2003 HOPPS Reimbursement: Proper Cost Data is Vital for Future Payments

By Denise A. Merlino, MBA, FSNMTS

Effective January 1 many drug and radiopharmaceutical costs were bundled into the payment rate for nuclear medicine procedures. Hospitals and their nuclear medicine outpatient departments are just now beginning to feel the effects of this change, often through reduced cash flow and revenue.

Under the Hospital Outpatient Prospective Payment System (HOPPS), radiopharmaceuticals and drugs costing less than $150.00 are paid, but the cost is included in the procedure payment. Even though these charges are "bundled," it is very important that hospitals should continue to report all codes and charges for the procedures they perform. The CMS uses this hospital charge information to determine future payment rates.

The Society of Nuclear Medicine and the Nuclear Medicine APC Task Force recommend that nuclear medicine departments continue to use Healthcare Common Procedure Coding System (HCPCS) codes to describe and report radiopharmaceutical charges separate from procedure charges during 2003. See www.snm.org/policy/reimburse_020303_1.html on the SNM website for more details and specific recommendations.

Radiopharmaceuticals and drugs over $150.00 continue to be paid separately; however, hospitals must use the HCPCS codes and Revenue Code 0636 for these products in order to continue to receive separate payment.

Why did this happen?

Three years into this new HOPPS payment system, the CMS is still testing various methods and calculations of payments for hospital outpatient departments. This latest test is a hybrid where some drugs and radiopharmaceuticals are paid separately and in addition to the procedure payment while others are bundled and paid as part of the procedure. The current payment system is only capturing about 10% of the cost data that the CMS system needs to set appropriate reimbursement levels for future payments. CMS is trying hard to move toward a more bundled system, but clearly, they did not get it right for the nuclear medicine community. Unfortunately, the American Hospital Association has not complained about this hybrid model; overall, hospital payments are up, and they are happy with that.

Nuclear medicine departments need to urge their hospitals to encourage the American Hospital Association to tell CMS that it needs to readdress its charge capturing practices for nuclear medicine procedures and that it needs to work more closely with the Nuclear Medicine APC Task Force to get reimbursement right for nuclear medicine.

Within the department, it is important to update the charge description master as usual for bundled procedures. (Specific suggestions on revenue codes are listed on the SNM website mentioned above.) Even though reimbursements are bundled, charge data must be reported separately or the cost information will be lost. In effect, the radiopharmaceutical will appear "free." Finally, it is important to know the department-specific cost-to-charge ratio for nuclear medicine procedures and to understand how charges are translated into costs by CMS so that you do not report charges incorrectly—giving CMS the wrong data to use when they change the reimbursement method yet again.