2006 HOPPS Final Rule

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Practice Area: Health Law

On November 10, 2005, the Centers for Medicare and Medicaid Services (CMS), published the Hospital Outpatient Prospective Payment System and Calendar Year 2006 Payment Rates final rule in the Federal Register. The rule will be applicable to services furnished on or after January 1, 2006.

The following is a summary of select issues from the final rule that raise legal and compliance concerns. It is not meant to be a full analysis of the rule.

Financial Impact on Hospitals

Under the final rule, acute care hospitals will receive a 3.7 percent inflation update in Medicare payment rates in CY 2006. However, CMS estimates that overall, hospitals will see a 2.2 percent increase in payments for CY 2006, relative to total spending in 2005. This is due to a 2.25 percent loss from the expiration of additional payments for drugs and a .07 percent loss from the change in estimated passthrough payments for CY 2006. CMS estimates that hospitals in large urban areas will gain 1.9 percent and other urban hospitals will gain 2.8 percent. Overall, rural hospitals will see an increase of 3.9 percent, with sole community hospitals experiencing an increase of 7.6 percent and other rural hospitals experiencing an update of 1.5 percent. (For a complete set of impact changes for CY 2006, see Table 39 in the final rule.)

Payment for Rural Sole Community Hospitals for CY 2006

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) required the Health and Human Services Secretary to study whether the costs of rural hospitals (other than critical access hospitals) exceeded those of urban hospitals, and if so, to make an appropriate adjustment under the OPPS. CMS analysis showed that rural sole community hospitals have significantly higher costs than urban hospitals. Other rural hospitals did not have higher costs. Based on this analysis, CMS is instituting a 7.1 percent payment increase for rural sole community hospitals for CY 2006. The adjustment will apply to all services and procedures paid under the OPPS, with the exception of drugs and biologicals. The adjustment will be budget neutral, and will be applied before calculating outliers and coinsurance.

Decreased Coinsurance Rates

Coinsurance rates for OPPS services are being gradually reduced until the beneficiary's share for any outpatient service will be 20 percent of the hospital's total payment. In continuing this trend, the final rule reduces the maximum coinsurance rate for any service to 40 percent of the total payment to the hospital for Ambulatory Payment Classifications ("APCs") in 2006, down from 45 percent in 2005.

Access to Intravenous Immune Globulin (IVIG)

In response to comments expressing concern about beneficiary access to IVIG, CMS is instituting a temporary add-on payment to cover the additional preadministration-related services required to locate and acquire adequate IVIG product and prepare for an infusion of IVIG. Hospitals will be permitted to bill this add-on payment for CY 2006 only.

Payment Changes for Drugs, Biologicals and Radiopharmaceuticals

– Drugs and Biologicals With Pass-Through Status

Section 1833(t)(6)(C)(i) of the Social Security Act specifies that the duration of transitional pass-through payments for drugs and biologicals must be no less than two years nor any longer than three years. For CY 2006, CMS will eliminate passthrough status for 10 drugs and biologicals and continue pass-through status for 14 drugs and biologicals. (Lists of drugs and biologicals losing and retaining pass-through status in CY 2006 can be found in Tables 18 and 19 of the final rule.)

– Drugs and Biologicals Without Pass-Through Status

For CY 2006, CMS will continue to pay separately for drugs, biologicals, and radiopharmaceuticals whose median cost per day exceeds $50 and to package the cost of those whose median cost per day is less than $50 into the procedures with which they are billed.

– Payment Rates for Drugs and Biologicals Without Pass-Through Status that are Not Packaged

Payment for separately payable drugs and biologicals in CY 2006 will be average sale price (ASP) + 6 percent. CMS believes that this will serve as a proxy to make appropriate payment for both the acquisition cost and overhead cost of each product. ASP data for the final rule was based on figures from the second quarter of 2005, as these were the most recent numbers available during the development of the rule.

– Payment for Radiopharmaceuticals

Due to a lack of ASP data on which to base CY 2006 payment rates for radiopharmaceuticals, CMS has established a twopronged approach for payment.

1. For CY 2006, CMS will pay for radiopharmaceutical agents that are separately payable, based on a hospital's charge for each radiopharmaceutical agent adjusted to cost using the hospital's cost-to-charge ratio.
2. CMS will require ASP reporting for radiopharmaceuticals beginning in 2006.

Payment for Observation Services

In an effort to reduce the administrative burden on hospitals attempting to differentiate between packaged and separately payable observation services for correct billing purposes, CMS has established two new changes in payment policy for observation services in CY 2006.

1. Healthcare Common Procedure Coding System (HCPCS) codes G0244 (Observation care by facility to patient), G0263 (Direct admission with congestive heart failure (CHF), chest pain (CP), asthma), and G0264 (Assessment other than CHF, CP, asthma) will be discontinued, and two new HCPCS codes will be used by hospitals to report all observation services. The two new codes will be GXXXX (Hospital observation services, per hour) and GYYYY (Direct admission of patient for hospital observation care).
2. The determination of whether or not observation services are separately payable under APC 0339 will be made by OPPS claim processing logic, rather than the hospital billing department.

Under the new system, hospitals will bill GXXXX when observation services are provided to any patient admitted to "observation status," regardless of the patient's status as an inpatient or outpatient. In addition, hospitals will bill GYYYY when observation services are the result of a direct admission to "observation status" without an associated emergency room visit, hospital outpatient clinic visit, or critical care service on the day of or day before the observation services. Both of these new HCPCS codes will be assigned a new status indicator that will trigger Outpatient Code Editor logic during the processing of the claim to determine if the observation service is packaged with the other separately payable hospital services provided, or if a separate APC payment for observation services is appropriate.

Procedures that Will be Paid Only as Inpatient Services

CMS is also removing 26 procedures from the inpatient list and assigning 24 of the procedures to clinically appropriate APCs. The two procedures that have not been assigned to APC groups are anesthesia procedures, for which a separate payment is not made under the OPPS: 00634 (Anesthesia for procedures in lumbar region; chemonucleoysis) and 01190 (Anesthesia for obturator neurectomy; intrapelvic). Payment for these two procedures will be packaged into the procedures with which they are billed. (The procedures that will be removed from the inpatient list and APC assignments can be found in Table 36 of the final rule.)
