



Changes to MBS items and rules for diagnostic imaging services fact sheet – overview

- From 1 May 2020, there will be number of changes relating to Medicare Benefits Schedule (MBS) items and rules for diagnostic imaging services to implement the recommendations from the MBS Review Taskforce and the Medical Service Advisory Committee (MSAC). The changes will ensure the diagnostic imaging services provided under Medicare are contemporary and reflect best clinical practice.
- These changes are relevant for all health professionals delivering and claiming diagnostic imaging services, consumers receiving and claiming the services, private health insurers and hospitals.

What are the changes?

This fact sheet contains an overview of the changes coming into effect from 1 May 2020. There are supporting fact sheets/quick reference guides that provide more information on changes to the capital sensitivity arrangements, the radiologist co-claiming changes, and MBS items for each of the diagnostic imaging modalities, that is, ultrasound, computed tomography (CT), diagnostic radiology, nuclear medicine imaging and magnetic resonance imaging (MRI).

Changes made as a result of recommendations of MSAC are annotated.

Capital sensitivity

- From 1 May 2020, benefits will not be payable for diagnostic imaging services rendered on equipment that has reached its effective life age or maximum extended life age unless there is a remote area exemption or special exemption in place.
- All 'NK' items will be deleted from the MBS and remaining items will no longer include the annotation 'K'.

Ultrasound

A number of changes are being made related to ultrasound items, including:

- two new items for ultrasound of the breast in conjunction with a surgical procedure will be created. The new items are 55066 (both breasts) and 55071 (one breast). The relevant surgical procedure item in the General Medical Services Table is able to be claimed in conjunction with these items.
- items covering musculo-skeletal ultrasound of the extremities will be deleted and replaced with items covering unilateral and bilateral scans. The unilateral scans will retain the same schedule fee as the items being deleted. The bilateral scan fees will be approximately 11% higher than the unilateral scan fees.



- item descriptors for general ultrasound, obstetric and gynaecological ultrasound and musculoskeletal ultrasound will be amended to remove co-claiming restrictions with cardiac and/or vascular ultrasound. A restriction will still apply for vascular ultrasound of the lower leg and musculo-skeletal ultrasound of the lower leg.
- the general pelvic ultrasound items 55065 and 55068 will no longer be able to be claimed where an obstetric ultrasound item would apply.
- the item descriptor for breast ultrasound items 55076 and 55079 will be amended so that they also apply to post mastectomy surveillance. The chest or abdominal wall items 55812 and 55814 will no longer be able to be co-claimed with breast ultrasound items (items 55070, 55073, 55076 and 55079).
- the schedule fees for the interventional ultrasound items 55848 and 55850 will be increased.
- the list of conditions in the obstetric ultrasound items will be deleted. For the less than 12 week scan items (item 55700 and 55703), the items apply where the scan is for 'determining the gestation, location, viability or number of fetuses'. For the 12 to 16 week scan, the items (55704 and 55705) apply for 'determining the structure, gestation, viability or number of fetuses'. The later obstetric scans apply where clinically appropriate.
- MSAC change: the descriptors for abdominal ultrasound items 55036 and 55037 will be amended to include the term 'morphological assessment' so that the items should only be used for imaging purposes, not for non-imaging techniques such as transient elastography.

Computed tomography (CT)

A number of changes are being made related to CT items, including:

- the scan of extremities items 56619 and 56625 will be deleted and replaced by items covering the lower and upper limbs. The new items will be 56622 (scan of lower limb without contrast), 56623 (scan of lower limb with contrast), 56627 (scan of upper limb without contrast), and 56628 (scan of upper limb with contrast). The schedule fees for these items will be the same contrast and non contrast items they are replacing.
- the descriptor for item 57341 (CT in conjunction with a surgical procedure) will be amended to allow it to be co-claimed with any other diagnostic imaging item.
- the CT spiral angiography item 57350 will be deleted and replaced by three new items covering CT angiography of different arterial regions. The schedule fees for these items will remain the same as the item they replaced.
- MSAC change: item 57362 (cone beam computed tomography – CBCT) will be able to be claimed when the service is rendered on equipment that can also provide other services (such as x-ray and OPG). Currently, CBCT services have to be rendered on dedicated CBCT equipment in order to attract Medicare benefits. 'Approved dental practitioners' will also be able to request this service.

Diagnostic radiology

A number of changes are being made related to diagnostic radiology items, including:

- items 57903 (radiographic examination of the sinuses) and 57912 (radiographic examination of the facial bones) will be deleted and replaced with one item covering either the sinuses or facial bones. The new item 57907 will have a schedule fee of \$47.30.



- items 57906 (radiographic examination of the mastoids) and 57909 (radiographic examination of the petrous temporal bones) will be deleted and replaced with one item covering either the mastoids or petrous temporal bones. The new item 57905 will have a schedule fee of \$64.50.
- the descriptors for the mammography items 59300 (both breasts), 59303 (one breast), 59302 (three dimensional breast tomosynthesis - both breasts) and 59305 (three dimensional breast tomosynthesis - one breast) will be amended to ensure that the items are used in the investigation of a clinical abnormality of the breast/s and not for individual, group or opportunistic screening of asymptomatic patients.
- items 59306 (mammary ductogram – one breast) and 59309 (mammary ductogram – both breasts) will be deleted.
- fluoroscopy items 60506, 60509 and 61109 will be able to be co-claimed with any other diagnostic imaging service, except a diagnostic radiology service in Group I03 of the DIST. Currently, the items cannot be co-claimed with any other item in the DIST.

Nuclear Medicine Imaging

A number of changes are being made related to nuclear medicine imaging items, including:

- items 61352, 61401, 61405, 61417, 61437, 61458 and 61484 will be deleted. The items cover various procedures considered to be obsolete.
- items 61316, 61317 and 61320 (cardiac blood studies) will be deleted and the indications for these items will be included in item 61314.
- the item descriptors for most items that contain a reference to planar imaging or single photon emission tomography (SPECT) will be amended to remove those references.
- the descriptor for item 61473 will be amended to remove the phrase 'including uptake measurement when undertaken'.
- item 61505 (computed tomography for attenuation correction and anatomical localisation of single photon emission tomography) will be able to be co-claimed with positron emission tomography (PET). Consequently, the descriptor for item 61647 (Whole body 68Ga-DOTA-peptide PET study) will be amended to exclude references to CT for attenuation correction and anatomical localisation and the schedule fee item 61647 will be reduced by \$100.
- MSAC change: the descriptors for items 61446 and 61449 (regional bone studies) will be amended so that they can be claimed for scans on other body parts.

Magnetic resonance imaging (MRI)

Changes to MRI items are:

- items 63501 and 63502 (MRI of the breasts for Poly Implant Prosthèse implant integrity) will be only able to be claimed once in 24 months. Currently, these items can be claimed every 12 months.

Radiologists co-claiming consultation with certain diagnostic imaging services

Specialist radiologists will no longer be able to claim a consultation in conjunction with one of the following diagnostic imaging services:



- All musculoskeletal ultrasound – Group I1, Subgroup 6 (items 55812 – 55895)
- Diagnostic radiology items as follows:
 - Group I3, Subgroup 1 – Radiographic Examination of the Extremities (items 57506 to 57539)
 - Group I3, Subgroup 2 – Radiographic Examination of Shoulder and Pelvis (items 57700 to 57723)
 - Group I3, Subgroup 3 – Radiographic Examination of the Head (items 57901 to 57969)
 - Group I3, Subgroup 4 – Radiographic Examination of the Spine (items 58100 to 58127)
 - Group I3, Subgroup 5 – Bone Age Study and Skeletal Survey (items 58300 to 58308)
 - Group I3, Subgroup 6 – Radiographic Examination of Thoracic Region (items 58500 to 58529)
 - Group I3, Subgroup 7 – Radiographic Examination of Urinary Tract (items 58700 to 58723)
 - Group I3, Subgroup 8 – Radiographic Examination of Alimentary Tract and Biliary System (items 58900 to 58905)
 - Group I3, Subgroup 9 – Radiographic Examination of Localisation of Foreign Bodies (items 59103 to 59104)

When rendered, consultations may be co-claimed with other diagnostic imaging services.

The new consultation co-claiming rules do not apply to consultant physicians, other specialists and specialist radiologists who are also specialists in other medical disciplines where the service is rendered in a non-radiologist capacity.

Why are the changes being made?

These changes are a result of a review by the MBS Review Taskforce, which was informed by Diagnostic Imaging Clinical Committee (DICC), the Breast Imaging Working Group (BIWG) and the Nuclear Medicine Working Group (NMWG). More information about the Taskforce and associated Committees is available in [Medicare Benefits Schedule Review](#) in the consumer section of the Department of Health website (www.health.gov.au).

A full copy of the final reports can be found in the DICC section of the Department of Health website (www.health.gov.au).

What does this mean for providers and requesters of diagnostic imaging services?

Providers of diagnostic imaging services will need to familiarise themselves with the changes so that they can correctly bill for any new and amended items.

Requesters of diagnostic imaging services should also be aware of the changes to ensure that they request the most appropriate item.

How will these changes affect patients?

The changes will provide greater access for patients to services that are contemporary and reflect best clinical practice leading to improved health outcomes.

Patients should not be negatively affected by the changes and will have continued access to clinically relevant services.



Who was consulted on the changes?

The MBS Review included a targeted consultation process on the DICC report between 14 September and 23 November 2018. The Breast Imaging Working Group and Nuclear Medicine Imaging Working Group reports were released for consultation on 22 August 2018.

Feedback on the reports was received from the following organisations:

- Royal Australian and New Zealand College of Radiologists (RANZCR)
- Australian Diagnostic Imaging Association (ADIA)
- Royal Australian College of General Practitioners (RACGP)
- Royal Australasian College of Physicians (RACP)
- Royal Australian College of Obstetricians and Gynaecologists (RANZCOG)
- South Australia Medical Imaging (SAMI)
- Cancer Nurses Society of Australia (CNSA)
- Australian Private Hospitals Association (APHA)
- Australasian Association of Nuclear Medicine Specialists (AANMS)
- Australian Radiation Protection and Nuclear Safety Agency (ARPANSA)
- The Australasian Society for Ultrasound in Medicine (ASUM)
- Australian Rheumatology Association (ARA)
- Australian Sonographers Association (ASA)
- BreastSurgANZ
- Cancer Voices Australia (CVA)
- Endocrine Society of Australia (ESA)
- Northern Sydney Local Health District (NSLHD)

The submissions were considered by the DICC prior to making its final recommendations to the Taskforce.

Implementation of the recommendations and the development of these fact sheets were informed by an Implementation Liaison Group, consisting of RANZCR, ADIA, RACGP, AANMS, RANZCOG representatives, a consumer representative nominated by the Consumers Health Forum, and with input from the Australian Medical Association.

How will the changes be monitored and reviewed?

The changes will be monitored and reviewed through analysis of MBS utilisation figures.

Where can I find more information?

The full item descriptor(s) and information on other changes to the MBS can be found on the MBS Online website at www.mbsonline.gov.au. More detail is provided on separate fact sheets for capital sensitivity, ultrasound, CT, MRI, diagnostic radiology and nuclear medicine imaging.



You can also subscribe to future MBS updates by visiting [MBS Online](#) and clicking 'Subscribe'.

The Department of Health provides an email advice service for providers seeking advice on interpretation of the MBS items and rules and the Health Insurance Act and associated regulations. If you have a query relating exclusively to interpretation of the Schedule, you should email askMBS@health.gov.au.

Subscribe to '[News for Health Professionals](#)' on the Services Australia website and you will receive regular news highlights.

If you are seeking advice in relation to Medicare billing, claiming, payments, or obtaining a provider number, please go to the Health Professionals page on the Services Australia website or contact Services Australia on the Provider Enquiry Line – 13 21 50.

The data file for software vendors is expected to become available in late March 2020 and can be accessed via the MBS Online website under the [Downloads](#) page.

Please note that the information provided is a general guide only. It is ultimately the responsibility of treating practitioners to use their professional judgment to determine the most clinically appropriate services to provide, and then to ensure that any services billed to Medicare fully meet the eligibility requirements outlined in the legislation.

This sheet is current as of the Last updated date shown above, and does not account for MBS changes since that date.