relevant risk factors and presenting symptoms.

1.4.3. Does the proposed fee reflect the diagnostic complexity and clinical value of MRI in detecting early stage stress or insufficiency fractures, particularly in high risk populations such as older adults and athletes?

As stated previously, the rebates should be adjusted so there is no out of pocket expense for patients to ensure equitable access.

2. Phase 2: Inclusion of nurse practitioners and physiotherapists, and expansion of GP access

The RACGP supports the expansion of GP access for MRI requesting. It is important to recognise the range of skills of GPs working at the top of their scope of practice. Assessing MSK conditions is part of GP's core training and is well within the scope of practice of most GPs. In determining when an MRI is indicated, GPs rely on evidence-based clinical practice guidelines to inform their clinical decision-making.

Whilst the RACGP supports in principle, the expansion of MRI services particularly where GPs or specialists are unavailable, safeguards need to be in place to reduce duplication and avoid the provision of low-value MRIs.

The RACGP has concerns that the limited training and experience of some nurse practitioners (NPs) and physiotherapists may lead to low value MRI requests. It may, however, be appropriate to allow limited access to ordering an MRI by nurse practitioners and physiotherapists where they form part of a formal multidisciplinary care team with a GP.

Improving MRI access in rural areas

Patient access to MRI services in rural and remote areas is a critical issue. Limited access to non-GP specialists means patients often wait months (sometimes years) for an MRI that their GP cannot currently order. This delays diagnosis and treatment, prolongs pain, and leads to avoidable deterioration. Enabling GPs to request MRIs directly would significantly improve timely access to imaging, fast-track management, and ensure only those who truly need specialist care are referred on.

The current consultation suggests MRI requesting by both nurse practitioners and physiotherapists as potentially improving access in rural and remote areas. The adequacy of training and continuing professional development for these professions will be an important consideration requiring competency standards and safeguards



including: skills in patient assessment; differential diagnosis; clinical reasoning; interpretation of images; and provision of follow-up care at a minimum.

Regarding the premise that improving access to MRI in rural and remote areas where “*physiotherapists may be the primary provider*” - whilst physiotherapists are crucial in rural and remote areas where they may be the most accessible, or one of the few healthcare options available, it would be a rarity that they would be the only primary provider.

2.1. MRI requesting for nurse practitioners

2.1.1. What clinical indications should be included in nurse practitioner requestable MRI items to ensure alignment with NP scope of practice and training?

The adequacy of training and continuing professional development for NPs will be an important consideration requiring competency standards and safeguards including: skills in patient assessment; differential diagnosis; clinical reasoning; interpretation of images; and provision of follow-up care at a minimum.

Preferably, with the availability of telehealth, NPs should work with a doctor to review the patient and the doctor can then order the MRI if it is indicated.

2.1.2. What safeguards, such as evidence-based guidelines, monitoring mechanisms, and documentation requirements, are necessary to support safe and appropriate use of MRI services by nurse practitioners?

As for all practitioners, there is a broad range of considerations. These include but are not limited to:

- the use of up-to-date evidence-based guidelines;
- accurate and complete documentation of patient care;
- clear safety protocols and procedural records;
- documentation of communication with patients and relevant other healthcare providers, especially regarding risks, benefits, and any changes to the treatment plan

Of particular importance is financial consent and freedom from financial conflict of interest that may otherwise occur through integrated service models where a nurse works with or in close association with an imaging provider.

2.1.3. How can the Department ensure consistent acceptance of NP MRI requests across imaging providers, particularly in rural and remote settings where NPs may be the primary care provider?

The RACGP acknowledges that in remote areas a NP may be the only accessible provider of services. In such instances, it may be appropriate for NPs to request MRIs for clearly defined conditions and in collaboration with a GP, a non-GP specialist or radiologist. Radiology providers will need clear information about the circumstances where Medicare funded MRI can be requested by a NP.

2.2. MRI requesting for physiotherapists

Whilst physiotherapists are trained in clinical reasoning, differential diagnosis, and the identification of red flags requiring further investigation, they are not trained in imaging interpretation. The interpretation of imaging results should revert to the patient’s GP, which is a fundamental principle of multidisciplinary care.

An important consideration is where a physiotherapist is employed by or in a financial relationship with an imaging provider. Safeguards must be in place to prevent financial conflicts of interest.

In terms of streamlining patient journeys, particularly for musculoskeletal presentations, GPs are well placed to provide timely, appropriate care.

Regarding the claim of reducing demand on GPs for administrative referrals, a referral should never be administrative, it is up to the GP to properly examine and investigate the patient.

2.2.1. Which anatomical regions and what clinical indications (eg. knee trauma, spinal radiculopathy) should be prioritised for inclusion in physiotherapy requestable MRI items to ensure alignment with scope of practice and diagnostic capability?

Anatomical regions particularly pertinent to physiotherapy-requestable MRI include the cervical spine and knee. The primary clinical indications are acute knee trauma (e.g. torn meniscus or ligament), unexplained chronic knee pain (following inconclusive x-ray), post-traumatic assessment for evaluation after a knee injury, and spinal radiculopathy (for suspected nerve compression).

2.2.2. What safeguards, such as referral protocols, documentation standards, and access to patient records are necessary to support safe and appropriate use of MRI services by physiotherapists?

Establishment of clear processes for determining when an MRI is clinically indicated and appropriate for the patient's condition, rather than only addressing patient concern. Information sharing is also critical, ensuring that all necessary patient information, including cautions and contraindications are documented.

Proposed changes to MRI requesting should foster closer engagement with the patient's GP. Communication with the GP prior to requesting the MRI would help to safeguard against duplication and low-value scans while assisting the GP and physio to provide consistent care.

2.2.3. How can the Department ensure consistent implementation across settings, particularly in rural and remote areas where physiotherapists may be the primary provider of musculoskeletal care?

To ensure consistent implementation in rural and remote settings, the Department can focus on supporting physiotherapists with professional development, funding and resources while also improving service delivery through models like public-private partnerships, telehealth, and integrated primary care teams. This should include training for expanded roles, funding for continuing education and using technology to overcome geographic barriers.⁷

The RACGP emphasises there is a requirement that responsibility for arranging safe and prompt follow up rests with the practitioner who requests imaging. It is not safe to just provide a copy of the result to a patient's usual GP without comprehensive clinical handover.

2.3. Knee MRI for patients aged 50 and over

2.3.1. Do the proposed clinical indications for knee MRI in patients aged 50 and over (e.g. suspected fracture, ACL tear, septic arthritis) appropriately reflect the diagnostic needs of this age group? Are there additional indications that should be considered?

The RACGP supports the proposed clinical indications for knee MRI in patients aged 50 and over, recognising the benefits in expanding access in this population group. The proposed clinical indications may also prevent MRI for suspected 'simple' meniscal damage in the over 50 age group and also prevent MRI for osteoarthritis.



Whilst the proposed indications for knee MRI in patients over 50 are appropriate, the decision to order an MRI in this age group requires a patient specific approach based on the patient's history, physical examination, and clinical suspicion for a specific condition that is not diagnosed by an x-ray.

Other indications for consideration may include: persistent, non-specific pain where conservative management has not helped; mechanical problems such as knee locking or giving way, which may be due to a displaced meniscal tear; osteonecrosis (death of bone tissue); pre-surgical planning; other atypical symptoms e.g. unexplained pain not typical of osteoarthritis or degenerative changes alone.

Septic arthritis is rarely an indication for MRI. Bloodwork and an arthrocentesis is more appropriate.

2.3.2. What safeguards or documentation requirements should be implemented to ensure appropriate use and avoid unnecessary imaging in older patients?

In line with good clinical practice for consultations, it is standard to take a relevant health history, assess health risk factors, obtain informed consent and discuss and document the risks and benefits of having the imaging including the risks of not having the imaging.

The request form for the MRI should include sufficient clinical details to explain the need for the MRI and to assist the radiologist's reporting.

2.3.3. Does the proposed expansion adequately address current access barriers and align with best practice in musculoskeletal care for older Australians?

Equitable access to MRI includes: distribution of MRI machines; transport arrangements; out of pocket costs for MRI; and disability access.

2.4. Musculoskeletal MRI for joint injuries, spinal radiculopathy, and soft tissue conditions

The RACGP supports the expansion of MRI access to include the following clinical indications:

- Joint injuries: including suspected labral tears, ligamentous injuries, or occult fractures of the shoulder, hip or knee
- Spinal radiculopathy: particularly in the lumbar and thoracic spine, where neurological signs are present and MRI is superior to CT
- Soft tissue conditions: including suspected tendon or muscle tears, haematomas, or soft tissue masses not adequately characterised by ultrasound

2.4.1. Do the proposed clinical indications (e.g. labral tears, ligamentous injuries, spinal radiculopathy, soft tissue masses) appropriately reflect common presentation in general practice where MRI is the preferred modality? Are there additional indications that should be considered?

The proposed clinical indications in the consultation document are appropriate for common general practice presentations.

To address if MRI is the preferred modality and prevent overuse will require the results being evaluated for clinical significance by correlating them with clinical symptoms.⁸ The RACGP recommends a cautious approach, ensuring clinical symptoms are correlated with MRI findings. For example, the prevalence of superior labral tears diagnosed by MRI in asymptomatic shoulders of middle-aged people is high. Therefore, caution is needed when assessing MRI results as the superior labral tears may not necessarily be the cause of shoulder pain symptoms in

this patient population.⁹ Similarly for spinal radiculopathy, imaging findings can be misleading as it is possible to have radicular symptoms that are not clearly demonstrated on an MRI particularly if the findings are borderline.

Additional indications to consider include:

- spinal trauma,
- infections (e.g. spinal abscess or meningitis), and
- demyelinating diseases, (e.g. multiple sclerosis exacerbations present to GPs initially) are time sensitive and require an urgent MRI, which is the gold standard for diagnosis.

2.4.2. What safeguards, such as anatomical region-specific service limits, documentation requirements, and decision support tools, are needed to ensure appropriate use and manage utilisation effectively?

The RACGP supports MRI access for GPs under the same restrictions / freedoms as non-GP specialists as most musculoskeletal conditions will present in general practice.

Clinical indications should be included in the request forms. These clinical details should be included in the report from radiologists.

Rationing of MRI services by requiring referral to a non-GP specialist (i.e. the current situation) impacts rural, remote, and poorer patients the most. It does not necessarily lead to fewer low-value scans.

Allowing GPs to refer for MSK MRI will also avoid the patient needing to see a non-GP specialist twice - once for the initial assessment then again after the MRI, which currently results in a doubling of the rebate cost to Medicare.

2.4.3. Does the proposed expansion align with the evolving role of GPs as first-contact diagnosticians and support timely, evidence-based care across diverse practice settings, including rural and remote areas?

The RACGP supports the expansion of musculoskeletal MRI indications as a step in the right direction to foster better care continuity and accessibility to MRI services particularly in rural and remote areas where access to specialists may be limited. However, this will depend on available access to the MRI machines in these communities.

Access to non-GP specialists is also problematic in urban environments because of long waiting lists for public services and unaffordable out of pocket expenses for private non-GP specialist clinics.

It will be important for the Department to carefully consider how this expansion program will be evaluated in the three phases to determine the impact on the desired program outcomes.

3. Phase 3: Broader clinical indications

Phase 3 of the MRI requesting reform process will explore the extension of requesting rights to include follow-up imaging and complex conditions that require ongoing monitoring.

For screening and surveillance purposes, MRI ordering should have clear guidance for patient eligibility to avoid overservicing.

The proposed indications include:

3.1. Surveillance MRI for previously diagnosed conditions

Enabling GPs and other eligible health professionals to request MRI scans for the ongoing monitoring of conditions already diagnosed by a specialist, thereby improving continuity of care, reducing unnecessary specialist re-referrals and support timely clinical decision-making.

3.2. Breast MRI for high risk patients

Expanding requesting rights to GPs for patients who meet established high-risk criteria (e.g. BRCA mutation carriers, strong family history)

3.3. Pelvic and brain MRI for complex or chronic presentations

Allowing GPs to request MRI for selected complex chronic conditions where MRI is clinically indicated and supported by guidelines.

3.4. Expanded musculoskeletal indications for allied health professionals

The RACGP seeks clarity on the scope of practice for both physiotherapists and other allied health professionals in the context of diagnosing MSK conditions. Will there be further training in image interpretation? The interpretation of the radiologist report often isn't clinically correlated and will pose limitations for proper diagnosis.

Phase 3 questions:

- 3.4.1. Do the proposed Phase 3 reforms appropriately support continuity of care and reduce unnecessary specialist referrals for chronic or complex conditions such as multiple sclerosis, sarcoma and prostate cancer?**
- 3.4.2. Should GPs and eligible allied health professionals be permitted to request surveillance MRI for previously diagnosed conditions, and what safeguards (e.g. documentation, service limits) are needed to ensure appropriate use?**
- 3.4.3. Is it clinically appropriate to expand GP requested MRI access for complex presentations such as chronic pelvic pain and neurological symptoms? What criteria should guide eligibility to prevent over-servicing?**
- 3.4.4. Should breast MRI requesting rights be extended to GPs for high-risk patients (e.g. BRCA mutation carriers)? What protocols or referral conditions would support safe and equitable access?**
- 3.4.5. How can expanded MRI requesting rights for allied health professionals, particularly for follow-up imaging and rehabilitation monitoring, be implemented safely and effectively across multidisciplinary and rural settings?**
- 3.4.6. What decision support tools, audit mechanisms and training requirements are necessary to ensure Phase 3 reforms are clinically justified, cost-effective and aligned with scope of practice?**

As indicated in the consultation document, each phase will be informed by the previous phase. Therefore, these questions are best answered after insights from the initial phases have been garnered.



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Whilst the RACGP supports the intention of the expansion program it will be important for the Department to have a clear evaluation plan for each of the phases. At this point in time, it is difficult to determine how the changes will impact patient access, the quality of care, costs, etc.

The RACGP thanks the Department of Health, Disability and Ageing for the opportunity to provide feedback on the Review of MRI Services. If you have any questions regarding this response please contact Mr Stephan Groombridge, National Manager, eHealth, Quality Care & Standards, (03) 8699 0544 or stephan.groombridge@racgp.org.au

Yours sincerely

Dr Michael Wright
President



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