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

Last updated: 23 December 2021

- From 1 November 2021, there will be number of changes relating to Medicare Benefits Schedule (MBS) items and rules for diagnostic imaging services to implement the diagnostic imaging measures announced in the 2021-22 Federal Budget, including new and amended listings recommended by the Medical Services Advisory Committee, as well as some minor administrative changes.
- 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.

The following is a summary of the changes. Each of the item changes are covered in a supporting Quick Reference Guide.

2021-22 Budget changes

- A new rule will be introduced to prevent the co-claiming of MBS magnetic resonance imaging (MRI) items covering the head with other MBS MRI items covering the head and MRI items covering the spine with other MRI items of the spine. There will be exceptions to the rule, and these are discussed in Attachment A.
- A new rule will be introduced to prevent the co-claiming of consultation items 52, 53, 54, 57 104 and 105 with MRI scans. There will also be exceptions to this rule as discussed in Attachment A.

New and amended listings recommended by the Medical Services Advisory Committee

- A new item (61560) for 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 also cannot be claimed if single photon emission tomography item 61402 had been claimed in the previous 12 months.
- 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 be able 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 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 to access the service.

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 1 of the *Health Insurance (Diagnostic Imaging Services Table) Regulations*). 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. Items 57352, 57353, 57354 and 57357 have no frequency restrictions which 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.

Why are the changes being made?

The changes are being made to ensure that diagnostic imaging services provided under Medicare are contemporary and reflect best clinical practice.

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?

Consultation on the changes has been undertaken, where relevant, with the:

- Royal Australian and New Zealand College of Radiologists
- Australian Diagnostic Imaging Association
- Cardiac Society of Australia and New Zealand.
- 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.

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 was first released on 22 September 2021 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.

Attachment A

MRI co-claiming changes

Co-claiming head and spine MRI scans

New rules will be introduced into the Diagnostic Imaging Services Table that will prevent the co-claiming of:

- a head MRI scan with another head MRI scan at the same attendance. The items that will restrict with each other are in the range 63001 to 63131.
- a spine MRI scan with another spine MRI scan. The items that will restrict with each other are in the range 63151 to 63280.

The new rules also provide

- that the head or spine scan with the highest schedule fee can be claimed where indications spanning two or more service have been requested.
- more than one item can be claimed where the clinical need for the additional service is:
    - stated in the request for the service; and
    - appropriately documented in the record of the service.

The new rules apply from 1 November 2021.

The rules were introduced to clarify the policy intent for the items, that is, only one item should be claimable for a scan irrespective of the:

- number of clinical conditions being investigated; and
- the number of sequences required to complete the scan.

Where a request form seeks an investigation of more than one clinical condition, the item to claim is the item with the highest schedule fee. If the items have the same schedule fee, the item to be claimed is the item applicable to the first mentioned indication on the request form.

More than one item can be claimed where the request for the scan states that there is a clinical need for the additional service, and this is appropriately documented in the diagnostic imaging record for the patient. This does not mean different clinical indications listed in a request, rather it means that the requester is seeking separate and distinct scans.

Providers will need to indicate on the claim that separate and distinct scans have been requested.

Co-claiming consultations with MRI items

A new rule will be introduced into the *Health Insurance (General Medical Services Table) Regulations* that will prevent Medicare benefits being paid for a consultation items 52, 53, 54, 57, 104 or 105 when rendered in conjunction with any MRI scan.

The rule applies from 1 November 2021.

There will be an exception to this rule where the providing practitioner determines that a consultation is necessary for the treatment of the patient's condition. A consultation has to be meaningful, that is:

- the provider utilises their medical knowledge, clinical acumen, technical skills and personal experience in clinical radiology to consult with a patient so as to alter, or potentially alter, the course of the patient's management in the best interests of the patient.
- the provider takes primary clinical responsibility for the management decisions made during the consultation (even if the decision is to proceed with the planned course of management).
- the consultation itself includes components of history taking; physical examination; discussion with the patient; formulation of management plans; and referral for additional opinion or tests.

Not all the components need be present in any one consultation, but presence of at least some indicates that a meaningful consultation occurred.

Providers will need to include on the claim supporting text as to the need for the consultation.

To claim a specialist referred consultation (item 104 or 105), the provider must have received a valid referral (not simply a request for a diagnostic imaging service) from a medical practitioner for the investigation, opinion, treatment and/or management of a condition or problem of a patient or for the performance of a specific examination(s) or test(s). The referring practitioner must have undertaken a professional attendance with the patient (this need not mean an attendance on the occasion of the referral) and turned their mind to the patient's need for referral and have communicated relevant information about the patient to the specialist or consultant physician– see note GN.6.16.

A request for the undertaking of a diagnostic imaging service in the absence of the other elements of a referral as noted above does not constitute a valid referral for a specialist referred consultation.