Australian Government
Department of Health and Aged Care

Diagnostic Imaging Services Table – Changes from 1 November 2024

Last updated: 22 October 2024

What are the changes?

From 1 November 2024, there will be changes to nuclear medicine imaging, magnetic resonance imaging, ultrasound and computed tomography services on the Medicare Benefits Schedule (MBS). These changes are outlined below:

Nuclear medicine imaging

- Positron emission tomography (PET) item 61614 will be introduced for the assessment of treatment response and recurrence for patients with an eligible rare cancer.
- Item 61614 will provide a whole body fluorodeoxyglucose (FDG) PET study for the evaluation of suspected residual, metastatic or recurrent cancer for a patient who is undergoing or suitable for active therapy. It follows the introduction of PET item 61612 which was implemented on 1 November 2022 for the initial staging of rare cancers.
- Non-PET (Group I4 – Subgroup 1) nuclear medicine imaging items will receive a one-off increase of 3.5 per cent to the schedule fees. This increase will address discrepancies between the current fees and the costs of providing services.

Magnetic resonance imaging (MRI)

- Existing pelvic MRI item 63476 for the initial staging of rectal cancer will be amended to expand the eligible patient population to include its use for the restaging and follow up of rectal cancer.

Ultrasound

- Requesting rights for nurse practitioners will be expanded to cover MBS ultrasound items 55065, 55700 and 55704. This supports patients in the before and after care requirements of the MS-2 step medical abortion program.

Computed tomography (CT)

- The schedule fee for all CT (Group I2) services will be reduced by 2.0 per cent.

These changes affect all health professionals who request, provide and claim these services under the MBS, as well as consumers who receive the service, private health insurers and hospitals.

Why are the changes being made?

These changes were announced as part of the 2024-25 Budget. They are to help patients to access a wider range of diagnostic imaging services and provide more support for any out-of-pocket costs.

The reduction in the CT schedule fee is a responsible way to manage expenditure growth of this modality and reinvest in other areas of diagnostic imaging. This change is intended to support patients to access more appropriate imaging modalities, rather than limit access to CT, through reinvesting in MRI and nuclear medicine.

What does this mean for providers?

Expanding nurse practitioner requesting to include early pregnancy and gynaecological ultrasound services reflects their scope of practice and will enable nurse practitioners to apply timely and appropriate care to their patients, particularly in relation to the MS-2 step program.

Changes to nuclear medicine fees will better support providers to cover the costs of providing these services, particularly in regional and remote areas.

While there is a reduction to the schedule fee for CT services, with the application of annual indexation, CT benefits will continue to increase.

How will these changes affect patients?

The most vulnerable patients suffering from a wide range of conditions including cancers, cardiac disease, neurological conditions, and orthopaedic conditions, as well as those patients in need of medical abortions, will continue to have access to services which are vital for the diagnosis and management of their clinical needs.

Who was consulted on the changes?

In addition to the Medical Services Advisory Committee (MSAC) consultation processes outlined on its website, the Department of Health and Aged Care consulted with a wide range of stakeholders representing experts across the diagnostic imaging and medical sector, including consumer representative groups and those with particular expertise working with patients who have rare genetic conditions. Stakeholders were supportive of these changes.

How will the changes be monitored and reviewed?

The Department regularly reviews the use of new and amended MBS items in consultation with the profession.

Providers are responsible for ensuring services claimed from Medicare using their provider number meet all legislative requirements. These changes are subject to MBS compliance checks and providers may be required to submit evidence about the services claimed.

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. You can also subscribe to future MBS updates by visiting 'Subscribe to the MBS' on the MBS Online website.

The Department provides an email advice service for providers seeking advice on interpretation of the MBS items and rules and the *Health Insurance Act 1973* and associated regulations. If you have a query relating exclusively to interpretation of the Schedule, you should email askMBS@health.gov.au.

Private health insurance information on the product tier arrangements is available at www.privatehealth.gov.au. Detailed information on the MBS item listing within clinical categories is available on the Department's website. Private health insurance minimum accommodation benefits information, including MBS item accommodation classification, is available in the latest version of the *Private Health Insurance (Benefit Requirements) Rules 2011* found on the Federal Register of Legislation. If you have a query in relation to private health insurance, you should email PHI@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 the Services Australia on the Provider Enquiry Line – 13 21 50.

The data file for software vendors when available can be accessed via the Downloads page.

New and amended item descriptors (to take effect 1 November 2024)

Category 5 – Diagnostic Imaging Services

Group I4 – Nuclear Medicine Imaging

Subgroup 2 – Positron Emission Tomography

61614

Whole body FDG PET study, following initial therapy, performed for the evaluation of suspected residual, metastatic or recurrent cancer in a patient who is undergoing or is suitable for active therapy, if the eligible cancer type is:

(a) a rare or uncommon cancer (less than 12 cases per 100,000 persons per year); and

(b) a typically FDG-avid cancer. (R)

Fee: $953.00 Benefit: 75% and 85% benefits will apply

Private Health Insurance Classification:

- Clinical category: Support list (DI)
- Procedure type: Type C

Category 5 – Diagnostic Imaging Services

Group I5 – Magnetic Resonance Imaging

Subgroup 20 – Scans of pelvis and upper abdomen - for specified conditions

63476

MRI—scan of the pelvis for the initial staging, restaging or follow up of rectal cancer, if:

(a) a high resolution T2 technique is used; and

(b) the request for the scan identifies that the indication is for:

(i) the initial staging of rectal cancer (including cancer of the rectosigmoid and anorectum); or

(ii) the initial assessment of response to chemotherapy or chemoradiotherapy; or

(iii) the assessment of possible recurrent tumour after complete response to neoadjuvant therapy, within an active surveillance program; or

(iv) the assessment of recurrent disease prior to treatment planning

(R) (Anaes.) (Contrast)

Fee: No change

Category 5 – Diagnostic Imaging Services

Private Health Insurance Classification:

- Clinical category: Support list (DI)
- Procedure type: Type C

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