Radiopharmaceutical Reimbursement Guide

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Accurate management and monitoring of radiopharmaceutical reimbursement are essential due to their significant cost implications. Below, we outline essential billing practices and describe the comprehensive services we provide to ensure that your facility receives appropriate compensation

Per Study Dose

Radiopharmaceuticals for diagnostic purposes are typically billed using codes defined as "per study dose." These codes often specify an "up to" amount. For example, HCPCS code A9538 specifies: "Technetium Tc-99m pyrophosphate, diagnostic, per study dose, up to 25 mCi."

The Society of Nuclear Medicine and Molecular Imaging (SNMMI) clarifies that the "up-to-dose" definition refers to the maximum radiopharmaceutical quantity administered to a patient for a single imaging study. The Centers for Medicare and Medicaid Services (CMS) typically uses the manufacturer's package insert maximum dose as the upper limit. Although certain protocols might administer doses exceeding the insert recommendations, SNMMI advises billing for one "study dose" per imaging session, even if multiple syringes or containers are used or if the administered dose surpasses the "up to" amount.

However, unless specifically instructed otherwise by the payer, facilities should bill for two separate "study doses" if a patient receives separate injections for rest and stress imaging studies, regardless of the total radiopharmaceutical dosage.

Radiopharmaceutical Wastage

For detailed information on billing discarded radiopharmaceuticals, refer to our Physician Education Series on Discarded Drugs.

Assay Amount

Radiopharmaceutical doses are checked for radioactivity levels prior to administration. Usually, there's a minor variance between the ordered dose and the assay dose. Billing should reflect the ordered dose rather than the assay dose. Claims must match the radiopharmaceutical quantities listed on the purchase invoice to prevent claim denial.

Missed Appointments

If a patient misses an appointment for a scheduled radiopharmaceutical injection, Medicare does not allow billing for the radiopharmaceutical, as it was not administered. SNMMI emphasizes that discarded radiopharmaceuticals due to patient no-shows are not billable as wastage.

However, CMS permits charging patients for missed appointments if the policy uniformly applies to all patients, irrespective of payer. Such charges should be billed directly to the patient, not Medicare. Detailed guidelines

are available in the Medicare Claims Processing Manual, Chapter 1, Section 30.3.13. Some practices request patients sign agreements to cover costs associated with last-minute cancellations. Always consult with legal counsel before implementing such policies to ensure compliance with state laws.

In scenarios where a patient attends the initial appointment and receives the radiopharmaceutical but does not return for subsequent imaging sessions, bill the partial study and radiopharmaceutical administered. If no imaging was performed, submit the intended study code with modifier 52 (Reduced service), alongside the radiopharmaceutical code. Modifier 52 applies only to the imaging study code, not the radiopharmaceutical. The radiologist should provide a dictated report documenting ordered studies, administered radiopharmaceuticals, and patient contact attempts.

Payer Billing Requirements

Many payers limit reimbursement for radiopharmaceuticals to the facility's acquisition cost. Payer policies may require reporting the invoice cost on the claim form or submitting the invoice itself. For example, Novitas Medicare mandates including the total acquisition cost in Block 19 or Block 24D of the CMS 1500 form (or electronic equivalent), though invoice submission is not required. Claims lacking acquisition cost details will face denial.

When reporting acquisition costs, include any associated shipping and handling charges, as these are considered legitimate procurement expenses.

Imaging-Related Drugs

Medicare Part B covers drugs based on the Average Sales Price (ASP) methodology. Manufacturers report sales prices quarterly, and CMS sets reimbursement rates accordingly for the subsequent quarter. For updated reimbursement information, visit the Medicare Part B Drug Average Sales Price webpage: https://www.cms.gov/medicare/payment/fee-for-service-providers/part-b-drugs/average-drug-sales-price

Our Monitoring and Management Program

Our team provides meticulous oversight of high-dollar radiopharmaceutical reimbursement to ensure accurate and fair compensation. Our program includes:

- Close monitoring of reimbursement processes, ensuring equitable compensation for radiopharmaceuticals.
- Regular coding audits performed early and frequently, guaranteeing accurate billing for administered doses.
- Diligent claims monitoring and follow-up to address discrepancies promptly.
- Ongoing review of claim payments to identify instances where payors may not adhere to proper reimbursement guidelines, particularly for newer pharmaceuticals. We proactively seek renegotiation of contracts or necessary addendums to resolve these issues.
- Detailed tracking and analysis of profit and loss to ensure financial health and optimize reimbursement outcomes.