



# Quick Reference Guide: Diagnostic Imaging Changes for 1 November 2021

Date of change: 1 November 2021

New items: 61560

Amended items: 55065 55068 56553 57360 63489 63541 63543

Deleted items: 57351

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## Revised structure

### New and amended listings recommended by the Medical Services Advisory Committee

- A new item (61560) for Positron Emission Tomography (PET) for the diagnosis of Alzheimer's Disease in patients where other diagnostic methods are equivocal will be introduced. There will be a restriction on this item limiting its use to once per patient per year and a maximum of three services in the patient's lifetime. This item cannot be claimed if single photon emission tomography item 61402 had been claimed in the previous 12 months for the diagnosis of Alzheimer's Disease.
- The 36 month time restriction for a computed tomography (CT) scan for colorectal neoplasia (item 56553) will be removed. This change will allow high risk category patients to access diagnostic scans as frequently as needed and aligns the MBS with the National Health and Medical Research Council clinical guidelines.
- The MRI guided biopsy of the breast item (item 63489) will be amended to retain only the MRI-guidance component at a reduced fee and allow co-claiming with breast ultrasound and any relevant breast biopsy item.
- The item descriptor for multiparametric magnetic resonance imaging (MRI) item 63541 for the diagnosis of prostate cancer will include an expanded population to allow patients at very high risk of prostate cancer due to family history and a high prostate specific antigen level to access the service. In addition, this item and item 63543 have been moved from a determination under section 3C of the *Health Insurance Act* to the *Health Insurance (Diagnostic Imaging Services Table) Regulations (DIST)*. As part of this process, the item descriptors have been revised and the patient eligibility criteria are now stated as clauses in the DIST.



## Administrative changes

There are three administrative type changes:

- Pelvic ultrasound items 55065 and 55068 - this change is to remove a restriction that was placed on general pelvic ultrasound items 55065 and 55068 to allow the service to be rendered in association with gynaecological items 55736 and 55739. The restriction commenced on 1 May 2020 and should only have applied to pregnancy related services (recommendation 14 of the Diagnostic Imaging Clinical Committee of the MBS Review Taskforce). The restriction was applied to all services in the Obstetric and Gynaecological section (Subgroup 5 of Group I1 of the DIST). Gynaecological items 55736 and 55739 are not pregnancy related.
- CT angiography item 57351 will be deleted. Item 57351 applied to second and subsequent scans in a 12 month period following item 57350. Item 57350 was only able to be claimed once in a 12 month period. Item 57350 was split into three items on 1 May 2020 (items 57352, 57353 and 57354) and a further item (item 57357) was added on 1 November 2020. In addition to the recommendation to split item 57350, the MBS Review Taskforce recommended that the frequency restrictions be removed. Thus, items 57352, 57353, 57354 and 57357 have no frequency restrictions. This has rendered item 57351 obsolete.
- The descriptor for item 57360 (CT coronary angiography) will be amended to reflect changes recommended by the MBS Review Taskforce that were unintentionally omitted from the 1 July 2021 cardiac related changes.

## Private health insurance arrangements

- As a diagnostic imaging service, item 61650 will be classed as a Support service and be classified as a Type C procedure.
  - Deleted item 57351 will be removed from the Type A procedures: Surgical patient list of MBS items.
  - The existing private health insurance arrangements for the other changes in this guide remain the same.
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## New item – 61560 – PET for Alzheimer’s Disease

**Overview:** This item has been introduced on the recommendation of MSAC for the diagnosis of Alzheimer’s Disease where other diagnostic methods are equivocal.

### Descriptor:

FDG PET study of the brain, performed for the diagnosis of Alzheimer’s disease, if:

- (a) clinical evaluation of the patient by a specialist, or in consultation with a specialist, is equivocal; and
- (b) the service includes a quantitative comparison of the results of the study with the results of an FDG PET study of a normal brain from a reference database; and
- (c) a service to which this item applies has not been performed on the patient in the previous 12 months; and
- (d) a service to which item 61402 applies has not been performed on the patient in the previous 12 months for the diagnosis or management of Alzheimer’s disease

Applicable not more than 3 times per lifetime

### Indication:

This item applies when requested by a specialist or consultant physician following a clinical evaluation that was equivocal about whether or not the patient had Alzheimer’s disease.

### Other requirements:

- The PET study must include a quantitative comparison of the results with the results obtained from a PET study in a reference library of a normal brain.
- Benefits are not payable for the item if the patient has a previous PET scan for Alzheimer’s disease claimed in the previous 12 months.
- Benefits are not payable for the item if a cerebral perfusion study (item 61402) for the diagnosis or management of Alzheimer’s disease has been claimed in the previous 12 months.
- Benefits are only payable for a maximum of three services in the patient’s lifetime.

**MBS fee: \$605.05.**

**Benefit: 85% = \$517.15 75% = \$453.80 Out of hospital Bulk billed benefit = \$574.80**

### Proposed Private Health Insurance Classifications:

- **Proposed Clinical category:** Support treatment (as for other diagnostic imaging services)
- **Proposed Procedure type:** Type C

Note: Private Health Insurance classifications and categorisations are subject to the making and registration of the Private Health Insurance (Complying Product) Rules 2015 and Private Health Insurance (Benefit Requirements) Rules 2011.

For questions and feedback regarding the proposed PHI classifications, please email [PHI@health.gov.au](mailto:PHI@health.gov.au).



### Amended item 55065 – Pelvic ultrasound (R)

**Overview:** The descriptor has been amended to allow it to be claimed in association with gynaecological items 55736 (R) or 55739 (NR). These items are pelvic ultrasounds in association with saline infusion of the endometrial cavity.

**Descriptor:**

Pelvis, ultrasound scan of, by any or all approaches, if:

(a) the service is not solely:

- (i) a service to which an item in Subgroup 5 (other than item 55736 or 55739) of this Group applies, or
- (ii) a transrectal ultrasonic examination of the prostate gland, bladder base and urethra, or any of those organs; and
- (b) within 24 hours of the service, a service mentioned in item 55038 is not performed on the same patient by the providing practitioner

**Indication:** This item can now be claimed if rendered at the same attendance as items 55736 or 55739.

**MBS fee:** \$100.60 (no change)

**Benefit:** No change.

### Amended item 55068 – Pelvic ultrasound (NR)

**Overview:** The descriptor has been amended to allow it to be claimed in association with gynaecological items 55736 (R) or 55739 (NR). These items are pelvic ultrasounds in association with saline infusion of the endometrial cavity.

**Descriptor:**

Pelvis, ultrasound scan of, by any or all approaches, if the service is not solely a service to which an item in Subgroup 5 (other than a service to which item 55736 or 55739 applies) of this Group applies or a transrectal ultrasonic examination of any of the following:

- (a) prostate gland;
- (b) bladder base;
- (c) urethra (NR)

**Indication:** This item can now be claimed if rendered at the same attendance as items 55736 or 55739.

**MBS fee:** \$35.80 (no change)

**Benefit:** No change.



## Amended item 56553 – Computed tomography of the colon)

**Overview:** The descriptor has been amended to remove the time restriction on reclaiming the item.

### Descriptor:

Computed tomography—scan of colon for exclusion or diagnosis of colorectal neoplasia in a symptomatic or high risk patient if:

(a) one or more of the following applies:

(i) the patient has had an incomplete colonoscopy in the 3 months before the scan;

(ii) there is a high-grade colonic obstruction;

(iii) the service is requested by a specialist or consultant physician who performs colonoscopies in the practice of the specialist's or consultant physician's speciality; and

(b) the service is not a service to which item 56301, 56307, 56401, 56407, 56409, 56412, 56501, 56507, 56801, 56807 or 57001 applies (R) (Anaes.)

**Indication:** This change will allow high risk category patients to be able to access the item as frequently as clinically needed and aligns the MBS with the National Health and Medical Research Council clinical guidelines.

As is currently required, the request for the CT scan needs to make it clear that the patient has had an incomplete colonoscopy in the previous three month and/or there is a high grade colonic obstruction.

**MBS fee:** \$532.55 (no change)

**Benefit:** No change.



## Amended item 57360 – Computed tomography coronary angiography)

**Overview:** The descriptor has been amended to reflect changes recommended by the MBS Review Taskforce and Implementation Liaison Group on Cardiac Services that were unintentionally omitted from the 1 July 2021 cardiac related changes.

### Descriptor:

Computed tomography of the coronary arteries performed on a minimum of a 64 slice (or equivalent) scanner if:

- (a) the request is made by a specialist or consultant physician; and
- (b) the patient has stable or acute symptoms consistent with coronary ischaemia; and
- (c) the patient is at low to intermediate risk of an acute coronary event, including having no significant cardiac biomarker elevation and no electrocardiogram changes indicating acute ischaemia (R) (Anaes.).

### Restrictions/requirements not listed in the item descriptor:

Benefits are not payable for item 57360 more than once in a 5 year period following a service to which itself or 57364 applies that detected no obstructive coronary artery disease unless the patient meets the eligibility criteria for selective coronary angiography (items 38244, 38247, 38248 or 38249. The eligibility criteria for items 38244, 38247 are set out in clause 5.10.17A of the General Medical Services Table (GMST), while the criteria for items 38248 and 38249 are set in clause 5.10.17B of the GMST.

Clauses 5.10.17A and B of the GMST are restated at Attachment A to this guide.

**Indication:** The three changes made to this item are:

1. It is no longer necessary for it to be known that the patient does not have coronary artery disease at the time the request is made. The item can be claimed if the patient has known coronary artery disease.
2. The 5 year frequency restriction on the claiming of this item does not apply if obstructive coronary artery disease was detected as part of the previous service.
3. The 5 year frequency restriction does not apply if no obstructive coronary disease was detected at the previous service AND the patient meets the criteria for item 38244, 38247 or 38249 – selective invasive coronary angiography. The criteria for these items are set out in explanatory notes [TR8.2](#) and [TR8.3](#).

The changes effectively increase the population eligible for the item and provide a non-invasive alternative to selective coronary angiography.

**MBS fee:** \$716.90 (no change)

**Benefit:** No change.



## Amended item 63489 – MRI guidance for breast biopsy

**Overview:** The item descriptor has been amended to retain only the MRI-guidance component at a reduced fee and allow co-claiming with breast ultrasound and any relevant breast biopsy item.

### Service/Descriptor:

MRI—scan of one breast, performed in conjunction with a biopsy procedure on that breast and an ultrasound scan of that breast, if:

- (a) the request for the scan identifies that the patient has a suspicious lesion seen on MRI but not on conventional imaging; and
- (b) the ultrasound scan is performed immediately before the MRI scan and confirms that the lesion is not amenable to biopsy guided by conventional imaging; and
- (c) a dedicated breast coil is used (R) (Anaes.)

**Indication:** This item now only applies to the MRI scan element of the service. As previously required, an ultrasound scan of the affected breast needs to have been undertaken immediately before undertaking the biopsy under MRI guidance. If the results of the ultrasound scan show that the lesion could be biopsied under other types of image guidance, for example ultrasound or mammography, the MRI scan should not be undertaken.

The following are four scenarios as to which items could be claimed in particular clinical circumstances:

1. If MRI guidance **is not needed**, and it is determined that a biopsy is not required, a claim for the ultrasound scan under item 55070 could be made.
2. If MRI guidance **is not needed** and a breast biopsy is undertaken under ultrasound guidance following the preliminary ultrasound, a claim for the ultrasound scan could be made under item 55071. A claim **could not** also be made for the preliminary ultrasound scan. A claim could also be made for the relevant breast biopsy procedure item, for example, item 31548.
3. If MRI guidance **is not needed** and the biopsy is undertaken under radiographic guidance, the preliminary ultrasound scan could be claimed under item 55070 as for scenario 1. The relevant radiographic item 59314 along with the relevant breast biopsy procedural item could also be claimed.
4. If MRI guidance **is needed**, item 63489, along with a breast ultrasound item 55071 and the relevant breast biopsy procedural item could be claimed.

It is not necessary that claims be made for the ultrasound or procedural items for item 63489 to be claimed. as long as those elements have been undertaken.

**MBS fee:** \$1,008.00

**Benefit:** 85% = 920.10 75% = \$756.00 Out of hospital bulk billed benefit = \$1,008.00

NOTE: The Out of hospital bulk billed benefit for MRI services will be changing from 1 July 2022.



## Amended item 63541 – MRI prostate

**Overview:** The item has been amended to include an expanded population to allow patients at very high risk of prostate cancer due to family history and a high prostate specific antigen result to access the service. Some slight wording changes have also been made.

### Service/Descriptor:

Multiparametric MRI—scan of the prostate for the detection of cancer, requested by a specialist in the speciality of urology, radiation oncology or medical oncology:

(a) if the request for the scan identifies that the patient is suspected of developing prostate cancer:

- (i) on the basis of a digital rectal examination; or
- (ii) in the circumstances mentioned in clause 2.5.9A; and

(b) using a standardised image acquisition protocol involving T2-weighted imaging, diffusion-weighted imaging and dynamic contrast enhancement (unless contraindicated) (R) (Anaes)

### Restrictions/requirements not listed in the item descriptor:

Clause 2.5.9A referred to in the descriptor contains the patient eligibility criteria. These are the essentially the same as the previous item but with an expanded population.

In summary:

- for a person 70 years or older, at least two PSA tests performed within an interval of 1- 3 months have a PSA concentration of greater than 5.5 µg/L and the free/total PSA ratio is less than 25%.
- for a person under 70 years, at least two prostate specific antigen (PSA) tests are performed within an interval of 1- 3 months have a PSA concentration of greater than 3.0 µg/L, and the free/total PSA ratio is less than 25%, or the repeat PSA exceeds 5.5 µg/L; or
- for a person under 70 years, whose risk of developing prostate cancer based on relevant family history is at least double the average risk, at least two PSA tests performed within an interval of 1- 3 months have a PSA concentration greater than 2.0 µg/L, and the free/total PSA ratio is less than 25%, or the repeat PSA exceeds 5.5 µg/L. Relevant family history is a first degree relative with or has had prostate cancer or suspected of carrying a BRCA 1 or BRCA 2 mutation.

The limit of one service each 12 months still applies.

**Indication:** Before this item was amended, patients with a high risk of developing prostate cancer as described had to have results from their PSA be above 2 micrograms per litre with a free/total PSA ratio of less than 25%. The item now also applies to high risk patients whose results from the repeat PSA test exceed 5.5 micrograms per litre, irrespective of free/total ratio result.

**MBS fee:** \$450.00 (no change)

**Benefit:** No change.



## Amended item 63543 – MRI prostate – monitoring low risk diagnosed patients

**Overview:** The item has had minor description changes for administrative purposes. The frequency restrictions have also been clarified.

### Service/Descriptor:

Multiparametric MRI—scan of the prostate for the assessment of cancer, requested by a specialist in the speciality of urology, radiation oncology or medical oncology:

(a) if the request for the scan identifies that the patient:

- (i) is under active surveillance following a confirmed diagnosis of prostate cancer by biopsy histopathology; and
- (ii) is not undergoing, or planning to undergo, treatment for prostate cancer; and

(b) using a standardised image acquisition protocol involving T2-weighted imaging, diffusion-weighted imaging and dynamic contrast enhancement (unless contraindicated) (R) (Anaes)

### Restrictions/requirements not listed in the item descriptor:

A period of at least 12 months needs to have elapsed before benefits for a second service under 63543 are payable. Benefits are then only payable after a period of three years has elapsed from the date of the second scan and at least each three years thereafter. The previous restrictions used the date of diagnosis of prostate cancer as the reference for the timing intervals.

Benefits are not payable where the service is provided for the purposes of treatment planning or monitoring after treatment for prostate cancer.

### Indication:

This item is used for monitoring low risk patients who have been diagnosed with prostate cancer and who have not been already treated or are not planning or undergoing treatment.

## Deleted item – 57351 – Computed tomography angiography

This item has been deleted as it is now obsolete. It applied to second and subsequent scans in a 12 month period following item 57350. Item 57350 was only able to be claimed once in a 12 month period. Item 57350 was split into three items on 1 May 2020 (items 57352, 57353 and 57354) and a further item (item 57357) was added on 1 November 2020. In addition to the recommendation to split item 57350, the MBS Review Taskforce recommended that the frequency restrictions be removed. Items 57352, 57353, 57354 and 57357 have no frequency restrictions and can be claimed instead of item 57351.



**Eligibility criteria for items 38244, 38247, 38248 and 38249 for the purposes of item 57360**

**5.10.17A Items 38244, 38247, 38307, 38308, 38310, 38316, 38317 and 38319—patient eligibility and timing**

- (1) A patient is eligible for a service to which item 38244, 38247, 38307, 38308, 38310, 38316, 38317 or 38319 applies if:
  - (a) subclause (2) applies to the patient; and
  - (b) a service to which the item applies has not been provided to the patient in the previous 3 months, unless:
    - (i) the patient experiences a new acute coronary syndrome or angina, as described in paragraph (2)(a), (b) or (c), in that period; or
    - (ii) for a service to which item 38316, 38317 or 38319 applies—the service was provided to the patient in that period as a subsequent stage following an initial primary percutaneous coronary intervention procedure.
- (2) This subclause applies to a patient who has:
  - (a) an acute coronary syndrome evidenced by any of the following:
    - (i) ST segment elevation;
    - (ii) new left bundle branch block;
    - (iii) troponin elevation above the local upper reference limit;
    - (iv) new resting wall motion abnormality or perfusion defect;
    - (v) cardiogenic shock;
    - (vi) resuscitated cardiac arrest;
    - (vii) ventricular fibrillation;
    - (viii) sustained ventricular tachycardia; or
  - (b) unstable angina or angina equivalent with a crescendo pattern, rest pain or other high-risk clinical features, such as hypotension, dizziness, pallor, diaphoresis or syncope occurring at a low threshold; or
  - (c) either of the following, detected on computed tomography coronary angiography:
    - (i) significant left main coronary artery disease with greater than 50% stenosis or a cross-sectional area of less than 6 mm<sup>2</sup>;
    - (ii) severe proximal left anterior descending coronary artery disease (with stenosis of more than 70% or a cross-sectional area of less than 4 mm<sup>2</sup> before the first major diagonal branch).



### 5.10.17B Items 38248 and 38249—patient eligibility

- (1) A patient is eligible for a service to which item 38248 or 38249 applies if:
  - (a) subclause (2) applies to the patient; or
  - (b) the patient is recommended for coronary angiography as a result of a heart team conference that meets the requirements of subclause (3).
- (2) This subclause applies to a patient who has:
  - (a) limiting angina or angina equivalent, despite an adequate trial of optimal medical therapy; or
  - (b) high risk features, including at least one of the following:
    - (i) myocardial ischaemia demonstrated on functional imaging;
    - (ii) ST segment elevation, sustained ST depression, hypotension or a Duke treadmill score of minus 11 or less, demonstrated by stress electrocardiogram testing;
    - (iii) computed tomography coronary angiography evidence of one or more coronary arteries with stenosis of 70% or more; or
    - (iv) left ventricular dysfunction with an ejection fraction of less than 40% or segmental wall motion abnormality at rest.
- (3) For the purposes of paragraph (1)(b), the requirements for a heart team conference are as follows:
  - (a) the conference must be conducted by a team of specialists or consultant physicians practising in the speciality of cardiology or cardiothoracic surgery, including each of the following:
    - (i) an interventional cardiologist;
    - (ii) a non-interventional cardiologist;
    - (iii) a specialist or consultant physician; and
  - (b) the team must:
    - (i) assess the patient's risk and technical suitability to receive the service; and
    - (ii) make a recommendation about whether or not the patient is suitable for invasive coronary angiography; and
  - (c) a record of the conference must be created, and must include the following:
    - (i) the particulars of the assessment of the patient during the conference;
    - (ii) the recommendations made as a result of the conference;
    - (iii) the names of the members of the team making the recommendations.