Diagnostic Imaging Services – Changes from 1 July 2025

Last updated: 17 June 2025

Starting from 1 July 2025, there will be several updates to various diagnostic imaging services listed under the Medicare Benefits Schedule (MBS). These include changes to two positron emission tomography (PET) services, adjustments to two fluoroscopy services, the reintroduction of indexation to non-PET nuclear medicine services and an administrative update to a mobile x-ray 'call out' fee item.

These changes will 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.

The updates aim to ensure that diagnostic imaging services provided under Medicare are current and reflect best clinical practice.

What are the changes?

- **MBS Indexation of diagnostic imaging items from 1 July 2025**

  Starting from 1 July 2025, annual indexation of 2.4% will be applied to non-PET nuclear medicine MBS items (Category 5, Group I4, Subgroup 1).

  Annual MBS Indexation of Ultrasound, CT, Diagnostic Radiology, and MRI will also occur on 1 July 2025. The indexation factor is 2.4%.

  Items in Category 5, Group I4, Subgroup 2 and Subgroup 3 will not be indexed at this time and are scheduled to begin indexation from 1 July 2027.

- **Updates to item descriptor 57541 and requests by participating nurse practitioner** for 58903

  Starting from 1 July 2025, the item descriptor for MBS item 57541('call out' fee) will be updated to clarify a change made on 1 March 2025 that mobile x-ray providers can claim a 'call out' fee when a service associated with item 57541 is requested by a medical practitioner or a participating nurse practitioner.

  Additionally, from 1 March 2025, participating nurse practitioners were given requesting rights to item 58903 (plain abdominal x-ray) to enable them to request all services associated with item 57541.

- **Fluoroscopy**

  Starting from 1 July 2025, minor editorial adjustments to the descriptors for items 60506 and 60509. These changes aim to clarify the long-standing interpretation regarding the time component use of these imaging services.

- **PET**

  Starting from 1 July 2025, there will be changes made to MBS PET items 61612 and 61614. These items will be expanded to enable their use in the initial staging of any cancer that is typically fluorodeoxyglucose (FDG)-avid, and evaluation of FDG-avid cancers following initial therapy. This supports recommendations made by the Medicare Services Advisory Committee on these services.

Why are the changes being made?

These changes are being made to enhance the overall quality and accessibility of Medicare funded diagnostic imaging services for patients. By updating item descriptors, the aim is to ensure that services better support patient access to these services leading to better health outcomes. Additionally, these changes support continued access to essential medical services. Overall, the updates are designed to improve patient care, affordability, and the efficiency of service delivery for these services.

What does this mean for requesters and providers?

These changes will provide more options for requesters and providers. Requesters will benefit from improved clarity and consistency in claiming Medicare benefits. Providers will see enhanced support for their services, particularly through annual indexation. Overall, these updates will benefit both requesters and providers.

How will these changes affect patients?

These changes will enhance patient care by improving access to essential medical services and providing clarity in service provision. Patients will benefit from better access to diagnostic and treatment services, and those in aged care facilities will see increased requesting options for mobile x-ray services. These updates will lead to improved health outcomes and greater affordability for patients.

Who was consulted on the changes?

The Department of Health, Disability and Ageing (The department) consulted with a range of stakeholders including experts from the diagnostic imaging and medical sectors, as well as consumer representative groups. Some of the stakeholders consulted for changes to the MBS included:

- Australasian Association of Nuclear Medicine Specialists
- Australian and New Zealand Society of Nuclear Medicine
- Australian Diagnostic Imaging Association
- Royal Australian and New Zealand College of Radiologists
- Rural Alliance in Nuclear Scintigraphy
- Australian Society of Medical Imaging and Radiation Therapy
- Royal Australian College of General Practitioners
- Australian College of Nurse Practitioners.

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.

Amended item descriptors (from 1 July 2025)

Item 57541

Category – DIAGNOSTIC IMAGING SERVICES

Group – I3 Diagnostic Radiology

Subgroup – Miscellaneous

57541

Fee for a service rendered using first eligible x-ray procedure carried out during attendance at a residential aged care facility, where the service has been requested by a medical practitioner or a participating nurse practitioner who has attended the patient in person and the request identifies one or more of the following indications:

a. the patient has experienced a fall and one or more of the following items apply to the service 57509, 57515, 57521, 57527, 57703, 57709, 57712, 57715, 58521, 58524, 58527; or
b. pneumonia or heart failure is suspected and item 58503 applies to the service; or
c. acute abdomen or bowel obstruction is suspected and item 58903 applies to the service.

This call-out fee can be claimed once only per visit at a residential aged care facility irrespective of the number of patients attended.

NOTE: If the service is bulked billed 95% of the fee is payable. The multiple services rule does not apply to this item. (R)

Fee: $84.55 Benefit: 75% and 85% benefits will apply

Private Health Insurance Classification

- Clinical category: N/A (Not hospital treatment)
- Procedure type: N/A (Not hospital treatment)

Fluoroscopy items 60506 and 60509

Category 5 – Diagnostic Imaging Services

Group I3 – Diagnostic Radiology

Subgroup 15 - Fluoroscopic examination

60506

Fluoroscopy, using a mobile image intensifier, that:

(a) lasts less than 1 hour; and
(b) is in conjunction with a surgical procedure; not being a service associated with a service to which another item in this Group applies (R) (H)

Fee: $73.20 Benefit: 75% benefit will apply

85% benefit does not apply.

Private Health Insurance Classification:

- Clinical category: Support list (DI)
- Procedure type: Unlisted

Category 5 – Diagnostic Imaging Services

Group I3 – Diagnostic Radiology

Subgroup 15 - Fluoroscopic examination

60509

Fluoroscopy, using a mobile image intensifier, that:

(a) lasts 1 hour or more; and
(b) is in conjunction with a surgical procedure; not being a service associated with a service to which another item in this Group applies (R) (H)

Fee: $113.55 Benefit: 75% benefit will apply

85% benefit does not apply.

Private Health Insurance Classification:

- Clinical category: Support list (DI)
- Procedure type: Unlisted

PET items 61612 and 61614

Category 5 – Diagnostic Imaging Services

Group I4 – Nuclear Medicine Imaging

Subgroup 2 – Positron Emission Tomography

61612

Whole body FDG PET study for the initial staging of cancer, for a patient who is considered suitable for active therapy, if:

(a) the cancer is a typically FDG-avid cancer; and
(b) there is at least a 10% likelihood that the PET study result will inform a significant change in management for the patient

Applicable once per cancer diagnosis (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 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 cancer is 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

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.