



Quick reference guide

MBS Review recommendations: Computed tomography (CT) - Group I02

Date of change: 1 May 2020

Amended items: 57341 57351

New items: 56622 56623 56627 56628 56629 56630 57352 57353
57354

Deleted items: 56619 56625 57350

Revised structure

- All CT items annotated with 'NK' will be deleted. The annotation 'K' will be deleted from the remaining items (see the capital sensitivity quick reference guide).
- 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 or limbs without contrast), 56623 (scan of lower limb or limbs with contrast), 56627 (scan of upper limb or limbs without contrast), and 56628 (scan of upper limb or limbs with contrast). The schedule fees for these items will be the same as the replaced contrast and non contrast items.
- 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 (57352-57354) covering CT angiography of different arterial regions. The schedule fees for these items will remain the same as the item they replaced.
- 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 now be able to request this service.

Patient impacts

- Removal of some restrictions provides greater access for patients, leading to improved health outcomes.
- A Medicare rebate will no longer be paid for imaging on equipment that have not been updated. This means the best diagnosis can be achieved as the imaging is of higher quality.



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

Restrictions or requirements

- An explanatory note will be introduced for PET items as follows:

Co-claiming of CT with PET

It is inappropriate to claim a diagnostic CT together with a PET scan when:

- the diagnostic CT scan has not been specifically requested by the requestor; and
 - a recent diagnostic CT scan (covering the relevant anatomy and of appropriate quality) is available that is suitable for the purposes of managing the patient's condition.
- Diagnostic imaging request forms must make it clear that requester has the option of requesting a PET scan only, rather than making the request for PET/CT the default.

Amended item 57341– CT interventional

Overview: The descriptor has been amended so that the item can now be claimed with any other diagnostic imaging item at the same attendance. Before the amendment, the item couldn't be claimed at same time as any other diagnostic imaging service.

Service/Descriptor: Computed tomography, in conjunction with a surgical procedure using interventional techniques (R) (Anaes.)

Indication: This item can now be claimed when rendered at the same attendance as another diagnostic imaging item, for example, a diagnostic CT of the spine followed by a CT-guided spinal injection.

MBS fee: \$470.00 (no change)

Benefit: No change.

Amended item 57351– CT angiography (non-coronary) subsequent scan

Overview: The descriptor has been amended to remove the word 'spiral' as this is outdated terminology and allow for the recording of the images digitally.

Service/Descriptor: Computed tomography – angiography with intravenous contrast medium, including any scans performed before intravenous contrast injection – one or more data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy or digital recording of multiple projections, if:

- (a) both:
 - (i) the service is requested by a general practitioner; and
 - (ii) the request indicates that the patient's case has been discussed with a specialist or a consultant physician; and
- (b) the service is not a service to which another item in this group applies; and



- (c) the service is performed for the exclusion of acute or recurrent pulmonary embolism, acute symptomatic arterial occlusion, post-operative complication of arterial surgery, acute ruptured aneurysm, or acute dissection of the aorta, carotid or vertebral artery; and
- (d) a service to which item 57352, 57353 or 57354 applies has been performed on the same patient within the previous 12 months; and
- (e) the service is not a study performed to image the coronary arteries (R) (Anaes).

Indication: This item can now be claimed when rendered at the same attendance as another diagnostic imaging item, for example, a diagnostic CT of the spine followed by a CT-guided spinal injection.

MBS fee: \$ 510.00 (no change)

Benefit: No change.

Amended item 57362– Cone beam CT

Overview: The descriptor has been amended so that services rendered on equipment on that can also provide other services (such as x-ray and OPG) will be claimable. Currently, CBCT services have to be rendered on dedicated CBCT equipment in order to attract Medicare benefits. 'Approved dental practitioners' will now be able to request this service. These changes are recommendations from MSAC.

Service/Descriptor: Cone beam computed tomography – dental and temporo-mandibular joint imaging (without contrast medium) for diagnosis and management of any of the following:

- (a) mandibular and dento-alveolar fractures;
- (b) dental implant planning;
- (c) orthodontics;
- (d) endodontic conditions;
- (e) periodontal conditions;
- (f) temporo-mandibular joint conditions

Applicable once per patient per day, not being for a service to which any of items 57960 to 57969 apply, and not being a service associated with another service in Group I2 (R) (Anaes.)

Indication: This item can now be claimed when rendered on equipment that can also provide other types of diagnostic imaging services. The list of providers who can request CBCT services has been expanded to include 'approved dental practitioners'. Approved dental practitioners are dentists who were approved by the Medical Benefits (Dental Practitioners) Advisory Committee to provide oral and maxillofacial MRI services and request certain diagnostic imaging services. This committee no longer exists. Practices should contact Services Australia to determine their eligibility for providing and requesting these services.

It is important to note that CBCT services still need to be provided under the supervision of, and reported by, a specialist radiologist.

MBS fee: \$113.15 (no change) **Benefit:** No change.



New item – 56622 CT Lower limb(s) without contrast

Overview: This item replaces item 56619 which has been deleted. The item has been created to better identify the extremity(ies) being scanned.

Service/Descriptor: Computed tomography – scan of lower limb, left or right or both, one region (other than knee), or more than one region (which may include knee), without intravenous contrast medium, not being a service to which item 56620 applies (R) (Anaes.)

Indication: This applies when one or both lower limbs are scanned without contrast. The item covers all or any part(s) of the lower limbs. For example, if a foot and thigh are scanned, the one item applies. The item also includes a scan of the knee(s) where this has been done along with another region(s) of the lower limb. The item cannot be claimed more than once for multiple regions, even if the scans are undertaken over several days.

Other requirements: The item cannot be claimed twice where a scan of any part, or all of, the left and right lower limbs have been requested by the patient's treating medical practitioner, even if the scans are undertaken on separate occasions. The knee item 56620 cannot be co-claimed with item 56622 because item 56622 includes a scan of the knee where undertaken as part of a multiple region scan. Similarly, the item cannot be co-claimed with the contrast scan item 56623 because the descriptor for item 56623 includes any scans without contrast when performed.

MBS fee: \$220.00.

Benefit: 85% = \$187.00 Bulk billed benefit = \$209.00

New item – 56623 CT Lower limb(s) with contrast

Overview: This item replaces item 56625 which has been deleted. The item has been created to better identify the extremity(ies) being scanned.

Service/Descriptor: Computed tomography – scan of lower limb, left or right or both, one region (other than knee), or more than one region (which may include knee), with intravenous contrast medium and with any scans of the lower limb before intravenous contrast injection, when performed, not being a service to which item 56626 applies (R) (Anaes.)

Indication: This applies when one or both lower limbs are scanned using contrast. The item covers all or any part(s) of the lower limbs. For example, if a foot and thigh are scanned, the one item applies. The item also includes a scan of the knee(s) where this has been done along with another region(s) of the lower limb. The item cannot be claimed more than once for multiple regions, even if the scans are undertaken over several days.

Other requirements: The item cannot be claimed twice where a scan of any part, or all of, the left and right lower limbs have been requested by the patient's treating medical practitioner, even if the scans are undertaken on separate occasions. The knee item 56626 cannot be co-claimed with item 56623 as item 56623 includes a scan of the knee where undertaken as part of a multiple region scan.

MBS fee: \$334.65

Benefit: 85% = \$284.45 Bulk billed benefit = \$317.95



New item – 56627 CT Upper limbs without contrast

Overview: This item replaces item 56619 which has been deleted. The item has been created to better identify the extremity(ies) being scanned.

Service/Descriptor: Computed tomography – scan of upper limb, left or right or both, any one region, or more than one region, without intravenous contrast medium (R) (Anaes.)

Indication: This item applies when one or both upper limbs are scanned without contrast. The item covers all any part(s) of the upper limbs. For example, if an elbow and a shoulder are scanned, the one item applies. The item cannot be claimed more than once for multiple regions, even if the scans are undertaken over several days.

Other requirements: The item cannot be claimed twice where a scan of any part, or all of, the left and right upper limbs have been requested by the patient's treating medical practitioner, even if the scans are undertaken on separate occasions. The item cannot be co-claimed with the contrast scan item 56628 because the descriptor for item 56628 includes any scans without contrast when performed.

MBS fee: \$220.00.

Benefit: 85% = \$187.00 Bulk billed benefit = \$209.00

New item – 56628 CT Upper limb(s) with contrast

Overview: This item replaces item 56625 which has been deleted. The item has been created to better identify the extremity(ies) being scanned.

Service/Descriptor: Computed tomography – scan of upper limb, left or right or both, any one region, or more than one region, with intravenous contrast medium and with any scans of the upper limb before intravenous contrast injection, when performed (R) (Anaes.)

Indication: This item applies when one or both upper limbs are scanned with contrast. The item covers all or any part(s) of the upper limbs. For example, if an elbow and a shoulder are scanned, the one item applies. The item cannot be claimed more than once for multiple regions, even if scans are undertaken over several days.

Other requirements: The item cannot be claimed twice where a scan of any part, or all of, the left and right upper limbs have been requested by the patient's treating medical practitioner, even if the scans are undertaken on separate occasions.

MBS fee: \$334.65

Benefit: 85% = \$284.45 Bulk billed benefit = \$317.95

New item – 56629 CT Upper and lower limb(s) without contrast

Overview: This item replaces item 56619 which has been deleted. The item has been created to better identify the extremity(ies) being scanned.



Service/Descriptor: Computed tomography – scan of upper limb and lower limb, left or right or both, any one region (other than knee), or more than one region (which may include knee) without intravenous contrast medium not being a service to which item 56620 applies (R) (Anaes.)

Indication: This item applies when the scan involves the upper and lower limbs without contrast. The item covers all parts of the upper and lower limbs or any combination of parts of the upper and lower limbs. For example, if a shoulder and thigh are scanned, this item applies. It also applies where multiple regions of the upper and lower limbs are scanned, for example, a shoulder, a hand, a knee and a foot. The item cannot be claimed more than once for multiple regions, even if scans are undertaken over several days.

Other requirements: The item cannot be claimed twice where a scan of any part, or all of, the left and right upper and lower limbs have been requested by the patient's treating medical practitioner, even if the scans are undertaken on separate occasions. The knee item 56620 cannot be co-claimed with item 56629 because item 56629 includes a scan of the knee where undertaken as part of a multiple region scan. Similarly, the item cannot be co-claimed with the contrast scan item 56630 because the descriptor for item 56630 includes any scans without contrast when performed.

MBS fee: \$220.00.

Benefit: 85% = \$187.00 Bulk billed benefit = \$209.00

New item – 56630 CT Lower and upper limb(s) with contrast

Overview: This item replaces item 56625 which has been deleted. The item has been created to better identify the extremity(ies) being scanned.

Service/Descriptor: Computed tomography – scan of upper limb, left or right or both, any one region, or more than one region, with intravenous contrast medium and with any scans of the upper limb before intravenous contrast injection, when performed, not being a service to which item 56626 applies (R) (Anaes.)

Indication: This item applies when one or both upper limbs are scanned without contrast. The item covers all or just one part of the upper limbs. For example, if an elbow and a shoulder are scanned, the one item applies.

Other requirements: The item cannot be claimed twice where a scan of any part, or all of, the left and right upper limbs have been requested by the patient's treating medical practitioner, even if the scans are undertaken on separate occasions.

MBS fee: \$334.65

Benefit: 85% = \$284.45 Bulk billed benefit = \$317.95

New item – 57352 CT angiography (non-coronary) – head and neck

Overview: This item replaces item 57350 which has been deleted. The item has been created to better identify the arteries being scanned.

Service/Descriptor: Computed tomography – angiography with intravenous contrast medium of any or all, or any part, of:



- (a) the arch of the aorta; or
- (b) the carotid arteries; or
- (c) the vertebral arteries and their branches (head and neck);

including any scans performed before intravenous contrast injection – one or more data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy or digital recording of multiple projections, if:

- (d) either:
 - (i) the service is requested by a specialist or consultant physician; or
 - (ii) the service is requested by a general practitioner and the request indicates that the patient's case has been discussed with a specialist or consultant physician; and
- (e) the service is not a service to which another item in this group applies; and
- (f) the service is performed for the exclusion of arterial stenosis, occlusion, aneurysm or embolism; and
- (g) the service is not a study performed to image the coronary arteries (R) (Anaes.)

Indication: This item applies to examinations of the arteries supplying the head and neck region. Where the service has been requested by a general practitioner, the item should not be itemised by providers on bulk billing forms or accounts/receipts to be used for Medicare claiming purposes unless the request indicates that the patient's case has been discussed with a specialist or consultant physician.

Other requirements: The item cannot be claimed more than once in any 12 month period. Item 57351 should be used for follow-up examinations within a 12 month period.

MBS fee: \$510.00

Benefit: 85% = \$ 433.50 Bulk billed benefit = \$484.50

New item – 57353 CT angiography (non-coronary) – chest, abdomen and upper limbs – Name of item

Overview: This item replaces item 57350 which has been deleted. The item has been created to better identify the arteries being scanned.

Service/Descriptor: Computed tomography – angiography with intravenous contrast medium of any or all, or any part, of:

- (a) the ascending and descending aorta; or
- (b) the common iliac and abdominal branches including upper limbs (chest, abdomen and upper limbs); including any scans performed before intravenous contrast injection – one or more data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy or digital recording of multiple projections, if:
- (c) either:
 - (i) the service is requested by a specialist or consultant physician; or



- (ii) the service is requested by a general practitioner and the request indicates that the patient's case has been discussed with a specialist or consultant physician; and
- (d) the service is not a service to which another item in this group applies; and
- (e) the service is performed for the exclusion of arterial stenosis, occlusion, aneurysm or embolism; and
- (f) the service is not a study performed to image the coronary arteries (R) (Anaes.)

Indication: This item applies to examinations of the arteries supplying the chest, abdomen and upper limbs. Where the service has been requested by a general practitioner, the item should not be itemised by providers on bulk billing forms or accounts/receipts to be used for Medicare claiming purposes unless the request indicates that the patient's case has been discussed with a specialist or consultant physician.

Other requirements: The item cannot be claimed more than once in any 12 month period. Item 57351 should be used for follow-up examinations within a 12 month period.

MBS fee: \$510.00

Benefit: 85% = \$ 433.50 484.50 Bulk billed benefit = \$484.50.

New item – 57354 CT angiography (non-coronary) – lower arteries –

Overview: This item replaces item 57350 which has been deleted. The item has been created to better identify the arteries being scanned.

Service/Descriptor: Computed tomography – angiography with intravenous contrast medium of any or all, or any part, of:

- (a) the descending aorta; or
- (b) the pelvic vessels (aorto iliac segment) and lower limbs; including any scans performed before intravenous contrast injection—one or more data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy or digital recording of multiple projections, if:
- (c) either:
 - (i) the service is requested by a specialist or consultant physician; or
 - (ii) the service is requested by a general practitioner and the request indicates that the patient's case has been discussed with a specialist or consultant physician; and
- (d) the service is not a service to which another item in this group applies; and
- (e) the service is performed for the exclusion of arterial stenosis, occlusion, aneurysm or embolism; and
- (f) the service is not a study performed to image the coronary arteries (R) (Anaes.)

Indication: This item applies to examinations of the arteries not examined under item 57352 and 57353. Where the service has been requested by a general practitioner, the item should not be itemised by providers on bulk billing forms or accounts/receipts to be used for Medicare claiming purposes unless the request indicates that the patient's case has been discussed with a specialist or consultant physician.



Other requirements: The item cannot be claimed more than once in any 12 month period. Item 57351 should be used for follow-up examinations within a 12 month period.

MBS fee: \$510.00

Benefit: 85% = \$ 433.50 484.50 Bulk billed benefit = \$484.50.

Deleted items – items 55800-55810 55816-55842 and all the NK ultrasound items

To view previous item descriptors and deleted items, visit MBS Online at www.mbsonline.gov.au, navigate to 'Downloads' and then select the relevant time period at the bottom of the page. The old items can then be viewed by downloading the MBS files published in the month before implementation of the changes

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 below, and does not account for MBS changes since that date.