**QUESTIONS AND ANSWERS ON THE APPLICATION OF THE NEW MEDICARE BENEFITS SCHEDULE FOR RADIATION ONCOLOGY**

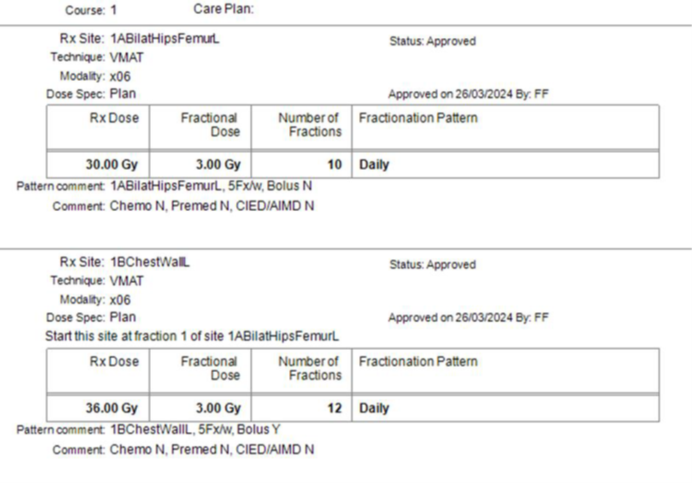
**TRANCHE 1 Q&A: Provided to sector on 06/05/2024**

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|  | **Question** | **Response** |
| 1 | How do we bill VMAT/IMRT treatment courses containing a sequential boost?  For example, in the breast setting 40Gy in 15# to whole breast delivered with VMAT/IMRT followed by 10Gy in 4# to the tumour bed delivered with VMAT/IMRT. Would this be treated as a 2-dose level plan and have item number 15907 applied as a plan would be produced for 40Gy, a plan produced for 10Gy as well as a composite plan displaying 50Gy | No, this should be considered as a one dose level VMAT plan. If there is no motion management then it will be a simple complexity plan. Only one plan can be billed.  If there are different techniques within a plan; the most complex planning item will be billed for simulation and planning. Treatment technique relevant to the treatment phase will be billed for the treatment and imaging. |
| 2 | Some breast radiation oncologists will prescribe a sequential breast treatment including VMAT/IMRT to the whole breast and an electron boost to the tumour bed. What would be the correct simulation and dosimetry code for this case? For DIBH case would it be compliant to use 15907 due to the use of VMAT/IMRT and motion management? If this case did not utilise DIBH would the correct code be 15905 and missing the electron boost work? Following on what would be the correct treatment codes to apply? 15920 for the DIBH case, and 15919 no DIBH? | The correct simulation and dosimetry code for the VMAT plan will be based on whether there is motion management, i.e. DIBH (15914) or if there is not (15910). If DIBH is used the correct treatment code for the IMRT component is 15940 or if no DIBH 15938. The electron boost plan is not billable, but treatment can be billed using 15930.  If there are different techniques within a plan; the most complex planning item will be billed for simulation and planning. Treatment technique relevant to the treatment phase will be billed for the treatment and imaging. |
| 3 | We require an update regarding multi superficial codes - what code are we meant to use for this? | Under the new schedule, both orthovoltage and superficial items will be referred to as kilovoltage services. There will be 4 kilovoltage items, i.e.  15950 – planning  15952 – treatment to one anatomical site (excluding orbital structures)  15954 – treatment to 2 or more anatomical sites (excluding orbital structures)  15956 – treatment to orbital structures. |
| 4 | Megavoltage Level 2.1 - (b) describes must include multi-leaf collimator-based shaping to achieve target dose conformity. Would this exclude using this code for electron treatments. The explanatory notes Meaning of Level 2.1 Items examples include image-based planning for electrons. Does this mean if image-based electron planning is conducted and three dimensional dose is calculated and items 9B) i, iii, iv, and v are met items 15903 and 15917 can be applied to electron treatments? | Yes, it does. Planning item number 15906 Megavoltage level 2.1 is appropriate for electron planning meeting the criteria. |
| 5 | Megavoltage Level 3.2: for lung cases we routinely use 4DCT for simulation and planning to enable the RO to accurately draw the target volumes. For treatment we use daily CBCT or 4DCBCT. In instances where 4DCBCT is not used are we still ok to use the Megavoltage 3.2 treatment code 15920? The descriptor states (with motion management functionality if required) | No, if strategies are employed for planning only and not for treatment delivery then the lower-level items should be claimed for delivery. If treatment requires additional motion management strategy such as surface guidance, breath hold, then it falls under complex treatment. |
| 6 | What happens when one scan is acquired, but two separate plans are created from the one CT data set. eg bilateral breast patient - each breast is planned separately with two separate isocentres. What would be the correct coding for this case? | While the new planning items cover both simulation and planning, it is not necessary to undertake separate simulation for separate sites if the original imaging can be used to effectively produce the two (or more) separate treatment plans. We do not want to force patients have any more imaging than is necessary if the original imaging is sufficient. Planning items for multiple sites can be billed however the sites must be clearly identified and differentiated in billing notes (in this case ‘L breast’ and ‘R breast’). See revised explanatory notes in the updated schedule. |
| 7 | If we simulate a patient on Thursday 27th June, but complete their plan on Tuesday 2nd July - how should we bill this patient? | One planning item only would be billed after 2 July to cover both simulation and dosimetry. |
| 8 | Scenario: The team experience a problem with the imaging equipment on the linear accelerator while a patient in on the couch. The patient is being treated for pain relief and has set up well on previous fractions. The team determine it is safe and accurate and appropriate to proceed with treatment. How do we bill for this treatment now that the treatment and imaging codes are combined? | If you do not perform imaging on the said day and only treatment is done, it will be billed under a treatment item of lower level without imaging instead of treatment item which stipulates imaging. |
| 9 | Intracranial stereotactic (SRT) Case - multiple metastases, i.e. 12 mets. The patient has undergone 1 CT scan. The plan is designed with two separate stereotactic plans requiring two separate isocentres, 2 sets of plan QA checks. How should we bill this patient? | The SRT item does not include an option to treat multiple sites at this point, hence it will all be billed under one plan.  This does not include multiple intracranial metastasis treated at one time. |
| 10 | Stereotactic Body (SBRT) Case - bony pelvis met and lung lesion. Both sites are prescribed a stereotactic treatment. Two stereotactic plans are produced to deliver the radiation oncologists prescription. Both plans undergo QA. Each site undergoes imaging verification and treatment. How should we bill this patient? | Separate anatomical sites, with separate treatment plans may be billed separately using the appropriate planning item. Each site will need to be clearly identified and differentiated in the billing notes so that Medicare can easily identify that the 2 (or more) plans have not been claimed in error. The intention of the re-planning items for complexity levels 3.1 and above are to allow one additional plan for the original site/s identified in the original treatment plan, where require adjustments to the initial plan are inadequate to satisfy treatment protocol requirements. |
| 11 | Radiotherapy to bi-lateral breasts are not uncommon. The patient undergoes one CT scan to the thorax. The RO writes 2 separate prescriptions and we design 2 treatment plans which each undergo RO approval and Plan QA. How do you bill for these cases? | See question 6 and revised explanatory notes in the updated schedule. |
| 12 | For electron patient treatments, our current process is that we do a CT scan (current MBS#15550) an electron plan is formulated based on volumes and multiple OAR’s (current MBS#15562), is 15930 applicable to the upcoming new MBS item?  If so, can you suggest a MBS for the planning involved that does not require imaging to go with this new MBS code. As we read it, we are unsure if it could be a 15902 or 15904/06. | For planning:   * If based on volume/OARs on planning CT, use 15906. * If field based on CT, use 15904. * If clinical mark-up without CT, use 15902.   In all the 3 scenarios use 15930 for treatment. |
| 13 | For 15906, we do not meet this requirement as electron use a liquid metal alloy to collimate the beam instead of the MLC.  (b) Dosimetry for three-dimensional radiation therapy if:  i. The three-dimensional planning process is required to calculate dose to three-dimensional volume structures, and which require a dose-volume histogram to complete the planning process; and  ii. The three-dimensional planning process is required to optimise the differential between target dose and normal tissue dose, based on review and assessment by a radiation oncologist (which must include multi-leaf collimator-based shaping to achieve target dose conformity and organs at risk avoidance or dose management or reduction); and | Thank you for pointing this out however it is too late to change the descriptor prior to implementation of the new schedule on 1 July 2024. The descriptor for item 15906 will be changed on 1 November 2024 as follows:  (b) Dosimetry for three-dimensional radiation therapy if:   1. The three-dimensional planning process is required to optimise the differential between target dose and normal tissue dose, based on review and assessment by a radiation oncologist (which ~~must~~ may include multi-leaf collimator-based shaping to achieve target dose conformity and organs at risk avoidance, or dose management or reduction);   The explanatory note will also be modified as follows:  “Planning is based on three-dimensional planning processes with simple beam shaping (multileaf collimators—MLCs) and simple modulation (large-segment field in field, wedges, MLCs or tissue compensation) to deliver a conformal dose distribution and assessment of dose to organs at risk. Multiple-field delivery via MLC shaped beams requires image verification. Examples include three-dimensional planned spine treatments (single or opposed fields) breast tangents without target volumes definition, and image-based planning for electrons. Non-MLC based collimation are appropriate for electron treatments. The final dosimetry plan is validated by a radiation therapist or medical physicist, using robust quality assurance processes, with the plan approved by the radiation oncologist prior to delivery.” |
| 14 | Can you please confirm if a Linear Accelerator (LINAC) is no longer required to Quality Assure (QA) a plans delivery to meet the new Radiation Oncology Planning and Simulations Codes?  Radiation Oncology now has many Robust Software applications that Quality Assure patient plans delivery without the need to use a LINAC. Departments still QA plans on LINAC's to meet the MBS requirements for MBS Ite 15565.  Below is the current MBS Radiation Oncology descriptor for item 15565.  MBS indicates Validation Checks must be completed on a LINAC  (b) the final IMRT dosimetry plan is validated by the radiation therapist and the medical physicist, using robust quality assurance processes that include:  (i) determination of the accuracy of the dose fluence delivered by the multi-leaf collimator and gantry position (static or dynamic); and  (ii) ensuring that the plan is deliverable, data transfer is acceptable and validation checks are completed on a linear accelerator; and  (iii) validating the accuracy of the derived IMRT dosimetry plan; and  The New Radiation Oncology MBS coming in July 1st 2024 no longer indicate that LINAC delivery for QA is required  The final dosimetry plan is validated by both the radiation therapist and medical physicist, using robust quality assurance processes, with the plan approved by the radiation oncologist prior to delivery. | No longer needed to be on a LINAC as long as there are robust QA processes, it’s been recognised the processes have evolved. |
| 15 | For all Simulation and Planning codes there is obviously no separation of the CT process from the planning one. Is there any way to bill just for the CT scan if a patient has a full CT process but then never has the plan due to changes in their medical condition? | No. |
| 16 | Some patients have a CT scan and plan but then have a large delay prior to starting treatment due to their condition – this sometime necessitates a second CT scan to ensure their anatomy has not altered. If the patient does not require a new plan can we bill for the second CT anyway? | No. |
| 17 | Some patients will be having multiple sites treated concurrently using completely separate plans from the same CT e.g. Megavoltage Level 3.1 plans and treatments to both the Neck and the Pelvis daily. Can we bill for 2 x code 15910 and then 2 x 15938 for each day of treatment? | Multiple site billing is permitted for planning and treatment, in line with revised explanatory notes in the updated schedule. |
| 18 | Similarly, some of our simple skin cases will have multiple Level 1.1 planning and treatment processes concurrently – up to 5 separate lesions planned at one appointment and then treated daily in a single, long, appointment. To bill for each of these planning processes (15902) and treatments (15930) do we need to record as multiple, distinct appointments or are multiple codes allowed within one appointment? | Multiple site billing is permitted for planning and treatment, in line with revised explanatory notes in the updated schedule. |
| 19 | In regard to the level 4 items (stereotactic body RT) around the RO needing to be present on day 1 of treatment or if our trained and credentialed RT’s fit the criteria outlined within the MBS changes explanatory notes? | Credentialed delegate at machine is possible (documented and auditable competency assessment and delegation) – but at all highly complex and complex treatments a radiation oncologist should to be immediately available for critical decision making. For **ALL** treatments regardless of complexity a radiation oncologist should be available to physically review a patient when required. |
| 20 | We currently charge our SIM appointment (CT) on day of scan (prior to planning and first day of treatment), the new item codes indicate we can’t charge for SIM appointment until 1st day of treatment – this presents a potential loss of revenue for patients that don’t return for treatment or can we generate the SIM charges once this is known and post the Medicare DB4 form to the patient for them to sign and return? | Simulation and planning are combined so can only be charged at the time of combined simulation and planning is completed. |

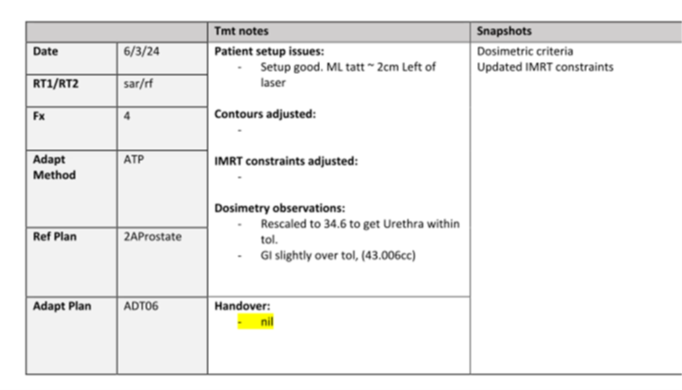
**TRANCHE 2 Q&A: Provided to sector on 04/06/2024**

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|  | **Question** | **Response** |
| 1 | In regard to the level 4 items (stereotactic body RT) around the RO needing to be present on day 1 of treatment or if our trained and credentialed RT’s fit the criteria outlined within the MBS changes explanatory notes? | Credentialed delegate at machine is possible (documented and auditable competency assessment and delegation) - but at all highly complex and complex treatments a radiation oncologist should to be immediately available for critical decision making. For **ALL** treatments regardless of complexity a radiation oncologist should be available to physically review a patient when required. |
| 2 | We currently charge our SIM appointment (CT) on day of scan (prior to planning and first day of treatment), the new item codes indicate we can’t charge for SIM appointment until 1st day of treatment – this presents a potential loss of revenue for patients that don’t return for treatment or can we generate the SIM charges once this is known and post the Medicare DB4 form to the patient for them to sign and return? | Simulation and planning are combined so can only be charged at the time of combined simulation and planning is completed. |
| 3 | 15902 ‘Clinical Mark-up’ We assume a ‘treatment plan’ is an approved radiation prescription within the OIS as dosimetry is not generated within a treatment planning system for this clinical scenario. | Yes. |
| 4 | Does this [see Image 1 below] meet the requirements for ‘a separate prescription’ for different anatomical sites? (all one course, but separate ‘sites’). | Yes, this would be an appropriate example for ‘a separate prescription’ for different anatomical sites. |
| 5 | Daily adaptive planning on Unity MRLinac – are we providing sufficient documentation to meet criteria for replan coding? (daily running sheet uploaded into Mosaiq – but everything else is in planning system). [ASMIRT produced [Images 2 and 3](file:///C:/Users/sipinn/AppData/Local/Microsoft/Windows/INetCache/Content.Outlook/Q0C3NAD5/20240529%20response%20to%20questions%20relating%20to%20the%20new%20MBS%20restructure%20for%20radiation%20oncology%20(002).docx#Images2and3) to assist original poster]. | Clinical need for re-planning must be consistent with the guidance provided in the item descriptor and clearly documented in the patient’s record. In addition to this, they need to clearly document the clinical justification. |
| 6 | Wording around RO’s being present for the L4 items. What is available? | Credentialed delegate at machine is possible (documented and auditable competency assessment and delegation) - but at all highly complex and complex treatments a radiation oncologist should to be immediately available for critical decision making. For **ALL** treatments regardless of complexity a radiation oncologist should be available to physically review a patient when required. |
| 7 | How far in the planning process do we need to get to (and how much documentation is required to demonstrate) before claiming the new ‘bundled’ codes? Particularly relevant for patients cancelled prior to treatment starting. | Centres can bill once the planning process is completed as per the descriptor. |
| 8 | Image fusion, does it need to be multimodal? What if it is not clinically appropriate? | Only raise relevant fusion(s), there is no required minimum number. |
| 9 | How should we bill a 2 phase breast treatment which includes VMAT/IMRT to the whole breast 40.05Gy in 15 fractions followed by an electron boost to the tumour bed 10Gy in 5 fractions. If this patient was treated using DIBH case how would this be billed? If this case did not utilise DIBH would the correct code be 15905 and missing the electron boost work? Following on what would be the correct treatment codes to apply?15920 for the DIBH case and 15919 no DIBH?  Currently these cases frequently have the Medicare claims for the electron treatments rejected as these codes don't match the planning and treatment codes of the first 15 fractions. Is this likely to occur post 1 July with these claims? | The correct simulation and dosimetry code for the VMAT plan will be based on whether there is motion management, i.e. DIBH (15914) or if there is not (15910). If DIBH is used the correct treatment code for the IMRT component is 15940 or if no DIBH 15938. The electron boost plan is not billable, but treatment can be billed using 15930.    If there are different techniques within a plan; the most complex planning item will be billed for simulation and planning. Treatment technique relevant to the treatment phase will be billed for the treatment and imaging. |
| 10 | How should a CT planned electron treatment to the face? Megavoltage Level 2.1 - (b) describes must include multi-leaf collimator-based shaping to achieve target dose conformity. The explanatory notes Meaning of Level 2.1 Items (3-D without motion management) examples include image-based planning for electrons. Does this mean if image based electron planning is conducted and three dimensional dose is calculated and items (b) i, iii, iv, and v are met items 15906 and 15934 can be applied to electron treatments?  Noting that electron fields are not shaped using Multi-leaf collimator and there is typically no image verification for electron fields or should 2.1 simulation/planning 15906 and 1.1 treatment 15930 be applied? Would the mismatch in code levels result in a Medicare claim rejection? | Yes, it does. Planning item number 15906 Megavoltage level 2.1 is appropriate for electron planning meeting the criteria.    For the second part of question, yes if there is no image verification for electron fields use 2.1 for simulation/planning (15906) and 1.1 for treatment (15930). |
| 11 | Lung: Lung cases are planned using 4DCT for accurate tumour volume delineation hence Complex 3.2 15914 IMRT sim and planning. For treatment we frequently use daily CBCT or 4DCBCT. When we use CBCT for image verification what treatment code should be applied noting that the Megavoltage 3.2 treatment code descriptor states (with motion management functionality if required) | No, if strategies are employed for planning only and not for treatment delivery then the lower-level items should be claimed for delivery. If planning requires additional Motion management strategy such as Surface guidance, breath hold, then it falls under complex treatment. |
| 12 | How do we bill simulation/planning correctly when one high quality dataset is acquired, but two separate plans are created eg Lumbar spine and Right Pubic ramis. Each site is planned separately, with each plan validated by both the radiation therapist and medical physicist and each plan is approved by the radiation oncologist prior to delivery. | While the new planning items cover both simulation and planning, it is not necessary to undertake separate simulation for separate sites if the original imaging can be used to effectively produce the two (or more) separate treatment plans. We do not want to force patients to have any more imaging than is necessary if the original imaging is sufficient. Planning items for multiple sites can be billed however the sites must be clearly identified and differentiated in billing notes (in this case Lumbar spine and Right Pubic ramis), in line with revised explanatory notes in the updated schedule. |
| 13 | Pituitary cases are treated with small fields using 54Gy in 30 fractions. As per the explanatory note for Megavoltage Level 3.2 small-field fractionated treatment strategies are included in this complexity level. Therefore the correct codes would be 15914 sim/planning and 15940 for each treatment fraction | As per explanatory note EN6 this will be compliant under Level 3.2. |
| 14 | Several of our sites have CT scanners owned by providers that we work closely with. When patients are simulated on these scanners by our staff and planned by our staff are we still able to charge the sim & planning code? | Yes |
| 15 | Kilovoltage treatments: Currently there is a max of 6 fields that can be billed daily. Does this apply post 1 July 2024? | **Correction (14/6/24)**  ~~There’s no maximum amount if treatments are to different anatomical sites.~~ A maximum of 10 sites can be billed.  Please see updated Explanatory Note 21 on billing kilovoltage items. |
| 16 | IGRT for TBI and TBE is not routinely performed due to the nature of the treatment delivery | This will be addressed in the training video, for these items visual inspection is acceptable. |
| 17 | Can we confirm when the XML file with finalised MBS fees will be available online at the following website  (<https://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/CAAE520031F2799DCA258AA5000C0848/$File/MBS-XML-20240301.XML>  this file/material is critical for us to develop resources (including software) to implement the new schedule in time for 1 Jul)? | The .xml file is available via the following link at [MBSOnline](https://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Downloads-240701) . |
| 18 | For Multi-site billing, when a re-plan is required on one or all treatment sites, is it possible to bill for up to 3 x re-plans? Aligned to the original replanning activity. | Yes, given clinical need for re-planning must be consistent with the guidance provided in the item descriptor and clearly documented in the patient’s record. In addition to this, clinical justification must be clearly documented. For billing purposes, each site must be clearly identified and differentiated on billing notes (see explanatory notes 12-15 in updated schedule. |

[Image 1]



[Image 2 and 3]





**TRANCHE 3 Q&A: Provided to sector on 19/06/2024**

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|  | **Question** | **Response** |
| 1 | Full craniospinal irradiation (whole brain and spinal cord) is considered a highly complex and specialised treatment technique. Are we able to use Megavoltage Level 5 - 15926 for planning? To utilise the Megavoltage Level 5 - 15948 code there is a requirement to have complex multidisciplinary team involvement and direct involvement in the treatment delivery process, including in vivo dosimetry. If we are unable to comply with this descriptor for each fraction which treatment code should be used? | This scenario should be billed under Level 2 or Level 3 depending on complexity and technique. |
| 2 | Kilovoltage Treatment code 15954 fee column states Amount under clause 5.3.1.  There does not appear to be a clause 5.3.1 in this document (and therefore there doesn't seem to be any corresponding fee). | “Amount under clause 5.3.1” for kilovoltage treatment item 15954, relates to the updated regulations.  In item 15954, amount under clause 5.3.1 means:  (a) the fee for item 15952 (for the first of multiple sites); and  (b) $22.00 for each subsequent site  **See also updated Explanatory Note 21 on kilovoltage billing.** |
| 3 | Can we confirm when the XML file with finalised MBS fees will be available online at the following website https://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/CAAE520031F2799DCA258AA5000C0848/$File/MBS-XML-20240301.XML    this file/material is critical for us to develop resources (including software) to implement the new schedule in time for 1 Jul)? | The .xml file was released on MBS Online on 24 May. |
| 4 | In the responses to stakeholder questions, it is stated that Level 2.1 item is appropriate for 3D planned electrons but not for treatment because no imaging is performed. However, the explanatory notes specifically mention “planned electrons”. Please remove the ambiguity from the explanatory notes. | For planning:  If based on volume/OARs on planning CT, use 15906.  If field based on CT, use 15904.  If clinical mark-up without CT, use 15902.  In all the 3 scenarios use 15930 for treatment. |
| 5 | In the responses to stakeholder questions, response 13 indicates that the reference that MLC must be included won’t be amended until November 2024. Is it OK to claim item 15906 in the interim for 3D image based planned electrons? | Yes. |
| 6 | Will there be a dedicated Medicare team/person and/or “hotline” to answer radiation oncology queries post implementation? | Yes. Enquiries relating to the new schedule can be directed to the policy area at [MBSOncology@health.gov.au](mailto:MBSOncology@health.gov.au) |
| 7 | A. Currently Medicare rejects claims if the treatment item doesn’t match the plan item complexity.  B. Come July 1st there will be claims with the new treatment items for those patients on treatment. Confirmation that these won’t be rejected by Medicare because there isn’t a new planning item would be appreciated. | A. Explanatory Note 13which relates to all megavoltage treatment and planning items has been updated as follows:  The complexity level of the treatment regimen must be appropriate for the plan. Accordingly, treatment items must not be billed at higher levels than the complexity level associated with planning item for that site.  Treatment can be billed however at a higher sub-level within a band. For example, it may be appropriate to use level 3.2 treatment for a site planned at Level 3.1, but billing for Level 3 treatment items following Level 2 planning will not be processed.  If treatment is for multiple sites, each site must be clearly identified and differentiated by name in billing notes (e.g., Breast, Pelvis, Brain).  B. Claims will not be rejected on this basis. Where treatments are delivered after 1 July (billed using the new schedule), the MBS claims system will look back to confirm that planning has been undertaken using either the old or new schedule. |
| 8 | To reduce the risk of a claim being rejected by Medicare please confirm any rules regarding using different level items for dosimetry and treatment. | Explanatory Note 13 addresses the rules on this (also covered in the training videos). |
| 9 | As per the wording of the current version of item 15942 and the response to question 9, is this item now claimable for more locoregional sites or synchronous primaries (as per EN 14)? | The cranium is considered to be a single site. As it could only relate to a single plan (15918), 15942 intracranial stereotactic RT is therefore billable once per day only. |
| 10 | Where we treat multiple separate sites, can we add a single item number with the quantity we are claiming and a single billing note stating all of the sites we treated in that session, or do we require separate invoices for each site? | Separate invoices are required. |
| 11 | For the kV item 15954 do we just use a total quantity of this item for the number of sites we have treated (i.e. not individual codes for each site) | Yes. Multiple sites should be claimed in a single billing instance of 15954.  \* Some systems are set up to select number of ‘fields’ instead of sites. This can be used if the number selected is equivalent to the number of sites treated (rather than fields used). |
| 12 | Is Gammaknife included in the MegaVoltage sections? (was specified in the pervious version the codes for level 4.1) | Gamma Knife is included in the megavoltage items. The items are intentionally equipment agnostic providing instead detail on how services should be delivered.  Eligible Gamma Knife services can be billed using the following stereotactic items:  15918 – Intracranial stereotactic radiation therapy planning  15920 – Stereotactic body radiation therapy planning  15922 – Intracranial stereotactic radiation therapy or stereotactic body radiation therapy re-planning  15942 – Intracranial stereotactic radiation therapy treatment  15944 – Stereotactic body radiation therapy treatment. |
| 13 | When will we get a final version of the codes? | The codes (and descriptors) are final and remain unchanged since their circulation to the sector on 6 May 2024. |
| 14 | What date should be used for the planning activity? The date the patient attended or the completion of the of the planning process (could be 2-3 week difference) | The date of completion should be used. Medicare items are not billable until all services described in those items have been undertaken.  Where service components within a new planning item i.e., simulation and dosimetry are undertaken either side of 1 July, billing should be withheld until the completion of all components in the new item. For example, if simulation is undertaken prior to 1 July and dosimetry is conducted after 1 July, the relevant new planning item should be billed after 1 July for both components.  Payments for new planning items will not be processed if a bill for a component of a new item has already been processed using an old item. |
| 15 | Patients who are on treatment on the 1st July 2024 (effects around 500 patients), we submit the new treatment codes, but do we need to submit the new planning code as they are linked? | If planning has been billed using the old schedule and the patient’s treatment continues past 1 July using new planning items, it is not necessary to submit a new planning item. The claims system has the ability to look back to find the relevant planning item for the patient under the old schedule, thereby allowing processing of treatment items under the new schedule. (Submitting 2 planning items for the same course/site would also be double-dipping.)  For services delivered prior to 1 July 2024, current MBS items 15000-15850 should be used for billing. For services delivered after 1 July 2024, new MBS items 15902-19584 should be used for billing. This includes cases where patients commence a course of planning and treatment prior to 1 July 2024 and complete the course of treatment after that date. Benefit payments will not be processed if old MBS items are used to bill services performed after 1 July 2024. Similarly, payments will not be processed if new MBS items are used to bill services where all components within the item were performed before 1 July 2024.  Please refer to the information sheet for further information on transitional arrangements. |
| 16 | Is there a minimum time period between treatment episodes of care? I.e can we plan the C-spine then plan a L-spine? Currently we are required to have a minimum of six weeks between episodes of care if we want claim for payment. | There are no minimum time periods between planning or treatment items for different sites (the ‘42 day rule’ time limit will not be retained under the new schedule).  Clear annotation of tumour site(s) on billing documentation will be required. See explanatory notes 12, 14, 15. |
| 17 | If a patient is referred to a specialised treatment after their planning i.e. was going to be VMAT at PAH now needs Tomo at RBWH, can both centres claim planning? | Only the centres where planning has been undertaken can claim a planning item. If planning was undertaken by both centres, they will both be able to claim; however, the second claim will trigger a flag when Medicare processes the claim and appropriate notes will need to be included in the bill to explain the need for the second plan. |
| 18 | If motion management is used for simulation for a level 3.2 plan but not for treatment, do we still claim for level 3.2 treatment? The descriptor reads as though you can. | In line with updated Explanatory Note 13:  The complexity level of the treatment regimen must be appropriate for the plan. Accordingly, treatment items must not be billed at higher levels than the complexity level associated with planning item for that site.  Treatment can be billed however at a higher sub-level within a band. For example, it may be appropriate to use level 3.2 treatment for a site planned at Level 3.1, but billing for Level 3 treatment items following Level 2 planning will not be processed.  If treatment is for multiple sites, each site must be clearly identified and differentiated by name in billing notes (e.g., Breast, Pelvis, Brain). |
| 19 | If a patient is planned and starts treatment with simple VMAT and motion management plan 15914, then needs replanning without motion management can we bill 15912? Instead of 15916? | Yes. Replanning can be billed at lower level than initial planning. |
| 20 | Image fusion, does it need to be multimodal? What if it is not clinically appropriate? | Only the relevant fusions should be raised. |
| 21 | Please provide examples of how Medicare would like the notations associated to each billing code to be written when treating multiple sites at one time. For example if we treated a patients Lt shoulder and Rt Hip in one appointment, when billing with the new codes we would bill for both anatomical prescriptions/areas individually and we would then distinguish them by annotating one code to be for the Lt shoulder and one for the Rt hip. How should this be annotated going forward, and if you could please provide us with some examples for commonly treated sites. For example would “Shoulder” and “Hip” suffice in the above example.    For multi sites being treated at the same time, can this be billed as a quantity (e.g. billing 15934 x 2) and then annotate appropriately, or is an individual code required for each area of treatment (e.g. 15934 for “Shoulder” and then 15934 for “Hip” and annotate for each code). | Annotations of anatomical sites in billing notes is adequate to identify and differentiate multiple sites. The full name of the treatment site must be included in all claims (i.e. right breast, right lung etc.). Text or notations using the wording ‘Separate sites’ or ’multiple sites’ including any abbreviations will not be accepted.    Please note, if the first claim is submitted with no text, and a second claim with text is provided, this could result in processing delays, rejected claims or requests for further information. |