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

**TRANCHE 4 Q & A: Provided to sector on 24/10/2024**

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|  | **Question** | **Response** |
| 1 | If a patient is simulated as an Inpatient and then discharged before planning finalized, is this billed as an IP or Outpatient ? And vice-versa, if the patient is simulated as an OP then admitted sometime after simulation, how is this billed? | As all components of an item must be delivered for a claim to be valid, the date of service should reflect the date of completion of all components of an MBS item. |
| 2 | Where motion management is used at treatment but not in simulation, what planning level should be billed? Should MVT planning level 2.2 be used as the planning code where MM is used at treatment? E.g. 15936 will be used for L2.2 pelvis treatment (where surface guidance is used to detect patient movement and hold the beam if the patient moves). Surface guidance MM is not used in the simulation although there are additional planning elements required to ensure the MM can be undertaken at treatment (eg ensuring suitable contouring, export of DICOM data to MM system). | A similar scenario for surface guided radiation therapy on the right breast has been addressed in RANZCR’s training video. You can access this information through the below YouTube playlist link or download as a PDF document. For this scenario, it would be appropriate to use either a Level 2.1 or 3.1 for planning and simulation for a single dose with no motion management, and a Level 2.2 or 3.2 for complex treatment.   * Playlist link: <https://www.youtube.com/playlist?list=PLkF5kezZnbx4LN-ma9jDwV0waOoD1PdmH> * Link to PDF content:<https://www.ranzcr.com/index.php?option=com_edocman&task=document.download&id=2208> |
| 3 | There is some ambiguity in what constitutes a specialized technique. We would consider Craniospinal Irradiation as a specialized technique as it is outside routine radiotherapy. (Radiotherapy delivered to the whole brain and spinal cord in much the way as some IMRT TBI techniques).  IGRT is not used in our TBI technique. How should a TBI be billed if IGRT is not used? Following the current descriptors, our TBI technique (that takes 90mins to setup, measure and deliver) would be considered a MVT treatment Level 1.1. | Craniospinal irradiation is not considered to be Level 5 treatment.  Please see the above YouTube training video link (in question 2) which addresses how TBI should be billed. |
| 4 | What constitutes a separate prescription? Depending on how an institution implements their Oncology Information System, some multisite techniques could be listed on the same prescription. In our institution, a Radiation Oncologist may specify 20Gy in 5 fractions to 2 separate sites (eg Spine & Shoulder) and list them on the same prescription because the share common prescription elements (but as separate line items per site). There is clear distinction of 2 treatment areas with separate plans and we would consider this different prescriptions. Please confirm this interpretation. | If radiation oncologists wish to bill for multiple sites they need to have separate prescriptions (see Information Sheet on multiple site billing and explanatory notes TN.2.3 in updated schedule) |
| 5 | If there are multiple SXRT fields requiring an internal eye shield are multiple 15956 allowed in the same attendance? | The eye shield is inserted once per treatment session so 15956 should only be billed once. |
| 6 | Can multiple treatment sites in the one attendance include a SRT treatment & an IMRT or SBRT treatment in the 1 attendance? (e.g. 15942 & 15940 or 15944) Our interpretation is that we just need to indicate that they are separate sites with separate prescriptions.  The updated definitions from 06/05/2025 indicate that only one 15944 SBRT treatment code can be claimed per day (similar to the 15942 SRT treatment) although the responses to the stakeholder questions indicate that two separate anatomical can be claimed. Please confirm 15944 is applicable once per plan per day. | Your interpretation is correct, for each of the non-stereotactic treatment items (15930-15942,15946-15948) you can claim multiple treatment items per plan per day so long as they are for separate sites under separate plans. Both SRT and SBRT items are limited to once per day each, i.e. you may only claim one SRT (15942) AND one SBRT (15944) per day if it is clinically relevant. |
| 7 | Seeking some clarification on intracranial vs head in relation to the Intracranial SRT codes - treating a lesion outside the cranium such as an orbit, would this be claimed under the intracranial SRT code? | No, the orbit is defined as an extracranial site. Definition of the SBRT codes would cover the delivery of stereotactic radiotherapy to this site. |
| 8 | In the case of a brain patient requiring SRT to multiple brain mets, we often have the case where the smaller lesions are treated in one fraction and larger lesions are treated in 3 fractions. In this case, are you able to claim SRT planning items for the 1# brain and an additional SRT planning item for the 3# plan? Are you able to claim SRT treatment item for all 4 fractions in total? | The SRT intracranial items may only be claimed once per course for planning (multiple fields within the cranium are not considered multiple sites) and once per day for treatment. |
| 9 | We are still unclear about the below scenario and we do not feel that this particular question has been answered.  A patient has a 4DCT and is planned for treatment with motion management  This would be a planning code of Level 3.2 15914  However, for treatment the patient is unable to do breath hold and therefore the treatment codes become Level 3.1 15938  In the description for the 15938 it states that this code can only be billed with planning code 15910  (level 3.1 planning code)  However, some of the explanatory notes seem to imply that we could still bill planning at 15914. | Most of the megavoltage treatment item descriptors contain wording similar to ‘used to implement a plan described in a corresponding planning item. This wording is changing on 1 Nov 2024 (see updated descriptors). The wording is a clinical guide and is not intended to be overly restrictive. It is reasonable to claim a higher level plan if that is what is required to appropriately plan the patient’s treatment and then claim the lower level treatment item because the treatment planned for is no longer appropriate. There is no limitation preventing claiming of planning item 15914 and treatment item 15938. |
| 10 | Craniospinal irradiation (CSI) – CSI is not specifically mentioned in the Level 5 Specialised planning description, but we feel this planning and treatment technique involving multiple isocentres and multiple, overlapping rotational treatment beams would qualify this technique as “specialised”. There is also extensive MDT involvement in this technique as described in explanatory note 9. Are we able to claim for CSI plans and treatments under the Level 5 planning and treatment items? Or is this level limited to only TBI or TSE (or whole body) techniques? | No. It is not permissible to claim for CSI plans and treatments under the Level 5 Megavoltage items. The only exception to its inclusion would be if CSI is administered under anaesthesia on a paediatric patient, in which case it could be billed under level 5 treatment. |
| 11 | Brachytherapy – A number of the brachytherapy item descriptions contain the annotation “(Anaes.)” at the end. Does this mean that anaesthetic is a required part of these items & they cannot be claimed without the use of anaesthetic for that particular procedure? Are you able to clarify what this annotation means? | The MBS book states that ‘If the service attracts an anaesthetic, the word (Anaes.) appears following the description. This means that for where (Anaes.) appears at the end of an item, anaesthetic MAY be required. |
| 12 | Multiple treatment sites within one organ – can we confirm if we are able to claim planning and treatment items for multiple sites within the one organ, if there are separate prescriptions and plans for each treatment site? i.e. Left Upper Lobe & Left Lower Lobe, or Liver Segment 2 & Liver Segment 8. | Multi-site billing is permitted for planning and treatment, in line with the revised explanatory notes in the updated schedule.  For billing purposes, each site must be clearly identified and differentiated by a unique name in billing notes (see Information Sheet on multiple site billing and explanatory notes TN.2.3 in updated schedule). |
| 13 | In the case of a brain patient requiring SRT to multiple brain mets, we often have the case where the smaller lesions are treated in one fraction and larger lesions are treated in 3 fractions. In this case, are you able to claim SRT planning items for the 1# brain and an additional SRT planning item for the 3# plan? Are you able to claim SRT treatment item for all 4 fractions in total? | The SRT intracranial items may only be claimed once per course for planning (multiple fields within the cranium are not considered multiple sites) and once per day for treatment. |
| 14 | In the case of multiple treatment sites, is there a limit on the number of sites that can be claimed for planning items per patient? | Multiple site billing is permitted for planning and treatment, in line with revised explanatory notes in the updated schedule. There is no limit to how many sites can be billed, however the sites must be clearly identified and differentiated in the billing notes (see Information Sheet on multiple site billing and explanatory notes TN.2.3 in updated schedule). |
| 15 | In the case of multiple treatment sites, is there a limit on the number of treatment items that can be claimed in the same day? i.e. how many separate sites are you able to treat in one day and still claim a treatment item for each? | Multiple site billing at the same attendance is permitted for planning and treatment (see Information Sheet on multiple site billing and explanatory notes TN.2.3 in updated schedule). |
| 16 | Our site uses a CT scanner owned by providers that we work closely with. When patients are simulated on these scanners by their staff and planned by our staff are we still able to charge the sim & planning code? | Yes. |
| 17 | Seeking some clarification on intracranial vs head in relation to the Intracranial SRT codes - treating a lesion outside the cranium such as an orbit, would this be claimed under the intracranial SRT code? | No, the orbit is considered to be an extracranial site. |
| 18 | Having just changed over to the new MBS codes on Monday 01/07/2024 I have had several questions around how we should be code capturing those patients that have multiple plans/treatment sites. Prior to us finalizing our process in our R&V system, can you clarify and confirm that we are now able to bill the same MBS treatment code multiple times for the same patient on the same day? | Multi-site billing is permitted for planning and treatment (see Information Sheet on multiple site billing and explanatory notes TN.2.3 in updated schedule) |
| 19 | 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 items. 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) sites/plans have not been claimed in error.  As stated in the descriptor for treatment item 15944, when treating multiple sites with SBRT, only one treatment site can be claimed each day (high dosage considerations). |
| 20 | If we have 3 separate areas, prescribed separately, (for example a nose, ear and cheek) and they are to be treated with kV superficial radiotherapy at the same attendance what should our billing be?    In the RANZCR training (please see slide attached below) it says we should claim 15952 three times (one for each area). If so, should 15952 be entered 3 separate times or would we enter 15952 once and add a quantity of 3 (like we do for the current 15003 code).    On the other hand, I have read that we should claim 15954 for multiple areas? If so, should this be entered once with the appropriate quality of fields or entered 3 separate times?    With the RANZCR notes below, I am assuming the difference for claiming 15952 x3 or 15954 is purely due to whether there are separate prescriptions?    Can I please confirm that claiming 15952 three times in the above scenario as per RANZCR's instructions is the correct way to bill? | Kilovoltage planning (15950)  Where patients are having more than one anatomical site treated, there must be a separate prescription for each site. Sites should be clearly identified and differentiated in billing notes (see Information Sheet on multiple site billing and explanatory note TN.2.4 in updated schedule).  Kilovoltage treatment (15952 & 15954)  15952 is billed when one site only is being treated at the attendance.  Treatment to 2 or more sites during the same attendance should be billed as follows:   * 15952 for the first site, and * 15954 for each additional site.   Examples:   1. One prescription for one site: Use 15950 + 15952 2. One prescription for multiple sites: Use 15950 + 15952 (initial site) + 15954 (additional sites after the initial site) 3. Three prescriptions for three sites (non-orbital): Use (15950 x3) + 15952 (initial site) + 15954 (for the 2 additional sites after the initial site) 4. Three prescriptions for three sites (2x non-orbital, 1x orbital): Use (15950 x3) + 15952 (initial non-orbital site) + 15954 (for the 1 additional non-orbital site) + 15956 (for the orbital site)   \* Identify each site in billing notes only for planning multiple sites (multiple 15950). No need to Identify each site for Kv treatments. |
| 21 | We currently bill the Gamma knife patients who have a frame fitted by the neurosurgeons for a 15600 + 40803 (to cover frame fitting, planning and treatment).    Going forward, do you think we should add the 40803 to planning 15920 or to treatment 15944 bills (as it is present for both? Or should we choose either one? | Item 40803 does not have to be claimed at a certain time point, but is probably best claimed with Intracranial Stereotactic RT planning item 15918.    The items you mentioned (15920 and 15944) are for Stereotactic Body RT. |
| 22 | Replan Rules (page 25): The guidelines indicate that only one Replan is allowed during the treatment course. However, page 26 mentions that each attendance may be claimed as a replan under the same course due to multiple insertions/attendance. Could you please provide further clarification on this matter? | See revised descriptors and explanatory notes for brachytherapy. |
| 23 | MRI-Guided Cervix Brachytherapy (4 fractions): In our current practice, patients undergo an MRI before each treatment. We contour each MRI for each fraction and generate a plan for each MRI acquired. In this scenario, are we allowed to charge for four separate plans? | Yes. |
| 24 | Is there still a need for radiation oncologists to review patient images offline (ie. after the fact) or has it been noted that processes have evolved and radiation therapists are now making decisions at the time of treatment to verify the patient position. | It is acknowledged that the process of having a radiation oncologist review patient images offline has evolved. Contemporary treatment, regardless of complexity, allows for a radiation oncologist to be available to physically review a patient when required and therefore make decisions at the time of treatment to verify the patient position. For higher complexity treatments a radiation oncologist should be immediately available for critical decision making. |
| 25 | A patient was planned to have CyberKnife SBRT to Prostate in June 2024. The patient was billed for planning under item 15565 on 7th June 2024 and this was processed through to Medicare. The patient came in on the 11th June 2024 for the first fraction of this treatment and the team were unable to treat due inaccuracy in tracking the target. Shortly following this, the patient was admitted to hospital and found to have an abscess in the area for treatment. All treatment was cancelled until further notice.    The patient has now returned a few months later in August and is well enough for Prostate SBRT treatment. The patient will require full Simulation and treatment planning prior to starting treatment again.    We are a bit unsure of the planning item number we are allowed to bill due to the change over in Item numbers for Radiation Oncology and SBRT. How do you advise we bill for simulation and planning?     1. Are we able to bill item umber 15920 for simulation and planning? 2. OR Should we be using a replan item number such as 15922, however the initial plan was not billed under 15920. | On this occasion, it would be acceptable to bill MBS Item 15920 for a new SBRT simulation and dosimetry treatment plan (despite MBS Item 15565 previously billed under the old MBS schedule) as the patient’s initial treatment had to be entirely cancelled and full simulation and treatment planning is again required to enable treatment to commence. |
| 26 | Gynae cases typically have 2 scans acquired, a full bladder scan and an empty bladder scan to be able to delineate an ITV. Would this be considered motion management in planning as we are quantifying physiological motion? On treatment standard imaging is conducted to ensure the bladder and ITV align to planning scans. Would this be considered standard or complex treatment? | Yes, the acquisition of the 2 scans can be considered motion management. However, the Item Number to be used depends on the level of complexity of the dosimetry (for 3D MVT or IMRT) and whether any additional dosimetry is (re-planning) required for treatment adjustments. Relevant Item Numbers that maybe considered for this scenario are 15908, 15912, 15914 and 15916.    The level of complexity of treatment would include those for motion management and dosimetry (3D MVT or IMRT). Relevant Item Numbers that maybe considered for this scenario are 15936 and 15940. |
| 27 | Multi-met intracranial stereotactic cases often require separate prescriptions for each lesion due to differing lesion sizes and location. For example, Lesion 1 = 22Gy in 1 fraction, Lesion 2 = requires a fractionated treatment due to proximity to brain stem 27Gy in 3 fractions or 30Gy in 5 fractions. These prescriptions need to be planned separately, two stereotactic plans will be approved by the RO as well as RT and physics QA on each plan. Are we permitted to apply two 15918 Megavoltage planning - Level 4 codes for this patient? Some of our radiation oncologists that work across facilities (including publicly) have indicated that this is permitted. | The cranium is considered to be a single site.  Intracranial stereotactic radiation therapy (SRT) billing is restricted to one plan per course of treatment and one treatment per day. |
| 28 | I am seeking some clarification on what codes we should use for patients in the following example:  Prostate VMAT with fiducials inserted into the prostate  CT and plan:   * CT Acquired   + Fiducials move during the CT * Single Dose Level plan completed   + The Radiation Therapist contours the entire Seed projections (movement) as seen on the single CT scan   Treatment   * Pre imaging CBCT taken daily * Kilovoltage Images taken every 5 seconds during treatment delivery to track the motion of the fiducials and stop treatment delivery if outside thresholds   Does this scenario qualify for the use of complexity level 3.2 codes for both planning and treatment? | Fiducials inserted into prostate which are then outlined on a standard CT scan would not be seen as an appropriate method to predict intrafraction motion for the purposes of planning and so Item Number 15910 (Level 3.1) is applicable for planning.    The process of tracking described for treatment is motion management and so Item Number 15940 (Level 3.2) is applicable for treatment. |
| 29 | One question we have is the correct code to apply for or ‘hybrid’ breast cases. These are single dose level tangential treatment plans where a proportion of the prescription dose (70-80%) is delivered by ‘open’ tangents using MLC to shape the field to the target edge plus margin. These fields are then copied and used in the treatment planning system optimiser to create IMRT fields using sliding window MLC to deliver the remaining portion of the prescribed dose. Each patient plan as individual QA measurement using portal dosimetry. Can we bill as IMRT planning code level 3.1 15910 and treatment code level 3.1 15938 for patients not requiring motion management via DIBH & 3.2 (15914 / 15940) for those patients with DIBH? | Agree that the suggested IMRT codes are appropriate for the described scenarios. |
| 30 | As per the item descriptor, item 15944 may be claimed once per day.   1. 15944 - is it one claim per day regardless of the number of plans or treatment sites listed in that plan? 2. OR, is it once per day per plan that prescribes as such? | Due to high dosing, SBRT treatment should only be used once per day on the same patient. |
| 31 | If a treatment plan is using hypofractionation (e.g. to treat a site twice a day), expl note TN.2.1 notes that it comes under Complexity Level 3.2 – “Small-field fractionated treatment strategies”. Is that once per day per plan even though they may be treated twice in one day? | From 1 November 2024 bi-daily treatment for the same tumour site will be applicable. |
| 32 | EN. TN.2.2 states “One plan only will attract Medicare benefits in a course of treatment. Benefits are payable however for further planning items where planning is undertaken for a synchronous primary or different tumour site to that (or those) specified in the original prescription by the radiation oncologist”.   1. Does an initial treatment plan include all sites of treatment known at the time of planning? 2. Is this meant to mean that another plan may be created for a synchronis primary cancer site and/or treatment site/s that are evident at the time of initial treatment planning? 3. Or is it meant to say a second plan can be created whilst on an existing treatment plan as new sites of treatment become evident during the initial plan? | 1. If different plans are required for multiple sites, a separate plan can be billed for each site. 2. Yes. 3. Yes. Multiple plans may be evident at the time of initial planning or additional plans may be required if new sites are identified during or after treatment. |
| 33 | Attendance co-claiming – there are a number of expectations written in the ENs regarding the attendance of a Radiation Oncologist depending on MBS item. For example, explanatory note TN.2.1 - Level 4 - For stereotactic treatments this requires on the first day of treatment, a radiation oncologist or trained delegate with documented competencies in stereotactic treatments must be present at the start of the treatment fraction (prior to irradiation).   1. Is this attendance part of the item as per the complete medical service principle or can an attendance item like 105 be claimed? 2. Can an attendance item be claimed for other items like verification where the doctor is attending only to ensure the delivery of service as described in the item? 3. My understanding would be that the patient would need a clinically relevant attendance in person that is above and beyond the treatment or verification item service. | 1. The Level 4 requirement for the Radiation Oncologist to be in attendance at the first day of treatment is to verify position and dose etc. It is not to consult with the patient. Unless a dedicated consultation is required, a separate consultation item is not warranted. The fee for the attendance of a radiation oncologist for the first day Level 4 treatment has been incorporated into the overall MBS fee for the service. 2. See answer to (a). 3. Correct. |
| 34 | We often treat multiple treatment sites at the same time for skin cancers with electrons. For a single site these would be billed as:  Electron planning – 15902 – ($700.90)  Electron treatment – 15930 ($88.15)  If we are treating multiple areas that require separate simulation and planning processes (clinical mark ups) e.g. scalp + thigh, why can these not be billed as 2 separate areas treated within the same occasion? E.g. 2 x Electron treatment – 2 x 15930 ($88.15) = $176.30  Please can you confirm if we can bill for each area individually, or do we need to bill for a total of 1 area, regardless of how many we treat at the same time?  Is there a minimum time between billing for planning and treatment for different/separate areas. | Multi-site billing is permitted for planning and treatment (see Information Sheet on multiple site billing and explanatory notes TN.2.3 in updated schedule) |
| 35 | Please can you confirm if we are able to bill when the RO is out of the country for the following: Simulation and Planning – if the RO has reviewed the plan prior to billing? and Treatment? | Under the Health Insurance Act 1973, Medicare benefits are payable for professional services provided within Australia. Medicare does not cover medical expenses incurred outside of Australia, including telehealth services where the patient is in Australia and the health practitioner is outside Australia.  A radiation oncologist claiming a MBS benefit for a planning or treatment item must be in Australia at the time the service is performed.  If the medical practitioner (radiation oncologist) is overseas, the radiation oncologist providing local clinical cover is required to use their own provider number to claim any services provided to patients (not that of the overseas practitioner).  If, in accordance with accepted medical practice, an MBS service is performed under the supervision of a medical practitioner by a person other than a medical practitioner, the medical practitioner supervising the service must also be in Australia and available if needed. |