This document is scheduled to be published in the
Federal Register on 2026-11-06 and available online at
https://www.federalregister.gov/d/2026-22739, and on
https://govinfo.gov

de: 4169-69-P]

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 413, 416, 419, 427, and 488

[CMS-1850-FC]

RIN 0938-AV83

Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; and Quality Reporting Programs; including the Hospital Outpatient Quality Reporting Program and Ambulatory Surgical Center Quality Program; Request for Information on Strengthening the Standardization and Comparability of Hospital Price Transparency (HPT) Data; Prior Authorization; Accrediting Organization (AO) Deeming for Emergency Medical Treatment and Labor Act (EMTALA); and Notices of Closure of Teaching Hospitals and Opportunities To Apply for Available Slots

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Final rule with comment period.

SUMMARY: This final rule with comment period revises the Medicare Hospital Outpatient Prospective Payment System (OPPS) and the Medicare Ambulatory Surgical Center (ASC) payment system for calendar year 2027 based on our continuing experience with these systems. We also describe the changes to the amounts and factors used to determine the payment rates for Medicare services paid under the OPPS and those paid under the ASC payment systems. In addition, this final rule with comment period updates and refines the requirements for the Hospital Outpatient Quality Reporting Program and the Ambulatory Surgical Center Quality Reporting Program. There are no changes to the Rural Emergency Hospital Quality Reporting Program. We finalized the expansion of the prior authorization requirement to include additional

Botulinum Toxin Injection services. We also finalized implementation of certain provisions of the Consolidated Appropriations Act, 2026, for off-campus outpatient departments of a provider. In addition, this final rule with comment period announces notices of closure of teaching hospitals and opportunities to apply for available slots. Additionally, we finalized the policy that hospital accrediting organizations (AOs) with deeming authority may assess compliance with certain Emergency Medical Treatment and Labor Act (EMTALA) administrative requirements under 42 CFR 489.20 during accreditation and reaccreditation surveys.

DATES: *Effective Date*: The provisions of this rule are effective January 1, 2027.

Comment period: To be assured consideration, comments must be received at one of the addresses provided below, by **[**January 4, 2027.

ADDRESSES: In commenting, please refer to file code CMS-1850-FC.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. *Electronically*. You may submit electronic comments on this regulation to *https://www.regulations.gov/docket/CMS-2026-2344*. Follow the "Submit a comment" instructions.

2. *By regular mail*. You may mail written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-1850-FC,

P.O. Box 8010,

Baltimore, MD 21244-8010.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail*. You may send written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-1850-FC,

Mail Stop C4-26-05,

7500 Security Boulevard,

Baltimore, MD 21244-1850.

For information on viewing public comments, see the beginning of the "SUPPLEMENTARY INFORMATION" section.

FOR FURTHER INFORMATION CONTACT:

Regulation coordination questions, contact Gina Aughenbaugh via email at *OutpatientPPS@cms.hhs.gov.*

Accrediting Organization (AO) Deeming for Emergency Medical Treatment and Labor Act (EMTALA), contact Melissa Daly via email at *Melissa.Daly@cms.hhs.gov.*

Advisory Panel on Hospital Outpatient Payment (HOP Panel), contact the HOP Panel mailbox at *APCPanel@cms.hhs.gov*.

Ambulatory Surgical Center Covered Procedures List (ASC CPL), contact Abigail Cesnik via email at *Abigail.Cesnik@cms.hhs.gov*.

Ambulatory Surgical Center Quality Reporting Program measures, contact Marsha Hertzberg via email at *Marsha.Hertzberg@cms.hhs.gov*.

Ambulatory Surgical Center Quality Reporting Program policies, contact Grace Snyder via email at *Grace Snyder@cms.hhs.gov*.

All-Inclusive Rate (AIR) Add-On Payment for High-Cost Drugs Provided by Indian Health Service (IHS) and Tribal Facilities, contact Nate Vercauteren via email at *Nathan.Vercauteren@cms.hhs.gov*.

Blood and Blood Products, contact Edna Ayah via email at Edna.Ayah@cms.hhs.gov.

Cancer Hospital Payments, contact Scott Talaga via email at *Scott.Talaga@cms.hhs.gov*.

CMS Web Posting of the OPPS and ASC Payment Files, contact Gina Aughenbaugh via email at*Gina.Aughenbaugh@cms.hhs.gov.*

Composite APCs (Multiple Imaging and Mental Health) and Comprehensive APCs (C-APCs), contact Elise Barringer via email at *Elise.Barringer@cms.hhs.gov.*

Device-Intensive Status and No Cost/Full Credit and Partial Credit Devices, contact Scott Talaga via email at *Scott.Talaga@cms.hhs.gov*.

Hospital Outpatient Quality Reporting Program measures, contact Kristina Rabarison via email at *Kristina.Rabarison@cms.hhs.gov*.

Hospital Outpatient Quality Reporting Program policies, contact Kimberly Go via email at *Kimberly.Go@cms.hhs.gov*.

Hospital Outpatient Visits (Emergency Department Visits and Critical Care Visits), contact Elise Barringer via email at *Elise.Barringer@cms.hhs.gov*.

Hospital Price Transparency, contact Sarah Wheat via email at *PriceTransparencyHospitalCharges@cms.hhs.gov*.

Inpatient Only (IPO) Procedures List, contact Abigail Cesnik via email at *Abigail.Cesnik@cms.hhs.gov.*

Medicare OPPS Drug Acquisition Cost Survey, contact Cory Duke via email at *Cory.Duke@cms.hhs.gov* or Nate Vercauteren at *Nathan.Vercauteren@cms.hhs.gov*.

Method to Control Unnecessary Increases in the Volume of Outpatient Services, contact Elise Barringer via email at *Elise.Barringer@cms.hhs.gov*.

New Technology Intraocular Lenses (NTIOLs), contact Scott Talaga via email at *Scott.Talaga@cms.hhs.gov*.

Non-Opioid Policy or Implementation of Section 4135 of the Consolidated Appropriations Act (CAA), 2023, contact Cory Duke via email at *Cory.Duke@cms.hhs.gov* or Nicole Marcos via email at *Nicole.Marcos@cms.hhs.gov*.

OPPS Brachytherapy, contact Scott Talaga via email at *Scott.Talaga@cms.hhs.gov*.

OPPS Data (APC Weights, Conversion Factor, Copayments, Cost-to-Charge Ratios (CCRs), Data Claims, Geometric Mean Calculation, Outlier Payments, and Wage Index), contact Erick Chuang via email at *Erick.Chuang@cms.hhs.gov* or Scott Talaga via email at *Scott.Talaga@cms.hhs.gov*.

OPPS Drugs, Radiopharmaceuticals, Biologicals, and Biosimilar Products, contact Nonyem Oguejiofor via email at *Nonyem.Oguejiofor@cms.hhs.gov*, Cory Duke via email at *Cory.Duke@cms.hhs.gov*, or Nate Vercauteren via email at *Nathan.Vercauteren@cms.hhs.gov*.

OPPS New Technology Procedures/Services, contact the New Technology APC mailbox at *NewTechAPCapplications@cms.hhs.gov*.

OPPS Packaged Items/Services, contact Cory Duke via email at *Cory.Duke@cms.hhs.gov*.

OPPS Pass-Through Devices, contact the Device Pass-Through mailbox at *DevicePTapplications@cms.hhs.gov*.

OPPS Status Indicators (SI) and Comment Indicators (CI), contact Marina Kushnirova via email at *Marina.Kushnirova@cms.hhs.gov* or Tonya Gierke at *Tonya.Gierke@cms.hhs.gov.*

Outpatient Department Prior Authorization Requirements, contact Yuliya Cook via email at Yuliya.Cook@cms.hhs.gov.

Partial Hospitalization Program (PHP), Intensive Outpatient (IOP), and Community Mental Health Center (CMHC) Issues, contact the PHP Payment Policy Mailbox at *PHPPaymentPolicy@cms.hhs.gov*.

Consideration of Potential Approaches for Separate IPPS Payment for Domestic Procurement of Personal Protective Equipment and Essential Medicines Issues, please contact *DAC@cms.hhs.gov.*

Provider-Based Attestation Requirements, please contact CAA_2026_Section_6225@cms.hhs.gov.

Rural Emergency Hospital Quality Reporting Program policies, contact Grace Snyder via email at *Grace.Snyder@cms.hhs.gov*.

Rural Emergency Hospital Quality Reporting Program measures, contact Melissa Hager via email at *Melissa.Hager@cms.hhs.gov*.

Skin Substitute Products, contact Nicole Marcos via email at *Nicole.Marcos@cms.hhs.gov*.

Software as a Medical Service, contact Nicole Marcos via email at *Nicole.Marcos@cms.hhs.gov*.

All Other Issues Related to Hospital Outpatient Payments Not Previously Identified, contact the OPPS mailbox at *OutpatientPPS@cms.hhs.gov*.

All Other Issues Related to the Ambulatory Surgical Center Payments Not Previously Identified, contact the ASC mailbox at *ASCPPS@cms.hhs.gov*.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: *https://www.regulations.gov*. Follow the search instructions on that website to view public comments. CMS will not post on Regulations.gov public comments that make threats to individuals or institutions or suggest that the individual will take actions to harm the individual. CMS continues to encourage individuals not to submit duplicative comments. We will post acceptable comments from multiple unique commenters even if the content is identical or nearly identical to other comments.

Addenda Available Only Through the Internet on the CMS Website

In the past, a majority of the addenda referred to in our OPPS/ASC proposed and final rules were published in the **Federal Register** as part of the annual rulemakings. However, beginning with the calendar year (CY) 2012 OPPS/ASC proposed rule, the addenda no longer appear in the **Federal Register** as part of the annual OPPS/ASC proposed and final rules, in order to decrease administrative burden and reduce costs associated with publishing lengthy tables. Instead, these addenda are published and available only on the CMS website. The addenda relating to the OPPS are available at *https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices*. The addenda relating to the ASC payment system are available at *https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-regulations-and-notices*.

Current Procedural Terminology (CPT) Copyright Notice

Throughout this final rule with comment period, we use CPT codes and descriptions to refer to a variety of services. We note that CPT codes and descriptions are copyright 2026 American Medical Association (AMA). All Rights Reserved. CPT is a registered trademark of the AMA. Applicable Federal Acquisition Regulations and Defense Federal Acquisition Regulations apply.

I. Summary and Background

A. Executive Summary of this Document

1. Purpose

In this final rule with comment period, we are updating the payment policies and payment rates for services furnished to Medicare beneficiaries in hospital outpatient departments (HOPDs) and ambulatory surgical centers (ASCs), beginning January 1, 2027. Section 1833(t) of the Social Security Act (the Act) requires us to annually review and update the payment rates for services payable under the Hospital Outpatient Prospective Payment System (OPPS).

Specifically, section 1833(t)(9)(A) of the Act requires the Secretary of the Department of Health and Human Services (the Secretary) to review certain components of the OPPS not less often than annually, and to revise the groups, the relative payment weights, and the wage and other adjustments to take into account changes in medical practice, changes in technology, and the addition of new services, new cost data, and other relevant information and factors. In addition, under section 1833(i)(2)(D)(v) of the Act, we annually review and update the ASC payment rates. This final rule with comment period also includes additional policy changes made in accordance with our experience with the OPPS and the ASC payment system and recent changes in our statutory authority. We describe these and various other statutory authorities in the relevant sections of this final rule with comment period. In addition, this final rule with comment period announces the closure of a teaching hospital and the opportunity to apply for available slots. In addition, this final rule with comment period updates and refines requirements for the Hospital Outpatient Quality Reporting Program and the Ambulatory Surgical Center Quality Reporting Program. There are no changes to the Rural Emergency Hospital Quality Reporting Program. We finalized the expansion of the prior authorization requirement to include additional Botulinum Toxin Injection services. This final rule with comment period also includes changes to implement certain provisions of the Consolidated Appropriations Act, 2026, for off-campus outpatient departments of a provider. Additionally, we are finalizing a policy that hospital accreditation organizations (AOs) with deeming authority may assess compliance with certain EMTALA administrative requirements under 42 CFR 489.20 during accreditation and reaccreditation surveys.

2. Summary of the Major Provisions

- *OPPS Update*: For CY 2027, we are increasing the payment rates under the OPPS by an outpatient department (OPD) fee schedule increase factor of 2.3 percent. This increase factor is based on the inpatient hospital market basket percentage increase of 3.2 percent for inpatient services paid under the hospital inpatient prospective payment system (IPPS), reduced by the

productivity adjustment of 0.9 percentage point. Based on this update, we estimate that total payments to OPPS providers (including beneficiary cost sharing and estimated changes in enrollment, utilization, and case mix) for calendar year (CY) 2027 will be approximately $114.4 billion, an increase of approximately $11 billion compared to estimated CY 2026 OPPS payments.

We are continuing to implement the statutory 2.0 percentage point reduction in payments for hospitals that fail to meet the hospital outpatient quality reporting requirements by applying a reporting factor of 0.9804 to the OPPS payments and copayments for all applicable services. Under the final 340B remedy offset, payments for services at hospitals subject to the 340B remedy offset will be reduced by 2.0 percentage points.

- *ASC Payment Update*: For CYs 2019 through 2023, we adopted a policy to update the ASC payment system using the hospital market basket update. In light of the impact of the COVID-19 public health emergency (PHE) on healthcare utilization, we extended our policy to update the ASC payment system using the hospital market basket update an additional 2 years – through CYs 2024 and 2025. For CY 2026, we extended this interim period an additional year – through CY 2026. In this final rule, we are extending our utilization of the hospital market basket update as the update factor for the ASC payment system for one additional year (through CY 2027). Using the hospital market basket update, for CY 2027, we are increasing payment rates under the ASC payment system by 2.3 percent for ASCs that meet the quality reporting requirements under the ASCQR Program. This increase is based on a hospital market basket percentage increase of 3.2 percent reduced by a final productivity adjustment of 0.9 percentage point. Based on this update, we estimate that total payments to ASCs (including beneficiary cost sharing and estimated changes in enrollment, utilization, and case-mix) for CY 2027 will be approximately $9.9 billion, an increase of approximately $560 million compared to estimated CY 2026 Medicare payments.

- *Adjustment for Cost-of-Living in Alaska and Hawaii*: For CY 2027, we are establishing a cost-of-living adjustment (COLA) for outpatient hospital services provided in Alaska and Hawaii that applies the same COLA factors as finalized in the FY 2027 IPPS/LTCH PPS final rule for FY 2027 for hospitals located in these States.

- *Device Pass-Through Payment Applications*: For CY 2027, we received 19 complete applications for device pass-through payments. We sought public comment on 13 applications (six applicants withdrew) and are approving device pass-through payment status for nine applications. We are also denying device pass-through payment status for four applications in this final rule with comment period.

- *Changes to the List of ASC Covered Surgical Procedures and Ancillary Services Lists:* For CY 2027, we are continuing to expand the ASC covered procedures list (CPL) by adding 618 codes to the ASC CPL that were recommended by interested parties or were finalized for removal from the IPO list for CY 2027.

- *Changes to the Inpatient Only (IPO) List*: We are continuing to phase out the IPO list by removing 637 services from the auditory, digestive, endocrine, female genital, hemic and lymphatic systems, integumentary, male genital, maternity care and delivery, mediastinum and diaphragm, respiratory and urinary clinical families from the IPO list for CY 2027.

- *Cross-Program Updates for the Hospital Outpatient Quality Reporting and Ambulatory Surgical Center Quality Reporting Programs:* We are removing the Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients measure from the Hospital Outpatient Quality Reporting and Ambulatory Surgical Center Quality Reporting Programs.

- *Hospital Outpatient Quality Reporting Program:* In addition to finalizing the cross-program proposal to remove the Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients measure, we are updating and refining validation and validation

reconsideration procedures, including policies applicable to electronic clinical quality measures (eCQMs).

- *Rural Emergency Hospital Quality Reporting Program:* We are not making any updates to the Rural Emergency Hospital Quality Reporting Program in this final rule with comment period.

- *Ambulatory Surgical Center Quality Reporting Program:* We are finalizing the cross-program measure proposal to remove the Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients measure.

- *Expansion of Category for Hospital Outpatient Department Prior Authorization Process:* We added Botulinum Toxin Injection codes to the existing category of services subject to the Hospital Outpatient Department prior authorization process for dates of service on or after July 1, 2027.

- *Partial Hospitalization and Intensive Outpatient Programs:* We are updating the Partial Hospitalization Program (PHP) and Intensive Outpatient Program (IOP) payment rates for CY 2027 using the methodology we finalized in CY 2026.

- *Payment Adjustment for 340B-Acquired Drugs Based on Results of the Medicare OPPS Drug Acquisition Cost Survey:* Section 1833(t)(14)(D)(ii) of the Act requires the Secretary to periodically conduct surveys of hospital acquisition costs for each specified covered outpatient drug for use in setting the payment rates for such drugs. Additionally, on April 18, 2025, President Trump signed Executive Order (E.O.) 14273, "Lowering Drug Prices by Once Again Putting Americans First". Section 5 of the E.O., "Appropriately Accounting for Acquisition Costs of Drugs in Medicare", which directs the Secretary of HHS to publish in the **Federal Register** a plan to conduct a survey under section 1833(t)(14)(D)(ii) of the Act so he can determine the hospital acquisition cost for covered outpatient drugs at hospital outpatient departments. Accordingly, from January 1, 2026 through April 7, 2026, we conducted a survey of the acquisition costs for each separately payable drug acquired by all hospitals paid under the

OPPS. Taking the survey results into account, for CY 2027 we are paying ASP minus 28 percent for 340B acquired drugs. Statute requires that this policy be implemented in a budget neutral manner, so this will increase OPPS payments for non-drug services by an equivalent amount, which is estimated to be a 7.50 percent increase to non-drug service payments for this final rule with comment period.

- *Prospective Adjustment to Payments for Non-Drug Items and Services to Offset the Increased Payments for Non-Drug Items and Services Made in CY 2018 Through CY 2022 as a Result of the 340B Payment Policy:* The Remedy for the 340B-Acquired Drug Payment Policy for Calendar Years 2018-2022 (88 FR 77150) codified an annual 0.5 percent reduction in the OPPS conversion factor applicable to non-drug items and services, excluding hospitals that enrolled in Medicare after January 1, 2018, until we estimated that the reduction had fully offset the additional $7.8 billion in non-drug services payments made as part of the prior 340B drug payment policy. This reduction was effective January 1, 2026. For CY 2027, we are increasing the annual percent reduction to the OPPS conversion factor used to determine the payment amounts for non-drug items and services for hospitals for whom this adjustment applies from 0.5 percent to 2 percent.

- *Method to Control Unnecessary Increases in the Volume of Outpatient Services Furnished in Excepted Off-Campus Provider-Based Departments (PBDs)*: For CY 2027, we are using our authority under section 1833(t)(2)(F) of the Act to apply the Physician Fee Schedule equivalent rate for any Healthcare Common Procedure Coding System (HCPCS) codes assigned to the imaging without contrast APCs when provided at an off-campus PBD excepted from section 1833(t)(21) of the Act. We will exempt rural Sole Community Hospitals from this method to control the unnecessary volume of imaging without contrast services.

- *Payment for Software as a Medical Service (SaMS):* Recently, there have been rapid developments in the use of software-based technologies to diagnose disease and support clinical decision-making in outpatient and physician office settings. For CY 2027, we are finalizing

terminology for this group of services to be designated as Software as a Medical Service (SaMS) for Medicare payment purposes. As an interim policy as we continue to consider a longer-term payment methodology for this group of services, we are finalizing assignment of SaMS technologies to new technology APCs with payment rates that closely align with current CY 2026 payment rates. We are finalizing the creation of new status indicator (SI) "O1" (Software as a Medical Service, paid under OPPS; separate APC payment) and assigning the relevant HCPCS codes to this new (SI).

Similarly, for CY 2027, we are moving payment for stand-alone algorithmic analyses performed on data from prior laboratory tests, such as secondary genomic sequencing analyses, from the Clinical Laboratory Fee Schedule (CLFS) as "diagnostic laboratory tests" to the OPPS as "other diagnostic tests" as provided in section 1861(s)(3) of the Act.

3. Summary of Costs and Benefits

In section XXVI. of this final rule with comment period, we provide a detailed analysis of the regulatory and Federalism impacts that the changes will have on affected entities and beneficiaries. Key estimated impacts are described below.

a. Impacts of all OPPS Changes

Table 112 in section XXVI.C. of this final rule with comment period displays the distributional impact of all the OPPS changes on various groups of hospitals and CMHCs for CY 2027 compared to all estimated OPPS payments in CY 2026. We estimate that the finalized policies in this final rule with comment period will result in a 1.7 percent increase in OPPS payments to providers for services. We estimate that total OPPS payments for CY 2027, including beneficiary cost-sharing, to the approximately 3,600 facilities paid under the OPPS (including general acute care hospitals, children's hospitals, cancer hospitals, and CMHCs) will increase by approximately $1.78 billion compared to CY 2026 payments due to the OPD update, excluding changes in enrollment, utilization, and case-mix. However, for providers subject to

the 340B remedy offset, the 340B remedy offset is estimated to reduce payments by $1.6 billion in CY 2027.

We estimated the isolated impact of our OPPS policies on CMHCs because CMHCs have historically only been paid for partial hospitalization services under the OPPS. Beginning CY 2024, they are also paid for IOP services under the OPPS. Based on our policy to calculate CMHC PHP and IOP costs based on 40 percent of the corresponding proposed hospital-based PHP and IOP costs, we estimate a 29.0 percent increase in CY 2027 payments to CMHCs relative to their CY 2026 payments.

b. Impacts of the Updated Wage Index

We estimate that our update of the wage indexes based on the fiscal year (FY) 2027 IPPS final rule wage indexes will result in no change for urban hospitals under the OPPS and a 0.3 percent increase for rural hospitals. These wage indexes include continued utilization of the Office of Management and Budget (OMB) labor market area delineations based on 2020 Decennial Census data, with updates, as discussed in section II.C. of this final rule with comment period.

c. Impacts of the Rural Adjustment and the Cancer Hospital Payment Adjustment

For CY 2027, we will continue to provide additional payments to cancer hospitals so that a cancer hospital's payment-to-cost ratio (PCR) after the additional payments is equal to the weighted average PCR for the other OPPS hospitals using the most recently submitted or settled cost report data. Section 16002(b) of the 21st Century Cures Act requires that this weighted average PCR be reduced by 1.0 percentage point. For CY 2027, we are targeting PCR of 0.88 to determine the CY 2027 cancer hospital payment adjustment to be paid at cost report settlement. That is, the payment adjustments would be the additional payments needed to result in a PCR equal to 0.88 for each cancer hospital.

There are no significant impacts of our CY 2027 payment policies for hospitals that are eligible for the rural sole community hospital adjustment, as we are maintaining the current policy in the CY 2027 OPPS.

d. Impacts of the OPD Fee Schedule Increase Factor

For the CY 2027 OPPS/ASC, we are establishing an OPD fee schedule increase factor of 2.3 percent and applying that increase factor to the conversion factor for CY 2026. As a result of the OPD fee schedule increase factor and other budget neutrality adjustments, we estimate that urban hospitals will experience an increase in payments of 2.0 percent and that rural hospitals will experience an increase in payments of 5.6 percent. Classifying hospitals by teaching status, we estimate non-teaching hospitals will experience an increase in payments of 6.5 percent, minor teaching hospitals will experience an increase in payments of 3.5 percent, and major teaching hospitals will experience a decrease in payments of 2.0 percent. We also classified hospitals by the type of ownership. We estimate that hospitals with voluntary ownership will experience an increase of 2.1 percent in payments, while hospitals with government ownership will experience a decrease of 1.1 percent in payments. We estimate that hospitals with proprietary ownership will experience an increase of 10.5 percent in payments.

e. Impacts of the ASC Payment Update

For impact purposes, the surgical procedures on the ASC covered surgical procedure list are aggregated into surgical specialty groups using CPT and HCPCS code range definitions. The percentage change in estimated total payments by specialty groups under the final CY 2027 payment rates, compared to estimated CY 2026 payment rates, ranges between an increase of 35 percent and a decrease of 5 percent.

f. Impact of the Changes to the Hospital Outpatient Quality Reporting Program

Across 3,000 hospitals participating in the Hospital Outpatient Quality Reporting Program, we estimate that our finalized changes will reduce total information collection burden

by 17,439 hours for a cost savings of $997,143 beginning with the CY 2029 reporting period/CY 2031 payment determination.

g. Impact of the Changes to the Ambulatory Surgical Center Quality Reporting Program

Across 5,149 ASCs participating in the Ambulatory Surgical Center Quality Reporting Program, we estimate that our finalized changes will reduce total information collection burden by 16,753 hours for a cost savings of $957,937 beginning with the CY 2027 reporting period/CY 2029 payment determination.

B. Legislative and Regulatory Authority for the Hospital OPPS

When Title XVIII of the Act was enacted, Medicare payment for hospital outpatient services was based on hospital-specific costs. In an effort to ensure that Medicare and its beneficiaries pay appropriately for services and to encourage more efficient delivery of care, the Congress mandated replacement of the reasonable cost-based payment methodology with a prospective payment system (PPS). The Balanced Budget Act of 1997 (BBA) (Pub. L. 105-33) added section 1833(t) to the Act, authorizing implementation of a PPS for hospital outpatient services. The OPPS was first implemented for services furnished on or after August 1, 2000. Implementing regulations for the OPPS are located at 42 CFR parts 410 and 419.

The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106-113) made major changes in the hospital OPPS. The following Acts made additional changes to the OPPS: the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106-554); the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173); the Deficit Reduction Act of 2005 (DRA) (Pub. L. 109-171), enacted on February 8, 2006; the Medicare Improvements and Extension Act under Division B of Title I of the Tax Relief and Health Care Act of 2006 (MIEA-TRHCA) (Pub. L. 109-432), enacted on December 20, 2006; the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (Pub. L. 110-173), enacted on December 29, 2007; the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (Pub. L. 110-275),

enacted on July 15, 2008; the Patient Protection and Affordable Care Act (Pub. L. 111-148), enacted on March 23, 2010, as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA, Pub. L. 111-152), enacted on March 30, 2010 (these two public laws are collectively known as the Affordable Care Act); the Medicare and Medicaid Extenders Act of 2010 (MMEA, Pub. L. 111-309); the Temporary Payroll Tax Cut Continuation Act of 2011 (TPTCCA, Pub. L. 112-78), enacted on December 23, 2011; the Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA, Pub. L. 112-96), enacted on February 22, 2012; the American Taxpayer Relief Act of 2012 (Pub. L. 112-240), enacted January 2, 2013; the Pathway for SGR Reform Act of 2013 (Pub. L. 113-67) enacted on December 26, 2013; the Protecting Access to Medicare Act of 2014 (PAMA, Pub. L. 113-93), enacted on March 27, 2014; the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 (Pub. L. 114-10), enacted April 16, 2015; the Bipartisan Budget Act of 2015 (Pub. L. 114-74), enacted November 2, 2015; the Consolidated Appropriations Act, 2016 (Pub. L. 114-113), enacted on December 18, 2015, the 21st Century Cures Act (Pub. L. 114-255), enacted on December 13, 2016; the Consolidated Appropriations Act, 2018 (Pub. L. 115–141), enacted on March 23, 2018; the Substance Use Disorder- Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (Pub. L. 115-271), enacted on October 24, 2018; the Further Consolidated Appropriations Act, 2020 (Pub. L. 116-94), enacted on December 20, 2019; the Coronavirus Aid, Relief, and Economic Security Act (Pub. L. 116-136), enacted on March 27, 2020; the Consolidated Appropriations Act, 2021 (Pub. L. 116–260), enacted on December 27, 2020; the Inflation Reduction Act, 2022 (Pub. L. 117-169), enacted on August 16, 2022; the Consolidated Appropriations Act (CAA), 2023 (Pub. L. 117-328), enacted December 29, 2022; and the Consolidated Appropriations Act, 2026 (CAA, 2026; Pub. L. 119-75), enacted on February 3, 2026.

Under the OPPS, we generally pay for hospital Part B services on a rate-per-service basis that varies according to the APC group to which the service is assigned. We use the Healthcare

Common Procedure Coding System (HCPCS) (which includes certain Current Procedural Terminology (CPT) codes) to identify and group the services within each APC. The OPPS includes payment for most hospital outpatient services, except those identified in section I.C. of this final rule with comment period. Section 1833(t)(1)(B) of the Act provides for payment under the OPPS for hospital outpatient services designated by the Secretary (which includes partial hospitalization services furnished by CMHCs), and certain inpatient hospital services that are paid under Medicare Part B.

The OPPS rate is an unadjusted national payment amount that includes the Medicare payment and the beneficiary copayment. This rate is divided into a labor-related amount and a nonlabor-related amount. The labor-related amount is adjusted for area wage differences using the hospital inpatient wage index value for the locality in which the hospital or CMHC is located.

All services and items within an APC group are comparable clinically and with respect to resource use, as required by section 1833(t)(2)(B) of the Act. In accordance with section 1833(t)(2)(B) of the Act, subject to certain exceptions, items and services within an APC group cannot be considered comparable with respect to the use of resources if the highest median cost (or mean cost, if elected by the Secretary) for an item or service in the APC group is more than 2 times greater than the lowest median cost (or mean cost, if elected by the Secretary) for an item or service within the same APC group (referred to as the "2 times rule"). In implementing this provision, we generally use the cost of the item or service assigned to an APC group.

For new technology items and services, special payments under the OPPS may be made in one of two ways. Section 1833(t)(6) of the Act provides for temporary additional payments, which we refer to as "transitional pass-through payments", for at least 2 but not more than 3 years for certain drugs, biological agents, brachytherapy devices used for the treatment of cancer, and categories of other medical devices. For new technology services that are not eligible for transitional pass-through payments, and for which we lack sufficient clinical information and cost data to appropriately assign them to a clinical APC group, we have

established special APC groups based on costs, which we refer to as New Technology APCs. These New Technology APCs are designated by cost bands which allow us to provide appropriate and consistent payment for designated new procedures that are not yet reflected in our claims data. Similar to pass-through payments, an assignment to a New Technology APC is generally temporary; that is, we retain a service within a New Technology APC until we acquire sufficient data to assign it to a clinically appropriate APC group.

C. Excluded OPPS Services and Hospitals

Section 1833(t)(1)(B)(i) of the Act authorizes the Secretary to designate the hospital outpatient services that are paid under the OPPS. While most hospital outpatient services are payable under the OPPS, section 1833(t)(1)(B)(iv) of the Act excludes payment for ambulance, physical and occupational therapy, and speech-language pathology services, for which payment is made under a fee schedule. It also excludes screening mammography, diagnostic mammography, and effective January 1, 2011, an annual wellness visit providing personalized prevention plan services. The Secretary exercises the authority granted under the statute to also exclude from the OPPS certain services that are paid under fee schedules or other payment systems. Such excluded services include, for example, the professional services of physicians and nonphysician practitioners paid under the Medicare Physician Fee Schedule (MPFS); certain laboratory services paid under the Clinical Laboratory Fee Schedule (CLFS); services for beneficiaries with end-stage renal disease (ESRD) that are paid under the ESRD prospective payment system; and services and procedures that require an inpatient stay that are paid under the hospital IPPS. In addition, section 1833(t)(1)(B)(v) of the Act does not include applicable items and services (as defined in subparagraph (A) of paragraph (21)) that are furnished on or after January 1, 2017, by an off-campus outpatient department of a provider (as defined in subparagraph (B) of paragraph (21)). We set forth the services that are excluded from payment under the OPPS in regulations at 42 CFR 419.22.

Under § 419.20(b) of the regulations, we specify the types of hospitals that are excluded from payment under the OPPS. These excluded hospitals are:

- Critical access hospitals (CAHs);
- Hospitals located in Maryland and paid under Maryland's All-Payer or Total Cost of Care Model;
- Hospitals located outside of the 50 States, the District of Columbia, and Puerto Rico;
- Indian Health Service (IHS) hospitals; and
- Rural emergency hospitals (REHs).

D. Prior Rulemaking

On April 7, 2000, we published in the **Federal Register** a final rule with comment period (65 FR 18434) to implement a prospective payment system for hospital outpatient services. The hospital OPPS was first implemented for services furnished on or after August 1, 2000. Section 1833(t)(9)(A) of the Act requires the Secretary to review certain components of the OPPS, not less often than annually, and to revise the groups, the relative payment weights, and the wage and other adjustments to take into account changes in medical practices, changes in technology, the addition of new services, new cost data, and other relevant information and factors.

Since initially implementing the OPPS, we have published final rules in the **Federal Register** annually to implement statutory requirements and changes arising from our continuing experience with this system. These rules can be viewed on the CMS website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices.*

E. Advisory Panel on Hospital Outpatient Payment (the HOP Panel or the Panel)

1. Authority of the Panel

Section 1833(t)(9)(A) of the Act, as amended by section 201(h) of Pub. L. 106-113, and redesignated by section 202(a)(2) of Pub. L. 106-113, requires that we consult with an expert outside advisory panel composed of an appropriate selection of representatives of providers to

annually review (and advise the Secretary concerning) the clinical integrity of the payment groups and their weights under the OPPS. In CY 2000, based on section 1833(t)(9)(A) of the Act, the Secretary established the Advisory Panel on Ambulatory Payment Classification Groups (APC Panel) to fulfill this requirement. In CY 2011, based on section 222 of the Public Health Service Act (the PHS Act), which gives discretionary authority to the Secretary to convene advisory councils and committees, the Secretary expanded the panel's scope to include the supervision of hospital outpatient therapeutic services in addition to the APC groups and weights. To reflect this new role of the panel, the Secretary changed the panel's name to the Advisory Panel on Hospital Outpatient Payment (the HOP Panel). The HOP Panel is not restricted to using data compiled by CMS, and in conducting its review, it may use data collected or developed by organizations outside the Department.

2. Establishment of the Panel

On November 21, 2000, the Secretary signed the initial charter establishing the Panel, and, at that time, named the APC Panel. This expert panel is composed of appropriate representatives of providers (currently employed full-time, not as consultants, in their respective areas of expertise) who review clinical data and advise CMS about the clinical integrity of the APC groups and their payment weights. Since CY 2012, the Panel also is charged with advising the Secretary on the appropriate level of supervision for individual hospital outpatient therapeutic services. The Panel is technical in nature, and it is governed by the provisions of the Federal Advisory Committee Act (FACA). The current charter specifies, among other requirements, that the Panel--

- May advise on the clinical integrity of Ambulatory Payment Classification (APC) groups and their associated weights;
- May advise on the appropriate supervision level for hospital outpatient services;
- May advise on OPPS APC rates for ASC covered surgical procedures;
- Continues to be technical in nature;

- Is governed by the provisions of the FACA;
- Has a Designated Federal Official (DFO); and
- Is chaired by a Federal Official designated by the Secretary.

The Panel's charter was amended on November 15, 2011, renaming the Panel and expanding the Panel's authority to include supervision of hospital outpatient therapeutic services and to add critical access hospital (CAH) representation to its membership. The Panel's charter was also amended on November 6, 2014 (80 FR 23009), and the number of members was revised from up to 19 to up to 15 members. The Panel's current charter was approved on November 21, 2024, for a 2-year period.

The current Panel membership and other information pertaining to the Panel, including its charter, **Federal Register** notices, membership, meeting dates, agenda topics, and meeting reports, can be viewed on the CMS website at *https://www.cms.gov/Regulations-and-Guidance/Guidance/FACA/AdvisoryPanelonAmbulatoryPaymentClassificationGroups.html*.

3. Panel Meetings and Organizational Structure

The Panel has held many meetings, with the last meeting taking place on August 24, 2026. The recommendations of the Panel for the most recent meeting are available on the CMS website at *https://www.cms.gov/medicare/regulations-guidance/advisory-committees/hospital-outpatient-payment*. Prior to each meeting, we publish a notice in the **Federal Register** to announce the meeting, new members, and any other changes of which the public should be aware. Beginning in CY 2017, we have transitioned to one meeting per year (81 FR 31941). In CY 2022, we published a **Federal Register** notice requesting nominations to fill vacancies on the Panel (87 FR 68499). We are currently accepting nominations at *https://mearis.cms.gov*.

In addition, the Panel has established an administrative structure that, in part, currently includes the use of two subcommittee workgroups to provide preparatory meeting and subject support to the larger panel. The two current subcommittees include the following:

- APC Groups and Status Indicator Assignments Subcommittee, which advises and provides recommendations to the Panel on the appropriate status indicators to be assigned to HCPCS codes, including but not limited to whether a HCPCS code or a category of codes should be packaged or separately paid, as well as the appropriate APC assignment of HCPCS codes regarding services for which separate payment is made; and

- Data Subcommittee, which is responsible for studying the data issues confronting the Panel and for recommending options for resolving them.

Each of these workgroup subcommittees was established by a majority vote from the full Panel during a scheduled Panel meeting, and the Panel recommended at the August 24, 2026, meeting that these subcommittees continue. We accepted this recommendation.

For discussions of earlier Panel meetings and recommendations, we refer readers to previously published OPPS/ASC proposed and final rules, the CMS website mentioned earlier in this section, and the FACA database at *https://facadatabase.gov*.

F. Public Comments Received on the CY 2026 OPPS/ASC Final Rule With Comment Period

We received approximately 48 timely pieces of correspondence on the CY 2026 OPPS/ASC final rule with comment period that appeared in the **Federal Register** on November 25, 2025 (90 FR 53448).

II. Updates Affecting OPPS Payments

A. Recalibration of APC Relative Payment Weights

1. Database Construction

a. Database Source and Methodology

Section 1833(t)(9)(A) of the Act requires that the Secretary review not less often than annually and revise the relative payment weights for Ambulatory Payment Classifications (APCs). In the April 7, 2000 OPPS final rule with comment period (65 FR 18482), we explained in detail how we calculated the relative payment weights for each APC group; this methodology was implemented on August 1, 2000.

For the CY 2027 OPPS, we proposed to recalibrate the APC relative payment weights for services furnished on or after January 1, 2027, and before January 1, 2028 (CY 2027), using CY 2025 claims data and the same basic methodology that we described in the CY 2026 OPPS/ASC final rule with comment period (90 FR 53455 through 53457). That is, we proposed to recalibrate the relative payment weights for each APC using a database constructed from claims and cost report data for hospital outpatient department (HOPD) services.

For the purpose of recalibrating the proposed APC relative payment weights for CY 2027, we began with approximately 147 million final action claims (claims for which all disputes and adjustments have been resolved and payment has been made) for HOPD services furnished on or after January 1, 2025 and before January 1, 2026, before applying our exclusionary criteria and other methodological adjustments. After the application of those data processing changes, we used approximately 74 million final action claims to develop the proposed CY 2027 OPPS payment weights (91 FR 41740). For exact numbers of claims used and additional details on the claims accounting process, we refer readers to the claims accounting narrative under "Downloads" for the CY 2027 OPPS/ASC proposed rule on the CMS website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices.*

Addendum N to the CY 2027 OPPS/ASC proposed rule (which is available via the Internet on the CMS website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices*), includes the proposed list of bypass codes for CY 2027. Bypass codes allow the ratesetting process to use multiple-procedure claims to develop "pseudo" single claims, which are then used to develop OPPS payment rates. The proposed list of bypass codes contains codes that are reported on claims for services in CY 2025 and, therefore, includes codes that were in effect in CY 2025 and used for billing. We proposed to retain these deleted bypass codes on the proposed CY 2027 bypass list because these codes existed in CY 2025 and were covered HOPD services in that period, and CY 2025 claims data were used to calculate proposed CY 2027 payment rates (91 FR 41740). Keeping these deleted bypass codes on the bypass list potentially allows us to create more "pseudo" single procedure claims for ratesetting purposes. "Overlap bypass codes" that are members of the proposed multiple imaging composite APCs are identified by asterisks (*) in the third column of Addendum N to the CY 2027 OPPS/ASC proposed rule. HCPCS codes that we proposed to add for CY 2027 are identified by asterisks (*) in the fourth column of Addendum N.

We did not receive any public comments on our general proposal to recalibrate the relative payment weights for each APC based on claims and cost report data for HOPD services or on our proposed bypass code process. We are finalizing as proposed the ''pseudo'' single claims process and the CY 2027 proposed list of bypass codes, finalized in Addendum N to this final rule with comment period (which is available via the internet on the CMS website). For this final rule with comment period, for the purpose of recalibrating the final APC relative payment weights for CY 2027, we used approximately 81 million final action claims (claims for which all disputes and adjustments have been resolved and payment has been made) for HOPD services furnished on or after January 1, 2025, and before January 1, 2026. For the exact numbers of claims used and additional details on the claims accounting process, we refer readers to the claims accounting narrative under supporting documentation for this final rule with

comment period on the CMS website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient*.

b. Calculation and Use of Cost-to-Charge Ratios (CCRs)

For CY 2027, we proposed to continue to use the hospital-specific overall ancillary and departmental cost-to-charge ratios (CCRs) to convert charges to estimated costs through application of a revenue code-to-cost center crosswalk (91 FR 41740). To calculate the APC costs on which the proposed CY 2027 APC payment rates are based, we calculated hospital-specific departmental CCRs for each hospital for which we had CY 2025 claims data by comparing these claims data to the most recently available hospital cost reports, which, in most cases, are from CY 2024. For the proposed CY 2027 OPPS payment rates, we used the set of claims processed during CY 2025. We applied the hospital-specific CCR to the hospital's charges at the most detailed level possible, based on a revenue code-to-cost center crosswalk that contains a hierarchy of CCRs used to estimate costs from charges for each revenue code. To ensure the completeness of the revenue code-to-cost center crosswalk, we reviewed changes to the list of revenue codes for CY 2025 (the year of claims data we used to calculate the proposed CY 2027 OPPS payment rates) and updates to the National Uniform Billing Committee (NUBC) 2025 Data specifications Manual (91 FR 41740 through 41741). That crosswalk is available for review and continuous comment on the CMS website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices* and included with every proposed and final OPPS rule.

In accordance with our longstanding policy, similar to our finalized policy for CY 2026 OPPS ratesetting, we proposed to calculate CCRs for the standard cost centers – cost centers with a predefined label – and nonstandard cost centers – cost centers defined by a hospital – accepted by the electronic cost report database. In general, the most detailed level at which we calculate CCRs is the hospital-specific departmental level.

While we generally view the use of additional cost data as improving our OPPS ratesetting process, we have historically not included cost report lines for certain nonstandard cost centers in the OPPS ratesetting database construction when hospitals have reported these nonstandard cost centers on cost report lines that do not correspond to the cost center number. We believe it is important to further investigate the accuracy of these cost report data before including such data in the ratesetting process. Further, we believe it is appropriate to gather additional information from the public as well before including the data in OPPS ratesetting. For CY 2027 and future years, we proposed not to include the nonstandard cost centers reported in this way in the OPPS ratesetting database construction (91 FR 41741).

We did not receive any public comments on the general CCR process, and therefore, we are finalizing our proposal for CY 2027 to continue to use the hospital-specific overall ancillary and departmental CCRs to convert charges to estimated costs through application of a revenue code-to-cost center crosswalk. We are also finalizing the proposed methodology regarding the treatment of nonstandard cost centers.

2. Final Data Development and Calculation of Costs Used for Ratesetting

In this section of this final rule with comment period, we discuss the use of claims to calculate the OPPS payment rates for CY 2027. The Hospital OPPS page on the CMS website on which this final rule with comment period is posted (*https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient)* provides an accounting of claims used in the development of the final payment rates. That accounting provides additional detail regarding the number of claims derived at each stage of the process. In addition, later in this section we discuss the file of claims that comprises the data set that is available upon payment of an administrative fee under a CMS data use agreement. The CMS website *https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient*, includes information about obtaining the "OPPS Limited Data Set," which now includes the additional variables previously available only in the OPPS Identifiable Data Set,

including International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis codes and revenue code payment amounts. This file is derived from the CY 2025 claims that are used to calculate the final payment rates for the CY 2027 OPPS/ASC final rule with comment period.

Previously, the OPPS established the scaled relative weights on which payments are based using APC median costs, a process described in the CY 2012 OPPS/ASC final rule with comment period (76 FR 74188). However, as discussed in more detail in section II.A.2.f. of the CY 2013 OPPS/ASC final rule with comment period (77 FR 68259 through 68271), we finalized the use of geometric mean costs to calculate the relative weights on which the CY 2013 OPPS payment rates were based. While this policy changed the cost metric on which the relative payments are based, the data process in general remained the same under the methodologies that we used to obtain appropriate claims data and accurate cost information in determining estimated service cost.

We used the methodology described in sections II.A.2.a. through II.A.2.c. of this final rule with comment period to calculate the costs we used to establish the proposed relative payment weights used in calculating the OPPS payment rates for CY 2027 shown in Addenda A and B to this final rule with comment period (which are available via the Internet on the CMS website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices*). We refer readers to section II.A.4. of this final rule with comment period for a discussion of the conversion of APC costs to scaled payment weights.

We note that under the OPPS, CY 2019 was the first year in which the claims data used for setting payment rates (CY 2017 data) contained lines with the modifier "PN," which indicates nonexcepted items and services furnished and billed by off-campus provider-based departments (PBDs) of hospitals. Because nonexcepted items and services are not paid under the OPPS, in the CY 2019 OPPS/ASC final rule with comment period (83 FR 58832), we finalized a policy to remove those claim lines reported with modifier "PN" from the claims data used in

ratesetting for the CY 2019 OPPS and subsequent years. For the CY 2027 OPPS, we proposed to continue to remove claim lines with modifier "PN" from the ratesetting process (91 FR 41741).

We did not receive any public comments on our proposal to continue to remove claim lines reported with modifier ''PN'' from the ratesetting process and are finalizing as proposed.

For details of the claims accounting process used in this CY 2027 OPPS/ASC final rule with comment period, we refer readers to the claims accounting narrative under supporting documentation for this final rule with comment period on the CMS website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient*.

a. Calculation of Single Procedure APC Criteria-Based Costs

(1) Blood and Blood Products

Since the implementation of the OPPS in August 2000, we have made separate payments for blood and blood products through APCs rather than packaging payment for them into payments for the procedures with which they are administered. Hospital payments for the costs of blood and blood products, as well as for the costs of collecting, processing, and storing blood and blood products, are made through the OPPS payments for specific blood product APCs.

We proposed to continue to establish payment rates for blood and blood products using our blood-specific CCR methodology (90 FR 53457), which utilizes actual or simulated CCRs from the most recently available hospital cost reports to convert hospital charges for blood and blood products to costs. This methodology has been our standard ratesetting methodology for blood and blood products since CY 2005. It was developed in response to data analysis indicating that there was a significant difference in CCRs for those hospitals with and without blood-specific cost centers and past public comments indicating that the former OPPS policy of defaulting to the overall hospital CCR for hospitals not reporting a blood-specific cost center often resulted in an underestimation of the true hospital costs for blood and blood products. To address the differences in CCRs and to better reflect hospitals' costs, our methodology simulates

blood CCRs for each hospital that does not report a blood cost center by calculating the ratio of the blood-specific CCRs to hospitals' overall CCRs for those hospitals that do report costs and charges for blood cost centers and applies this mean ratio to the overall CCRs of hospitals not reporting costs and charges for blood cost centers on their cost reports. We proposed to calculate the costs upon which the proposed payment rates for blood and blood products are based using the actual blood-specific CCR for hospitals that reported costs and charges for a blood cost center and a hospital-specific, simulated, blood-specific CCR for hospitals that did not report costs and charges for a blood cost center.

We continue to believe that the hospital-specific, simulated, blood-specific CCR methodology takes into account the unique charging and cost accounting structure of each hospital, as it better responds to the absence of a blood-specific CCR for a hospital than alternative methodologies, such as defaulting to the overall hospital CCR or applying an average blood-specific CCR across hospitals. This methodology also yields more accurate estimated costs for these products and results in payment rates for blood and blood products that appropriately reflect the relative estimated costs of these products for hospitals without blood cost centers and for these blood products in general (91 FR 41742).

For a more detailed discussion of payments for blood and blood products through APCs, we refer readers to:

- The CY 2005 OPPS proposed rule (69 FR 50524 and 50525) for a more comprehensive discussion of the blood-specific CCR methodology;
- The CY 2008 OPPS/ASC final rule with comment period (72 FR 66807 through 66810) for a detailed history of the OPPS payment for blood and blood products; and
- The CY 2015 OPPS/ASC final rule with comment period (79 FR 66795 and 66796) for additional discussion of our policy not to make separate payments for blood and blood products when they appear on the same claims as services assigned to a C-APC.

We received one public comment on these proposals. The following is a summary of the

comment we received and our response.

Comment: A commenter supported CMS's proposal to continue to pay for blood and blood derived products in the HOPD rather than packaging the payment.

Response: We appreciate the commenter's support of our proposal.

After consideration of the public comment, we are finalizing our proposal to continue separate payment for blood and blood derived products in the HOPD for CY 2027.

We refer readers to Addendum B to this final rule with comment period (which is available via the internet on the CMS website at *https://www.cms.gov/medicare/payment/*prospective-*payment-systems/hospital-outpatient/regulations-notices*) for the final CY 2027 payment rates for blood and blood products (which are generally identified with status indicator "R").

(2) Brachytherapy Sources

Section 1833(t)(2)(H) of the Act mandates the creation of additional groups of covered OPD services that classify devices of brachytherapy – cancer treatment through solid source radioactive implants – consisting of a seed or seeds (or radioactive source) ("brachytherapy sources") separately from other services or groups of services. The statute provides certain criteria for the additional groups. For the history of OPPS payment for brachytherapy sources, we refer readers to prior OPPS final rules, such as the CY 2013 OPPS/ASC final rule with comment period (77 FR 68240 and 68241). For purposes of setting payment rates, as we have stated in prior OPPS updates, we believe that adopting the general OPPS prospective payment methodology for brachytherapy sources is appropriate for several reasons (77 FR 68240). The general OPPS methodology uses costs based on claims data to set the relative payment weights for hospital outpatient services. This payment methodology results in more consistent, predictable, and equitable payment amounts per source across hospitals by averaging the extremely high and low values, in contrast to payment based on hospitals' charges adjusted to costs. We believe that the OPPS methodology, as opposed to payment based on hospitals'

charges adjusted to cost, also would provide hospitals with incentives for efficiency in the provision of brachytherapy services to Medicare beneficiaries. Moreover, this approach is consistent with our payment methodology for most items and services paid under the OPPS. We refer readers to the CY 2016 OPPS/ASC final rule with comment period (80 FR 70323 through 70325) for further discussion of the history of OPPS payment for brachytherapy sources.

For CY 2027, except where otherwise indicated, we proposed to continue our policy and use the costs derived from CY 2025 claims data to set the proposed CY 2027 payment rates for brachytherapy sources because we proposed to use CY 2025 data to set the proposed payment rates for most other items and services that would be paid under the CY 2027 OPPS (91 FR 41742). With the exception of the proposed payment rates for brachytherapy sources A9527 (Iodine i-125, sodium iodide solution, therapeutic, per millicurie), C2636 (Brachytherapy linear source, non-stranded, palladium-103, per 1 mm), C2645 (Brachytherapy planar source, palladium-103, per square millimeter) and the proposed payment rates for low-volume brachytherapy APCs discussed in section III.D. of this final rule with comment period, we proposed to base the payment rates for brachytherapy sources on the geometric mean unit costs for each source, consistent with the methodology that we proposed for other items and services paid under the OPPS, as discussed in section II.A.2. of this final rule with comment period.

We also proposed for CY 2027 and subsequent years to continue the other payment policies for brachytherapy sources that we finalized and first implemented in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60537). For CY 2027 and subsequent years, we proposed to pay for the stranded and nonstranded not otherwise specified (NOS) codes, HCPCS codes C2698 (Brachytherapy source, stranded, not otherwise specified, per source) and C2699 (Brachytherapy source, nonstranded, not otherwise specified, per source), at a rate equal to the lowest stranded or nonstranded prospective payment rate for such sources, respectively, on a per-source basis (as opposed to, for example, per mCi), which is based on the policy we established in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66785). For

CY 2027 and subsequent years, we also proposed to continue the policy we implemented in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60537) regarding payment for new brachytherapy sources for which we have no claims data, for the same reasons we discussed in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66786, which was delayed until January 1, 2010, by section 142 of Pub. L. 110-275). Specifically, this policy is intended to enable us to assign new HCPCS codes for new brachytherapy sources to their own APCs, with prospective payment rates set based on our consideration of external data and other relevant information regarding the expected costs of the sources to hospitals. The proposed CY 2027 payment rates for brachytherapy sources are included in Addendum B to this proposed rule (which is available via the Internet on the CMS website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices*) and identified with status indicator "U (Brachytherapy Sources, Paid under OPPS; separate APC payment)."

For CY 2018, we assigned status indicator "U" to HCPCS code C2645 (Brachytherapy planar source, palladium-103, per square millimeter) in the absence of claims data and established a payment rate using external data (invoice price) at $4.69 per mm^2 for the brachytherapy source's APC – APC 2648 (Brachytx planar, p-103) (82 FR 59233 through 59234). For CY 2019, in the absence of sufficient claims data, we continued to establish a payment rate for C2645 at $4.69 per mm^2 for APC 2648 (Brachytx planar, p-103) (83 FR 58834 through 58836). Our CY 2018 claims data available for the CY 2020 OPPS/ASC final rule with comment period (84 FR 61142) included two claims with a geometric mean cost for HCPCS code C2645 of $1.02 per mm^2. In response to comments from interested parties, we agreed that, given the limited claims data available and a new outpatient indication for C2645, a payment rate for HCPCS code C2645 based on the geometric mean cost of $1.02 per mm^2 may not adequately reflect the cost of HCPCS code C2645. In the CY 2020 OPPS/ASC final rule with comment period, we finalized our policy to use our equitable adjustment authority under section

1833(t)(2)(E) of the Act, which states that the Secretary shall establish, in a budget neutral manner, other adjustments as determined to be necessary to ensure equitable payments, to maintain the CY 2019 payment rate of $4.69 per mm^2 for HCPCS code C2645 for CY 2020 (84 FR 61157 through 61158). Similarly, in the absence of sufficient claims data to establish an APC payment rate, in the CY 2021, CY 2022, CY 2023, CY 2024, CY 2025, and CY 2026 OPPS/ASC final rules with comment period (85 FR 85879 through 85880, 86 FR 63469, 87 FR 71760 through 71761, 88 FR 81553, 89 FR 93925, and 90 FR 53458), we finalized our policy to use our equitable adjustment authority under section 1833(t)(2)(E) of the Act to maintain the CY 2019 payment rate of $4.69 per mm^2 for HCPCS code C2645 for CYs 2021 through 2026.

There were no CY 2025 claims available that reported HCPCS code C2645 for the CY 2027 OPPS/ASC proposed rule. Therefore, in the absence of claims data, we proposed to continue to use our equitable adjustment authority under section 1833(t)(2)(E) of the Act to maintain the CY 2026 payment rate of $4.69 per mm^2 for HCPCS code C2645, which we proposed to be assigned to APC 2648 (Brachytx planar, p-103) for CY 2027 (91 FR 41743). Similarly, there were no CY 2025 claims available for the proposed rule that reported HCPCS A9527 (Iodine i-125, sodium iodide solution, therapeutic, per millicurie), which is assigned to APC 2632, or HCPCS code C2636 (Brachytherapy linear source, non-stranded, palladium-103, per 1 mm), which is assigned to APC 2636. While both APC 2632 and 2636 have historically been designated as Low Volume APCs, which uses up to 4 years of claims data, we are concerned that 4 years of historical claims data would only yield 2 claims for each APC, and that may not be reliable for ratesetting for these APCs for CY 2027. Therefore, we proposed to use our equitable adjustment authority under section 1833(t)(2)(E) of the Act, which states in part that the Secretary shall establish, in a budget neutral manner, other adjustments as determined to be necessary to ensure equitable payments, to maintain the CY 2026 payment rates for APC 2632 and APC 2636 for CY 2027. Specifically, for CY 2027, we proposed a payment rate of

$396.32 per millicurie for APC 2632 and a payment rate of $89.40 per 1 mm for APC 2636 (91 FR 41743).

Additionally, for CY 2022 and subsequent calendar years, we adopted a Universal Low Volume APC policy for clinical and brachytherapy APCs. As discussed in further detail in section X.C. of the CY 2022 OPPS/ASC final rule with comment period (86 FR 63743 through 63747), we adopted this policy to mitigate wide variation in payment rates that occur from year to year for APCs with low utilization. Such volatility in payment rates from year to year can result in even lower utilization and potential barriers to access. Brachytherapy APCs that have fewer than 100 single claims used for ratesetting purposes are designated as Low Volume APCs unless an alternative payment rate is applied, such as the use of our equitable adjustment authority under section 1833(t)(2)(E) of the Act in the case of APCs 2632, 2636, and 2648 as detailed above.

For CY 2027, we proposed to designate five brachytherapy APCs as Low Volume APCs as these APCs met our criteria to be designated as Low Volume APCs (91 FR 41743).

We invited interested parties to submit recommendations for new codes to describe new brachytherapy sources. Such recommendations should be directed via email to *outpatientpps@cms.hhs.gov*.

We did not receive public comments on the proposed brachytherapy payment policies discussed above, and therefore, we are finalizing them as proposed. With the exception for brachytherapy APCs designated as Low Volume APCs and APCs 2632, 2636, and 2648, we will continue our policy and use the costs derived from CY 2025 claims data to set the final CY 2027 payment rates for brachytherapy sources. We will continue to pay for the stranded and nonstranded not otherwise specified (NOS) codes, HCPCS code C2698 (Brachytherapy source, stranded, not otherwise specified, per source), at a rate equal to the lowest stranded or nonstranded prospective payment rate for such sources, respectively, on a per-source basis. Further, we will use our equitable adjustment authority under section 1833(t)(2)(E) of the Act to

maintain the CY 2026 payment rate of $4.69 per mm^2 for HCPCS code C2645, the CY 2026 payment rate of $396.32 per millicurie for APC 2632, and the CY 2026 payment rate of $89.40 per 1 mm for APC 2636 for CY 2027. We refer readers to section III.D. of this final rule with comment period for information on the brachytherapy APCs we are finalizing to designate as Low Volume APCs.

b. Comprehensive APCs (C-APCs) for CY 2027

(1) Background

In the CY 2014 OPPS/ASC final rule with comment period (78 FR 74861 through 74910), we finalized a comprehensive payment policy that packages payment for adjunctive and secondary items, services, and procedures into the costliest primary procedure under the OPPS at the claim level. The policy was finalized in CY 2014, but the effective date was delayed until January 1, 2015, to allow additional time for further analysis, opportunity for public comment, and systems preparation. The comprehensive APC (C-APC) policy was implemented effective January 1, 2015, with modifications and clarifications in response to public comments received regarding specific provisions of the C-APC policy (79 FR 66798 through 66810).

A C-APC is defined as a classification for the provision of a primary service and all adjunctive services provided to support the delivery of the primary service. We established C-APCs as a category broadly for OPPS payment and implemented 25 C-APCs beginning in CY 2015 (79 FR 66809 through 66811). We have gradually added new C-APCs since the policy was implemented beginning in CY 2015, with the number of C-APCs now totaling 74 (80 FR 70332; 81 FR 79584 through 79585; 83 FR 58844 through 58846; 84 FR 61158 through 61166; 85 FR 85885; 86 FR 63474; 87 FR 71769; 88 FR 81562; 89 FR 93926; and 90 FR 53448).

Under our C-APC policy, we designate a service described by a HCPCS code assigned to a C-APC as the primary service when the service is identified by OPPS status indicator “J1”. When such a primary service is reported on a hospital outpatient claim, taking into consideration

the few exceptions that are discussed below, we make payment for all other items and services reported on the hospital outpatient claim as being integral, ancillary, supportive, dependent, and adjunctive to the primary service (hereinafter collectively referred to as "adjunctive services") and representing components of a complete comprehensive service (78 FR 74865 and 79 FR 66799). Payments for adjunctive services are packaged into the payments for the primary services. This results in a single prospective payment for each of the primary, comprehensive services based on the costs of all reported services at the claim level. One example of a primary service would be a partial mastectomy, and an example of a secondary service packaged into that primary service would be a radiation therapy procedure.

Services excluded from the C-APC policy under the OPPS include services that are not covered OPD services, services that cannot, by statute, be paid for under the OPPS, and services that are required by statute to be separately paid. This includes certain mammography and ambulance services that are not covered OPD services in accordance with section 1833(t)(1)(B)(iv) of the Act; brachytherapy seeds, which also are required by statute to receive separate payment under section 1833(t)(2)(H) of the Act; pass-through payment drugs and devices, which also require separate payment under section 1833(t)(6) of the Act; self-administered drugs (SADs) that are not otherwise packaged as supplies because they are not covered under Medicare Part B under section 1861(s)(2)(B) of the Act; and certain preventive services (78 FR 74865 and 79 FR 66800 through 66801). A list of services excluded from the C-APC policy is included in Addendum J to this final rule with comment period (which is available via the Internet on the CMS website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices*). If a service does not appear on this list of excluded services, payment for it will be packaged into the payment for the primary C-APC service when it appears on an outpatient claim with a primary C-APC service.

The C-APC policy payment methodology set forth in the CY 2014 OPPS/ASC final rule with comment period and modified and implemented beginning in CY 2015 is summarized as follows (78 FR 74887 and 79 FR 66800):

Basic Methodology. As stated in the CY 2015 OPPS/ASC final rule with comment period, we define the C-APC payment policy as including all covered OPD services on a hospital outpatient claim reporting a primary service that is assigned to status indicator "J1,"[1] excluding services that are not covered OPD services or that cannot by statute be paid for under the OPPS. Services and procedures described by HCPCS codes assigned to status indicator "J1" are assigned to C-APCs based on our usual APC assignment methodology by evaluating the geometric mean costs of the primary service claims to establish resource similarity and the clinical characteristics of each procedure to establish clinical similarity within each APC.

In the CY 2016 OPPS/ASC final rule with comment period, we expanded the C-APC payment methodology to qualifying extended assessment and management encounters through the "Comprehensive Observation Services" C–APC (C–APC 8011). Services within this APC are assigned status indicator "J2."[2] Specifically, we make a payment through C–APC 8011 for a claim that:

- Does not contain a procedure described by a HCPCS code to which we have assigned status indicator "T[3];"
- Contains 8 or more units of services described by HCPCS code G0378 (Hospital observation services, per hour);
- Contains services provided on the same date of service or 1 day before the date of service for HCPCS code G0378 that are described by one of the following codes: HCPCS code

[1] Status indicator "J1" denotes Hospital Part B Services Paid Through a Comprehensive APC. Further information can be found in CY 2027 Addendum D1 to this final rule with comment period.
[2] Status indicator "J2" denotes Hospital Part B Services That May Be Paid Through a Comprehensive APC. Further information can be found in CY 2027 Addendum D1 to this final rule with comment period.
[3] Status Indicator "T" is defined as a "Procedure or Service, Multiple Procedure Reduction Applies" the OPPS payment status is "Paid under OPPS; separate APC payment." Definitions to all OPPS payment status indicators are available in Addenda D1 to this final rule with comment period.

G0379 (Direct admission of patient for hospital observation care) on the same date of service as HCPCS code G0378; CPT code 99281 (Emergency department visit for the evaluation and management of a patient (Level 1)); CPT code 99282 (Emergency department visit for the evaluation and management of a patient (Level 2)); CPT code 99283 (Emergency department visit for the evaluation and management of a patient (Level 3)); CPT code 99284 (Emergency department visit for the evaluation and management of a patient (Level 4)); CPT code 99285 (Emergency department visit for the evaluation and management of a patient (Level 5)) or HCPCS code G0380 (Type B emergency department visit (Level 1)); HCPCS code G0381 (Type B emergency department visit (Level 2)); HCPCS code G0382 (Type B emergency department visit (Level 3)); HCPCS code G0383 (Type B emergency department visit (Level 4)); HCPCS code G0384 (Type B emergency department visit (Level 5)); CPT code 99291 (Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes); or HCPCS code G0463 (Hospital outpatient clinic visit for assessment and management of a patient); and

- Does not contain services described by a HCPCS code to which we have assigned status indicator "J1."

The assignment of status indicator "J2" to a specific set of services performed in combination with each other allows for all other OPPS payable services and items reported on the claim (excluding services that are not covered OPD services or that cannot by statute be paid for under the OPPS) to be deemed adjunctive services representing components of a comprehensive service and resulting in a single prospective payment for the comprehensive service based on the costs of all reported services on the claim (80 FR 70333 through 70336).

Services included under the C-APC payment packaging policy, that is, services that are typically adjunctive to the primary service and provided during the delivery of the comprehensive service, include diagnostic procedures, laboratory tests, and other diagnostic tests and treatments that assist in the delivery of the primary procedure; visits and evaluations

performed in association with the procedure; uncoded services and supplies used during the service; durable medical equipment as well as prosthetic and orthotic items and supplies when provided as part of the outpatient service; and any other components reported by HCPCS codes that represent services that are provided during the complete comprehensive service (78 FR 74865 and 79 FR 66800).

In addition, payment for hospital outpatient department services that are similar to therapy services, such as speech language pathology, and delivered either by therapists or nontherapists is included as part of the payment for the packaged complete comprehensive service. These services that are provided during the perioperative period are adjunctive services and are deemed not to be therapy services as described in section 1834(k) of the Act, regardless of whether the services are delivered by therapists or other nontherapist health care workers. We have previously noted that therapy services are those provided by therapists under a plan of care in accordance with section 1835(a)(2)(C) and section 1835(a)(2)(D) of the Act and are paid for under section 1834(k) of the Act, subject to annual therapy caps as applicable (78 FR 74867 and 79 FR 66800). However, certain other services similar to therapy services are considered and paid for as hospital outpatient department services. Payment for these nontherapy outpatient department services that are reported with therapy codes and provided with a comprehensive service is included in the payment for the packaged complete comprehensive service. We note that these services, even though they are reported with therapy codes, are hospital outpatient department services and not therapy services. We refer readers to the July 2016 OPPS Change Request 9658 (Transmittal 3523)[4] for further instructions on reporting these services in the context of a C-APC service.

Items included in the packaged payment provided in conjunction with the primary service also include all drugs, biologicals, and radiopharmaceuticals, regardless of cost, except those drugs with pass-through payment status and self-administered drugs (SADs), unless they

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[4] *https://www.cms.gov/regulations-and-guidance/guidance/transmittals/downloads/r3523cp.pdf.*

function as packaged supplies (78 FR 74868, 74869, and 74909 and 79 FR 66800). We refer readers to Section 50.2M, Chapter 15 of the Medicare Benefit Policy Manual for a description of our policy on SADs treated as hospital outpatient supplies, including lists of SADs that function as supplies and those that do not function as supplies.[5]

We define each hospital outpatient claim reporting a single unit of a single primary service assigned to status indicator "J1" as a single "J1" unit procedure claim (78 FR 74871 and 79 FR 66801). Line-item charges for services included on the C-APC claim are converted to line-item costs, which are then summed to develop the estimated APC costs. These claims are then assigned one unit of the service with status indicator "J1" and later used to develop the geometric mean costs for the C-APC relative payment weights. (We note that we use the term "comprehensive" to describe the geometric mean cost of a claim reporting "J1" service(s) or the geometric mean cost of a C-APC, inclusive of all the items and services included in the C-APC service payment bundle.) Charges for services that would otherwise be separately payable are added to the charges for the primary service. This process differs from our traditional cost accounting methodology only in that all such services on the claim are packaged (except certain services as described previously). We apply our standard data trims, which exclude claims with extremely high primary units or extreme costs.

The comprehensive geometric mean costs are used to establish resource similarity and, along with clinical similarity, dictate the assignment of the primary services to the C-APCs. We establish a ranking of each primary service (single unit only) to be assigned to status indicator "J1" according to its comprehensive geometric mean costs. For the minority of claims reporting more than one primary service assigned to status indicator "J1" or units thereof, we identify one "J1" service as the primary service for the claim based on our cost-based ranking of primary services. We then assign these multiple "J1" procedure claims to the C-APC to which the service designated as the primary service is assigned. If the reported "J1" services on a claim

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[5] *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf.*

map to different C-APCs, we designate the "J1" service assigned to the C-APC with the highest comprehensive geometric mean cost as the primary service for that claim. If the reported multiple "J1" services on a claim map to the same C-APC, we designate the most costly service (at the HCPCS code level) as the primary service for that claim. This process results in initial assignments of claims for the primary services assigned to status indicator "J1" to the most appropriate C-APCs based on both single and multiple procedure claims reporting these services and clinical and resource homogeneity.

Complexity Adjustments. We use complexity adjustments to provide increased payment for certain comprehensive services. We apply a complexity adjustment by promoting qualifying paired "J1" service code combinations or paired code combinations of "J1" services and certain add-on codes (as described further below) from the originating C-APC (the C-APC to which the designated primary service is first assigned) to the next higher paying C-APC in the same clinical family of C-APCs. We apply this type of complexity adjustment when the paired code combination represents a complex, costly form- or version of the primary service according to the following criteria:

- Frequency of 25 or more claims reporting the code combination (frequency threshold); and
- Violation of the 2 times rule, as stated in section 1833(t)(2) of the Act and section III.B.2. of this final rule with comment period, in the originating C-APC (cost threshold).

These criteria identify paired code combinations that occur commonly and exhibit materially greater resource requirements than the primary service. The CY 2017 OPPS/ASC final rule with comment period (81 FR 79582) included a revision to the complexity adjustment eligibility criteria. Specifically, we finalized a policy to discontinue the requirement that a code combination (that qualifies for a complexity adjustment by satisfying the frequency and cost criteria thresholds described previously) also not create a 2 times rule violation in the higher level or receiving APC.

After designating a single primary service for a claim, we evaluate that service in combination with each of the other procedure codes reported on the claim assigned to status indicator "J1" (or certain add-on codes) to determine if there are paired code combinations that meet the complexity adjustment criteria. For a new HCPCS code, we determine initial C-APC assignment and qualification for a complexity adjustment using the best available information, crosswalking the new HCPCS code to a predecessor code(s) when appropriate.

Once we have determined that a particular code combination of "J1" services (or combinations of "J1" services reported in conjunction with certain add-on codes) represents a complex version of the primary service because it is sufficiently costly, frequent, and a subset of the primary comprehensive service overall according to the criteria described previously, we promote the claim including the complex version of the primary service as described by the code combination to the next higher cost C-APC within the clinical family, unless the primary service is already assigned to the highest cost APC within the C-APC clinical family or assigned to the only C-APC in a clinical family. We do not create new APCs with a comprehensive geometric mean cost that is higher than the highest geometric mean cost (or only) C-APC in a clinical family just to accommodate potential complexity adjustments. Therefore, the highest payment for any claim including a code combination for services assigned to a C-APC would be the highest paying C-APC in the clinical family (79 FR 66802).

We package payment for all add-on codes into the payment for the C-APC. However, certain primary service add-on combinations may qualify for a complexity adjustment. As noted in the CY 2016 OPPS/ASC final rule with comment period (80 FR 70331), all add-on codes that can be appropriately reported in combination with a base code that describes a primary "J1" service are evaluated for a complexity adjustment.

To determine which combinations of primary service codes reported in conjunction with an add-on code may qualify for a complexity adjustment for CY 2027, we apply the frequency and cost criteria thresholds discussed previously, testing claims reporting one unit of a single

primary service assigned to status indicator "J1" and any number of units of a single add-on code for the primary "J1" service. If the frequency and cost criteria thresholds for a complexity adjustment are met and reassignment to the next higher cost APC in the clinical family is appropriate (based on meeting the criteria outlined previously), we make a complexity adjustment for the code combination; that is, we reassign the primary service code reported in conjunction with the add-on code to the next higher cost C-APC within the same clinical family of C-APCs. As previously stated, we package payment for add-on codes into the C-APC payment rate. If any add-on code reported in conjunction with the "J1" primary service code does not qualify for a complexity adjustment, payment for the add-on service continues to be packaged into the payment for the primary service and is not reassigned to the next higher cost C-APC. We list the proposed complexity adjustments for "J1" and add-on code combinations for CY 2027, along with all the other proposed complexity adjustments, in Addendum J to this final rule with comment period (which is available via the Internet on the CMS website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices*).

Addendum J to this final rule with comment period includes the cost statistics for each code combination that would qualify for a complexity adjustment (including primary code and add-on code combinations). Addendum J to this final rule with comment period also contains summary cost statistics for each of the paired code combinations that describe a complex code combination that would qualify for a complexity adjustment and be reassigned to the next higher cost C-APC within the clinical family. The combined statistics for all proposed reassigned complex code combinations are represented by an alphanumeric code with the first four digits of the designated primary service followed by a letter. For example, the final geometric mean cost listed in Addendum J for the code combination described by complexity adjustment assignment 3320R, which is assigned to C-APC 5224 (Level 4 Pacemaker and Similar Procedures), includes all paired code combinations that will be reassigned to C-APC 5224 when CPT code 33208 is the

primary code. Providing the information contained in Addendum J to this final rule with comment period allows interested parties the opportunity to better assess the impact associated with the assignment of claims with each of the paired code combinations eligible for a complexity adjustment.

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: We received support from commenters for a variety of existing and proposed complexity adjustments.

Response: We thank the commenters for their support.

Comment: Multiple commenters requested that CMS apply a complexity adjustment to additional code combinations. The specific C–APC complexity adjustment code combinations requested by the commenters for CY 2027 are listed in Table 1.

TABLE 1: C-APC COMPLEXITY ADJUSTMENTS REQUESTED BY COMMENTERS FOR CY 2027

Primary "J1" HCPCS/CPT Code	Secondary "J1" HCPCS/CPT code	Primary C-APC Assignment	Requested complexity adjusted C-APC assignment
28740 (Arthrodesis, midtarsal or tarsometatarsal, single joint)	**28299** (Correction, hallux valgus, with bunionectomy, with sesamoidectomy, when performed; with double osteotomy, any method)	5114	5115
	28308 (Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; other than first metatarsal, each)	5114	5115
28750 (Arthrodesis, great toe; metatarsophalangeal joint)	**27691** (Transfer or transplant of single tendon (with muscle redirection or rerouting); deep (for example, anterior tibial or posterior tibial through interosseous space, flexor digitorum longus, flexor hallucis longus, or peroneal tendon to midfoot or hindfoot))	5114	5115
	28296 (Correction, hallux valgus with bunionectomy, with sesamoidectomy when performed; with distal metatarsal osteotomy, any method)	5114	5115
	28299 (Correction, hallux valgus, with bunionectomy, with sesamoidectomy,	5114	5115

Primary "J1" HCPCS/CPT Code	Secondary "J1" HCPCS/CPT code	Primary C-APC Assignment	Requested complexity adjusted C-APC assignment
	when performed; with double osteotomy, any method)		
37187 (Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance)	**37248** (Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein; initial vein)	5193	5194
	37252 (Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; initial noncoronary vessel)	5193	5194

Response: We reviewed each of the requested code combinations suggested by commenters, listed in Table 1, against our complexity adjustment criteria. The following code combination met our cost and frequency criteria, qualifying for a complexity adjustment for CY 2027:

- Primary HCPCS code 37187 with secondary HCPCS code 37248.

All the remaining code combinations listed failed to meet our cost or frequency criteria and do not qualify for complexity adjustments for CY 2027. Addendum J to this final rule with comment period includes the cost statistics for each code combination that was evaluated for a complexity adjustment.

Comment: Several commenters addressed the application of the C-APC complexity adjustment policy to the new lower extremity revascularization (LER) CPT code set. Commenters noted that CPT codes 37220 through 37235 were discontinued effective January 1, 2026, and replaced by CPT codes 37254 through 37299. Commenters stated that CMS used claims data from the predecessor codes to inform both C-APC assignment and complexity adjustment eligibility for the new LER codes for CY 2026 and continues to use predecessor-code information to establish C-APC assignments for the new codes for CY 2027. However,

commenters noted that the CY 2027 proposed rule complexity adjustment analysis reflected combinations involving the discontinued predecessor codes rather than the corresponding new LER codes. Commenters recommended that CMS apply the predecessor-code crosswalk methodology to the new LER codes for purposes of determining CY 2027 complexity adjustment eligibility under the OPPS and ASC payment systems. Commenters stated that doing so would ensure that a change in coding structure does not result in the loss of complexity-adjusted payment for clinically comparable and resource-intensive procedure combinations and would provide continuity until sufficient claims data are available for the new codes.

Response: We thank the commenters for their comments and bringing to our attention the application of the complexity adjustment policy to the new LER code set. As discussed in prior rulemaking (79 FR 66802), for a new HCPCS code, we determine the initial C-APC assignment and qualification for a complexity adjustment using the best available information, crosswalking the new HCPCS code to a predecessor code or codes when appropriate. Consistent with this policy, for this final rule we used the applicable predecessor-code information to evaluate the new LER codes for purposes of determining complexity adjustment eligibility for CY 2027. The results of our CY 2027 complexity adjustment evaluation, including the applicable LER code combinations and their complexity adjustment determinations, are reflected in Addendum J to this final rule. We refer readers to Addendum J for the final CY 2027 complexity adjustment assignments.

Comment: One commenter reviewed the proposed complexity adjustment evaluations and identified certain code combinations that met the applicable cost and frequency criteria for a complexity adjustment but that the commenter believed were not assigned to the appropriate next higher-paying C-APC within the applicable clinical family. The commenter requested that CMS review these combinations and assign qualifying combinations to the appropriate higher-level C-APC consistent with the complexity adjustment methodology.

Response: We thank the commenter for bringing this to our attention. It has been our

longstanding policy to promote coding pairings that qualify for complexity adjustments to the next highest APC in their clinical family. In Addendum J to this final rule with comment period, all code pairings that qualify for complexity adjustments are mapped to the next highest APC in their clinical family. All code pairings that qualify for complexity adjustments can be found in both "Complexity Adjustment Evaluation" tab and the "Complexity Adjustments" tab of Addendum J.

Comment: Several commenters encouraged CMS to modify or further refine the C-APC complexity adjustment methodology, including recommendations previously submitted in response to the CY 2026 OPPS/ASC proposed rule request for information. These prior recommendations included modifying the cost threshold used to determine eligibility for a complexity adjustment, expanding the methodology to evaluate clusters of a primary "J1" service and multiple associated add-on codes rather than only code pairs, expanding the types of codes eligible for consideration, and allowing qualifying code combinations involving a primary service already assigned to the highest level C-APC within a clinical family to receive an adjustment. Commenters generally stated that the current methodology may not adequately recognize certain complex and resource-intensive combinations of services, particularly as additional higher-cost procedures transition to the outpatient setting.

Commenters recommended a variety of changes, including modifying the cost threshold used to determine eligibility, particularly for higher-cost APCs and APCs with wider cost bands; harmonizing the methodology for evaluating different types of code combinations; and evaluating clusters of services in addition to code pairs. Several commenters also recommended expanding the types of codes eligible for complexity adjustment consideration to include certain packaged HCPCS device codes. These commenters stated that a primary J1 procedure furnished with a costly packaged device may represent a more resource-intensive encounter in the same manner as combinations currently eligible for a complexity adjustment, and, therefore, recommended that CMS evaluate J1 procedure and device code combinations when applicable

cost and frequency criteria are met. Some commenters specifically cited arthroscopic rotator cuff repair furnished with a graft augmentation device as an example of a procedure and device combination they believed should be eligible for consideration.

Commenters also recommended establishing a mechanism to provide additional payment when an otherwise qualifying combination involves a primary procedure already assigned to the highest-level or only APC in a clinical family, providing greater stability for qualifying combinations, such as maintaining complexity adjustments for a specified period before reevaluation, extending adjustments to clinically similar combinations or related code families, and increasing transparency regarding the claims accounting, inclusion and exclusion criteria, and other aspects of the complexity adjustment methodology. Commenters urged CMS to consider these and other refinements to improve payment accuracy and ensure that the C-APC methodology appropriately accounts for the resources associated with complex outpatient procedures.

Response: We thank the commenters for their thoughtful and detailed recommendations regarding potential refinements to the C-APC complexity adjustment methodology. We appreciate commenters' continued engagement on these issues, including their perspectives on how the complexity adjustment methodology could better account for complex and resource-intensive combinations of services as clinical practice evolves and additional procedures are furnished in the hospital outpatient setting. We recognize the importance of appropriately accounting for differences in resource use under the C-APC payment methodology while maintaining a methodology that is consistent, transparent, and based on reliable claims data. We appreciate the specific recommendations regarding the complexity adjustment cost threshold, the types and combinations of services considered for complexity adjustments, the treatment of packaged device codes and clusters of services, payment for qualifying combinations at the highest level of a clinical family, payment stability, and other aspects of the methodology. We will take these comments and recommendations into consideration as we continue to evaluate the

C-APC complexity adjustment methodology and consider whether refinements may be appropriate in future rulemaking.

After consideration of public comments, we are finalizing the C-APC complexity adjustment methodology and criteria for CY 2027 as proposed. We are also finalizing the specific C-APC complexity adjustments identified in the proposed rule, with the addition of the code combination of CPT codes 37187 and 37248, which was suggested by commenters and which we determined meets our complexity adjustment criteria.

(2) Exclusion of Procedures Assigned to New Technology APCs from the C-APC Policy

Services that are assigned to New Technology APCs are typically new procedures that do not have sufficient claims history to establish an accurate payment for them. Beginning in CY 2002, we retain services within New Technology APC groups until we gather sufficient claims data to enable us to assign the service to an appropriate clinical APC. This policy allows us to move a service from a New Technology APC in less than 2 years if sufficient data are available. It also allows us to retain a service in a New Technology APC for more than 2 years if sufficient data upon which to base a decision for reassignment have not been collected (82 FR 59277).

The C-APC payment policy packages payment for adjunctive and secondary items, services, and procedures into the most costly primary procedure under the OPPS at the claim level. Prior to CY 2019, when a procedure assigned to a New Technology APC was included on the claim with a primary procedure, identified by OPPS status indicator "J1," payment for the new technology service was typically packaged into the payment for the primary procedure. Because the new technology service was not separately paid in this scenario, the overall number of single claims available to determine an appropriate clinical APC for the new service was reduced. This was contrary to the objective of the New Technology APC payment policy, which is to gather sufficient claims data to enable us to assign the service to an appropriate clinical APC.

To address this issue and ensure that there are sufficient claims data for services assigned to New Technology APCs, in the CY 2019 OPPS/ASC final rule with comment period (83 FR 58847), we finalized excluding payment for any procedure that is assigned to a New Technology APC (APCs 1491 through 1599 and APCs 1901 through 1908) from being packaged when included on a claim with a "J1" service assigned to a C-APC. In the CY 2020 OPPS/ASC final rule with comment period, we finalized that beginning in CY 2020, payment for services assigned to a New Technology APC would be excluded from being packaged into the payment for comprehensive observation services assigned status indicator "J2" when they are included on a claim with a "J2" service (84 FR 61167).

(3) Exclusion of Drugs and Biologicals Described by HCPCS Code C9399 (Unclassified drugs or biologicals) from the C-APC Policy

Section 1833(t)(15) of the Act, as added by section 621(a)(1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108–173), provides for payment under the OPPS for new drugs and biologicals until HCPCS codes are assigned. Under this provision, we are required to make payment for a covered outpatient drug or biological that is furnished as part of covered outpatient department services but for which a HCPCS code has not yet been assigned in an amount equal to 95 percent of average wholesale price (AWP) for the drug or biological.

In the CY 2005 OPPS/ASC final rule with comment period (69 FR 65805), we implemented section 1833(t)(15) of the Act by instructing hospitals to bill for a drug or biological that is newly approved by the Food and Drug Administration (FDA) and that does not yet have a HCPCS code by reporting the National Drug Code (NDC) for the product along with the newly created HCPCS code C9399 (Unclassified drugs or biologicals). We explained that when HCPCS code C9399 appears on a claim, the Outpatient Code Editor (OCE) suspends the claim for manual pricing by the Medicare Administrative Contractor (MAC). The MAC prices the claim at 95 percent of the drug or biological's AWP, using Red Book or an equivalent

recognized compendium, and processes the claim for payment. We emphasized that this approach enables hospitals to bill and receive payment for a new drug or biological concurrent with its approval by the FDA. The hospital does not have to wait for the next quarterly release or for approval of a product-specific HCPCS code to receive payment for a newly approved drug or biological or to resubmit claims for adjustment. We instructed that hospitals would discontinue billing HCPCS code C9399 and the NDC upon implementation of a product-specific HCPCS code, status indicator, and appropriate payment amount with the next quarterly update. We also note that HCPCS code C9399 is paid in a similar manner in the ASC setting, as 42 CFR 416.171(b) outlines that certain drugs and biologicals for which separate payment is allowed under the OPPS are considered covered ancillary services for which the OPPS payment rate, which is 95 percent of AWP for HCPCS code C9399, applies.

Since the implementation of the C-APC policy in 2015, payment for drugs and biologicals described by HCPCS code C9399 had been included in the C-APC payment when these products appear on a claim with a primary C-APC service. Packaging payment for these drugs and biologicals that appear on a hospital outpatient claim with a primary C-APC service is consistent with our C-APC packaging policy under which we make payment for all items and services, including all non-pass-through drugs, reported on the hospital outpatient claim as being integral, ancillary, supportive, dependent, and adjunctive to the primary service and representing components of a complete comprehensive service, with certain limited exceptions (78 FR 74869). It was our position that the total payment for the C-APC with which payment for a drug or biological described by HCPCS code C9399 is packaged includes payment for the drug or biological at 95 percent of its AWP.

However, we determined that in certain instances, drugs and biologicals described by HCPCS code C9399 are not being paid at 95 percent of their AWPs when payment for them is packaged with payment for a primary C-APC service. In order to ensure payment for new drugs and biologicals described by HCPCS code C9399 at 95 percent of their AWP, for CY 2023 and

subsequent years, we finalized our proposal to exclude any drug or biological described by HCPCS code C9399 from packaging when the drug or biological is included on a claim with a "J1" service, which is the status indicator assigned to a C-APC, and a claim with a "J2" service, which is the status indicator assigned to comprehensive observation services. See Addendum J to this final rule with comment period for the final CY 2027 C-APC payment policy exclusions.

In the CY 2023 OPPS/ASC final rule with comment period, we finalized the proposal in section XI., "CY 2023 OPPS Payment Status and Comment Indicators", to add a new definition to status indicator "A" to include unclassified drugs and biologicals that are reportable with HCPCS code C9399 (87 FR 72051). The current definition of status indicator "A", including the finalized changes from the CY 2023 OPPS/ASC final rule with comment period, can be found in Addendum D1 to this final rule with comment period. This change ensures the MAC prices claims for drugs or biologicals billed with HCPCS code C9399 at 95 percent of the drug or biological's AWP and pays separately for the drug or biological under the OPPS when it appears on the same claim as a primary C-APC service.

(4) Exclusion of Cell and Gene Therapies from the C-APC Policy

As previously discussed in this section, and in the CY 2014 OPPS/ASC final rule with comment period (78 FR 74865), the C-APC policy packages payment for items and services that are typically integral, ancillary, supportive, dependent, or adjunctive to the primary service and provided during the delivery of the comprehensive service, including diagnostic procedures, laboratory tests and other diagnostic tests and treatments that assist in the delivery of the primary procedure. In the CY 2014 OPPS/ASC final rule with comment period (78 FR 74861), we finalized defining a comprehensive APC as a classification for the provision of a primary service and all adjunctive services provided to support the delivery of the primary service. Because a comprehensive APC treats all individually reported codes as representing components of the comprehensive service, we make a single prospective payment based on the cost of all

individually reported codes that represent the provision of a primary service and all adjunctive services provided to support that delivery of the primary service.

As discussed in the CY 2025 OPPS/ASC proposed rule (89 FR 59201 through 59204), we generally treat all items and services reported on a C-APC claim as integral, ancillary, supportive, dependent, and adjunctive to the primary service and representing components of a comprehensive service. Historically, items packaged for payment provided in conjunction with the primary C-APC service also include all drugs, biologicals, and radiopharmaceuticals, regardless of cost, except those drugs with pass-through payment status and those drugs that are usually SADs, unless they function as supplies (78 FR 74868 through 74869 and 74909).

However, we recognized in the CY 2025 OPPS/ASC proposed rule (89 FR 59201 through 59204) that there are rare instances in which cell and gene therapies appear on the same claim as a primary C-APC service and therefore, have their payment packaged with payment for the primary C-APC service. As stated in the CY 2025 OPPS/ASC final rule with comment period (89 FR 93932 through 93938), given the unique nature of these therapies, we do not believe they function as integral, ancillary, supportive, dependent, or adjunctive to any of the current primary C-APC services. Additionally, we stated that when these products are administered, they are the primary treatment being administered to a patient and thus, are not integral, ancillary, supportive, dependent, or adjunctive to any primary C-APC services.

Therefore, we finalized a policy for CY 2025 and subsequent years (89 FR 93932 through 93938), to not package payment for cell and gene therapies into C-APCs, when those cell and gene therapies are not functioning as integral, ancillary, supportive, dependent, or adjunctive to the primary C-APC service. For new cell and gene therapy products that are not integral, ancillary, supportive, dependent, or adjunctive to any C-APC primary service, we will continue to add their product-specific HCPCS codes, when created, to the C-APC exclusion list. The proposed list of qualifying products can be found in Table 2.

TABLE 2: CELL AND GENE THERAPIES PROPOSED FOR EXCLUSION FROM C-APC PACKAGING FOR CY 2027

Trade Name	HCPCS Code	Long Descriptor
Yescarta	Q2041	Axicabtagene ciloleucel, up to 200 million autologous anti-cd19 car positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose
Kymriah	Q2042	Tisagenlecleucel, up to 600 million car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose
Provenge	Q2043	Sipuleucel-t, minimum of 50 million autologous cd54+ cells activated with pap-gm-csf, including leukapheresis and all other preparatory procedures, per infusion
Tecartus	Q2053	Brexucabtagene autoleucel, up to 200 million autologous anti-cd19 car positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose
Breyanzi	Q2054	Lisocabtagene maraleucel, up to 110 million autologous anti-cd19 car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose
Abecma	Q2055	Idecabtagene vicleucel, up to 510 million autologous b-cell maturation antigen (bcma) directed car-positive t cells, including leukapheresis and dose preparation procedures, per therapeutic dose
CARVYKTI	Q2056	Ciltacabtagene autoleucel, up to 100 million autologous b-cell maturation antigen (bcma) directed car-positive t cells, including leukapheresis and dose preparation procedures, per therapeutic dose
Skysona	J3387	Injection, elivaldogene autotemcel, per treatment
Lenmeldy	J3391	Injection, atidarsagene autotemcel, per treatment
CASGEVY	J3392	Injection, exagamglogene autotemcel, per treatment
Luxturna	J3398	Injection, voretigene neparvovec-rzyl, 1 billion vector genomes
Zolgensma	J3399	Injection, onasemnogene abeparvovec-xioi, per treatment, up to 5x10^15 vector genomes
Ryoncil	J3402	Injection, remestemcel-l-rknd, per therapeutic dose
Hemgenix	J1411	Injection, etranacogene dezaparvovec-drlb, per therapeutic dose

We list all final C-APC exclusion categories for CY 2027 in Addendum J to this final rule with comment period (which is available via the Internet on the CMS website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices*). Comments on our proposed exclusions are below:

Comment: Commenters generally supported our proposal to continue excluding qualifying cell and gene therapies from C-APC packaging when those therapies are not integral, ancillary, supportive, dependent, or adjunctive to the primary C-APC service. Commenters stated that cell and gene therapies are generally the primary treatment being furnished to the patient and that separate payment appropriately recognizes the unique clinical and resource characteristics of these therapies. Commenters also stated that continuation of the policy would support appropriate payment and beneficiary access, including access to cell and gene therapies furnished in the outpatient setting. Several commenters encouraged CMS to continue adding qualifying cell and gene therapy product-specific HCPCS codes to the C-APC exclusion list as new codes are created.

Response: We thank commenters for their support. We continue to believe that, when cell and gene therapies do not function as integral, ancillary, supportive, dependent, or adjunctive to a primary C-APC service, packaging payment for these therapies under the C-APC policy would not appropriately reflect the role of these products in the outpatient encounter. As discussed in the CY 2025 OPPS/ASC final rule with comment period (89 FR 93932 through 93938), when these products are administered under these circumstances, they are the primary treatment being administered to the patient. Therefore, we are continuing our policy of excluding qualifying cell and gene therapies from C-APC packaging. Consistent with our existing policy, we will continue to review new cell and gene therapy products and add product-specific HCPCS codes to the C-APC exclusion list, as appropriate, when those codes are created.

Comment: One commenter recommended that CMS establish additional mechanisms to facilitate the identification of qualifying cell and gene therapies and provide greater transparency regarding their exclusion from C-APC packaging. Specifically, the commenter recommended adding a checkbox to the MEARIS HCPCS Level II code application to allow applicants to identify products that may qualify for the exclusion, establishing and publishing a formal off-cycle process through which interested parties could request additions to the exclusion list, and

creating a new OPPS status indicator to identify products that are excluded from C-APC packaging but no longer have pass-through payment status. The commenter stated that these changes could help ensure that qualifying products are identified when their pass-through payment status expires and allow interested parties to more readily confirm whether a particular product is excluded from C-APC packaging.

Response: We thank the commenter for these recommendations. As discussed in prior rulemaking, under our existing policy, for new cell and gene therapy products that are not integral, ancillary, supportive, dependent, or adjunctive to any C-APC primary service, we will continue to add their product-specific HCPCS codes, when created, to the C-APC exclusion list. We also review products through our regular quarterly update processes to identify qualifying cell and gene therapies that should be excluded from C-APC packaging. We appreciate the commenter's recommendations regarding additional mechanisms for identifying and communicating the C-APC exclusion status of qualifying products and will take these suggestions into consideration for potential future rulemaking and other appropriate associated processes.

Comment: Several commenters recommended that CMS expand the C-APC exclusion policy beyond cell and gene therapies to include other drugs and biologicals that commenters stated similarly constitute the primary treatment furnished during an outpatient encounter rather than an integral, ancillary, supportive, dependent, or adjunctive service. Commenters specifically discussed certain oncology therapies administered through procedures or novel delivery mechanisms, including bladder cancer diagnostics and therapies, and bispecific T-cell engager therapies that may be furnished with observation services. Commenters stated that, in these circumstances, the associated procedure or observation service facilitates the administration or monitoring of the drug, while the drug or biological itself is the primary therapeutic intervention.

Commenters expressed concern that, following expiration of transitional pass-through payment status or other temporary separate payment, packaging these therapies into a C-APC could result in payment that does not adequately reflect hospitals' acquisition costs, potentially creating financial disincentives to furnish the therapies and affecting beneficiary access. Some commenters also asserted that the costs of relatively low-volume, high-cost therapies may not be adequately reflected in C-APC rates because those rates are based on claims that include substantially higher volumes of lower-cost services. Commenters recommended various approaches, including establishing an exclusion for directly administered oncology therapies furnished via a procedure, excluding bispecific T-cell engager therapies, applying the rationale underlying the cell and gene therapy exclusion to other similarly situated drugs and biologicals, or soliciting public comment on such approaches in future rulemaking.

Response: We thank commenters for their feedback, analyses, and recommendations regarding the application of the C-APC packaging policy to other drugs and biologicals. As we have previously stated, the C-APC policy generally packages payment for items and services that are integral, ancillary, supportive, dependent, or adjunctive to the primary C-APC service, and historically this has included drugs and biologicals furnished in conjunction with a primary C-APC service, except where an applicable packaging exclusion applies. We established the cell and gene therapy exclusion based on our consideration of the unique nature of those therapies and our determination that, under the circumstances described in our policy, they do not function as integral, ancillary, supportive, dependent, or adjunctive to the primary C-APC service.

We acknowledge commenters' assertions that certain other drugs and biologicals may similarly represent the primary therapeutic intervention in an outpatient encounter. However, we do not believe that the fact that a drug or biological may be characterized as the primary therapeutic intervention alone provides sufficient basis to establish a categorical exclusion from the C-APC packaging policy. The recommendations described by commenters encompass different types of therapies, methods of administration, associated services, and clinical

circumstances and would represent a broader expansion of the C-APC packaging exclusions beyond the specific category of cell and gene therapies considered in prior rulemaking. We believe additional consideration and data would be necessary to determine whether, and under what circumstances, an exclusion for other classes of drugs or biologicals that are not supportive of a primary C-APC service but may nonetheless appear on the same claim as the primary C-APC procedure would be appropriate under the C-APC methodology.

We strongly believe in the principles of our prospective payment system and the C– APC policy; therefore, we want to ensure that any potential changes to our C–APC packaging policy maintain these principles.

We appreciate commenters' concerns regarding other therapies that may be furnished in conjunction with a C-APC service and their recommendations regarding potential alternative approaches to payment for such therapies. We are not expanding the C-APC exclusion policy to additional categories of drugs or biologicals for CY 2027. We will take commenters' feedback and recommendations into consideration as we continue to evaluate the C-APC methodology in future rulemaking.

Comment: A commenter asked CMS to add HCPCS codes J1413 (Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose), J3401 (Beremagene geperpavec-svdt for topical administration, containing nominal 5 × 10^9 pfu/mL vector genomes, per 0.1 mL), and J9029 (Intravesical instillation, nadofaragene firadenovec-vncg, per therapeutic dose) to the list of cell and gene therapies excluded from C-APC packaging for CY 2027. The commenter noted that these products currently have drug pass-through payment status that expires December 31, 2026, and stated that they should be excluded from C-APC packaging beginning January 1, 2027, consistent with our existing policy for qualifying cell and gene therapies.

Response: We thank the commenter for recommending the addition of HCPCS codes J1413, J3401, and J9029 to the cell and gene therapy C-APC exclusion list. These HCPCS codes have been added to the table of cell and gene therapies excluded from C-APC packaging for CY

2027. We note that these products currently have drug pass-through payment status through December 31, 2026, and therefore are already excluded from C-APC packaging through the end of CY 2026. Beginning January 1, 2027, following expiration of their drug pass-through payment status, we will exclude HCPCS codes J1413, J3401, and J9029 from C-APC packaging consistent with our policy finalized in the CY 2025 OPPS/ASC final rule with comment period (89 FR 93932 through 93938).

We note that we did not propose to alter the substance of our existing policy excluding qualifying cell and gene therapies from C-APC packaging. After consideration of the public comments received, we are continuing this policy without modification for CY 2027. We are also finalizing the list of qualifying cell and gene therapy products for CY 2027 in Table 3, including the additions discussed in response to comments, consistent with the policy finalized in the CY 2025 OPPS/ASC final rule with comment period (89 FR 93932 through 93938).

TABLE 3: CELL AND GENE THERAPIES FINALIZED FOR EXCLUSION FROM C-APC PACKAGING FOR CY 2027

Trade Name	HCPCS Code	Long Descriptor
Yescarta	Q2041	Axicabtagene ciloleucel, up to 200 million autologous anti-cd19 car positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose
Kymriah	Q2042	Tisagenlecleucel, up to 600 million car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose
Provenge	Q2043	Sipuleucel-t, minimum of 50 million autologous cd54+ cells activated with pap-gm-csf, including leukapheresis and all other preparatory procedures, per infusion
Tecartus	Q2053	Brexucabtagene autoleucel, up to 200 million autologous anti-cd19 car positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose
Breyanzi	Q2054	Lisocabtagene maraleucel, up to 110 million autologous anti-cd19 car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose
Abecma	Q2055	Idecabtagene vicleucel, up to 510 million autologous b-cell maturation antigen (bcma) directed car-positive t cells, including leukapheresis and dose preparation procedures, per therapeutic dose
CARVYKTI	Q2056	Ciltacabtagene autoleucel, up to 100 million autologous b-cell maturation antigen (bcma) directed car-positive t cells, including leukapheresis and dose preparation procedures, per therapeutic dose

Trade Name	HCPCS Code	Long Descriptor
Skysona	J3387	Injection, elivaldogene autotemcel, per treatment
Kresladi	J3388	Injection, marnetegragene autotemcel, per treatment
Lenmeldy	J3391	Injection, atidarsagene autotemcel, per treatment
CASGEVY	J3392	Injection, exagamglogene autotemcel, per treatment
Zynteglo	J3393	Injection, betibeglogene autotemcel, per treatment
Lyfgenia	J3394	Injection, lovotibeglogene autotemcel, per treatment
Luxturna	J3398	Injection, voretigene neparvovec-rzyl, 1 billion vector genomes
Zolgensma	J3399	Injection, onasemnogene abeparvovec-xioi, per treatment, up to 5x10^15 vector genomes
Ryoncil	J3402	Injection, remestemcel-l-rknd, per therapeutic dose
OTARMENI	J3407	Injection, lunsotogene parvec-cwha, per treatment
Hemgenix	J1411	Injection, etranacogene dezaparvovec-drlb, per therapeutic dose
Roctavian	J1412	Injection, valoctocogene roxaparvovec-rvox, per mL, containing nominal 2 × 10^13 vector genomes
Elevidys	J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose
Beqvez	J1414	Injection, fidanacogene elaparvovec-dzkt, per therapeutic dose
Vyjuvek	J3401	Beremagene geperpavec-svdt for topical administration, containing nominal 5 × 10^9 pfu/mL vector genomes, per 0.1 mL
Adstiladrin	J9029	Intravesical instillation, nadofaragene firadenovec-vncg, per therapeutic dose

(5) Exclusion of Non-Opioid Products for Pain Relief under Section 4135 of the Consolidated Appropriations Act, 2023 from the C-APC Policy

The Consolidated Appropriations Act (CAA), 2023 (Pub. L. 117-328), was signed into law on December 29, 2022. Section 4135(a) and (b) of the CAA, 2023, titled "Access to Non-Opioid Treatments for Pain Relief," amended section 1833(t)(16) and section 1833(i) of the Act, respectively, to provide for temporary additional payments for non-opioid treatments for pain relief (as that term is defined in section 1833(t)(16)(G)(iv) of the Act). In particular, section

1833(t)(16)(G) of the Act provides that with respect to a non-opioid treatment for pain relief furnished on or after January 1, 2025, and before January 1, 2028, the Secretary shall not package payment for the non-opioid treatment for pain relief into payment for a covered OPD service (or group of services) and shall make an additional payment for the non-opioid treatment for pain relief as specified in clause (ii) of that section. Clauses (ii) and (iii) of section 1833(t)(16)(G) of the Act provide for the amount of additional payment and set a limitation on that amount. As stated earlier in this section, our current policy is to exclude from the packaged C-APC payment those items and services that are required by statute to be separately paid.

Accordingly, in the CY 2025 OPPS/ASC final rule with comment period, we finalized a policy to exclude the non-opioid treatments for pain relief identified as satisfying the required criteria for payment under section 4135 of the CAA, 2023 from the C-APC policy to ensure payment is not packaged into any C-APC and that separate payment is made in accordance with the statute (89 FR 93938 through 93939).

(6) C-APCs for CY 2027

For CY 2027 and subsequent years, we proposed to continue to apply the C-APC payment policy methodology (91 FR 41749). We refer readers to the CY 2017 OPPS/ASC final rule with comment period (81 FR 79583) for a discussion of the C-APC payment policy methodology- and revisions.

Each year, in accordance with section 1833(t)(9)(A) of the Act, we review and revise the services within each APC group and the APC assignments under the OPPS. As a result of our annual review of the services and the APC assignments under the OPPS, we did not propose to convert any standard APCs to C-APCs in CY 2027; thus, we proposed that the number of C-APCs for CY 2027 (see Table 4) would be the same as the number for CY 2026, which is 74 C-APCs (91 FR 8384).

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: Some commenters expressed concerns with the C-APC methodology for surgical insertion procedures for brachytherapy treatment, stating that these concerns may affect beneficiary access to brachytherapy in the HOPD setting. Commenters stated that the C-APC methodology lacks appropriate charge capture mechanisms to accurately reflect the services associated with the C-APC, that there is significant variation in clinical practice and billing patterns reflected in the hospital claims data used for ratesetting, and that C-APC payment rates do not accurately or fully reflect the services and costs associated with the primary procedure. Commenters urged CMS to explore alternatives to the current methodology, including discontinuing the C-APC payment policy for brachytherapy insertion codes. Alternatively, one commenter recommended that CMS continue to pay for brachytherapy insertion codes assigned status indicator "J1" under the C-APC payment methodology but exclude certain preparation and planning services from C-APC packaging and make separate payment for those services. Another commenter requested that CMS provide education or guidance clarifying whether services assigned status indicator "J1" that are furnished over multiple patient encounters, such as certain brachytherapy services, may be reported separately for each encounter.

Response: We appreciate the commenters' concerns and recommendations regarding the application of the C-APC methodology to surgical insertion procedures for brachytherapy treatment. We continue to believe that application of the C-APC methodology to these surgical insertion procedures is appropriate and appropriately accounts for the costs associated with furnishing these services, particularly because the brachytherapy sources used in these procedures are excluded from C-APC packaging and instead are separately payable. Therefore, we are not adopting the commenters' recommendations to discontinue the C-APC payment policy for brachytherapy insertion procedures or to exclude designated preparation and planning services from C-APC packaging and make separate payment for those services. We will consider whether additional provider education regarding the reporting of services furnished over multiple patient encounters may be appropriate. We will continue to examine these concerns and

consider whether modifications to the C-APC methodology are warranted in future rulemaking.

After consideration of public comments we received, we are finalizing the C-APCs as proposed. Table 4 lists the final C-APCs for CY 2027. All C-APCs are displayed in Addendum J to this CY 2027 OPPS/ASC final rule with comment period (which is available via the internet on the CMS website). Addendum J to this final rule with comment period also contains all the data related to the C-APC payment policy methodology, including the list of complexity adjustments and other information for CY 2027.

TABLE 4: FINAL CY 2027 C-APCs

C-APC	CY 2027 APC Group Title	Clinical Family
5072	Level 2 Excision/Biopsy/Incision and Drainage	EBIDX
5073	Level 3 Excision/Biopsy/Incision and Drainage	EBIDX
5091	Level 1 Breast/Lymphatic Surgery and Related Procedures	BREAS
5092	Level 2 Breast/Lymphatic Surgery and Related Procedures	BREAS
5093	Level 3 Breast/Lymphatic Surgery and Related Procedures	BREAS
5112	Level 2 Musculoskeletal Procedures	ORTHO
5113	Level 3 Musculoskeletal Procedures	ORTHO
5114	Level 4 Musculoskeletal Procedures	ORTHO
5115	Level 5 Musculoskeletal Procedures	ORTHO
5116	Level 6 Musculoskeletal Procedures	ORTHO
5117	Level 7 Musculoskeletal Procedures	ORTHO
5153	Level 3 Airway Endoscopy	AENDO
5154	Level 4 Airway Endoscopy	AENDO
5155	Level 5 Airway Endoscopy	AENDO
5163	Level 3 ENT Procedures	ENTXX
5164	Level 4 ENT Procedures	ENTXX
5165	Level 5 ENT Procedures	ENTXX
5166	Cochlear Implant Procedure	COCHL
5182	Level 2 Vascular Procedures	VASCX
5183	Level 3 Vascular Procedures	VASCX
5184	Level 4 Vascular Procedures	VASCX
5191	Level 1 Endovascular Procedures	EVASC
5192	Level 2 Endovascular Procedures	EVASC
5193	Level 3 Endovascular Procedures	EVASC
5194	Level 4 Endovascular Procedures	EVASC
5200	Implantation Wireless PA Pressure Monitor	WPMXX
5211	Level 1 Electrophysiologic Procedures	EPHYS
5212	Level 2 Electrophysiologic Procedures	EPHYS
5213	Level 3 Electrophysiologic Procedures	EPHYS
5222	Level 2 Pacemaker and Similar Procedures	AICDP
5223	Level 3 Pacemaker and Similar Procedures	AICDP
5224	Level 4 Pacemaker and Similar Procedures	AICDP
5231	Level 1 ICD and Similar Procedures	AICDP
5232	Level 2 ICD and Similar Procedures	AICDP
5244	Level 4 Blood Product Exchange and Related Services	SCTXX
5302	Level 2 Upper GI Procedures	GIXXX
5303	Level 3 Upper GI Procedures	GIXXX

C-APC	CY 2027 APC Group Title	Clinical Family
5313	Level 3 Lower GI Procedures	GIXXX
5331	Complex GI Procedures	GIXXX
5341	Level 1 Abdominal/Peritoneal/Biliary and Related Procedures	GIXXX
5342	Level 2 Abdominal/Peritoneal/Biliary and Related Procedures	GIXXX
5361	Level 1 Laparoscopy and Related Services	LAPXX
5362	Level 2 Laparoscopy and Related Services	LAPXX
5372	Level 2 Urology and Related Services	UROXX
5373	Level 3 Urology and Related Services	UROXX
5374	Level 4 Urology and Related Services	UROXX
5375	Level 5 Urology and Related Services	UROXX
5376	Level 6 Urology and Related Services	UROXX
5377	Level 7 Urology and Related Services	UROXX
5378	Level 8 Urology and Related Services	UROXX
5414	Level 4 Gynecologic Procedures	GYNXX
5415	Level 5 Gynecologic Procedures	GYNXX
5416	Level 6 Gynecologic Procedures	GYNXX
5431	Level 1 Nerve Procedures	NERVE
5432	Level 2 Nerve Procedures	NERVE
5433	Level 3 Nerve Procedures	NERVE
5461	Level 1 Neurostimulator and Related Procedures	NSTIM
5462	Level 2 Neurostimulator and Related Procedures	NSTIM
5463	Level 3 Neurostimulator and Related Procedures	NSTIM
5464	Level 4 Neurostimulator and Related Procedures	NSTIM
5465	Level 5 Neurostimulator and Related Procedures	NSTIM
5471	Implantation of Drug Infusion Device	PUMPS
5491	Level 1 Intraocular Procedures	INEYE
5492	Level 2 Intraocular Procedures	INEYE
5493	Level 3 Intraocular Procedures	INEYE
5494	Level 4 Intraocular Procedures	INEYE
5495	Level 5 Intraocular Procedures	INEYE
5496	Level 6 Intraocular Procedures	INEYE
5503	Level 3 Extraocular, Repair, and Plastic Eye Procedures	EXEYE
5504	Level 4 Extraocular, Repair, and Plastic Eye Procedures	EXEYE
5627	Level 7 Radiation Therapy	RADTX
5881	Ancillary Outpatient Services When Patient Dies	N/A
8011	Comprehensive Observation Services	N/A

C-APC Clinical Family Descriptor Key:
AENDO = Airway Endoscopy
AICDP = Automatic Implantable Cardiac Defibrillators, Pacemakers, and Related Devices.
BREAS = Breast Surgery
COCHL = Cochlear Implant
EBIDX = Excision/ Biopsy/Incision and Drainage
ENTXX = ENT Procedures
EPHYS = Cardiac Electrophysiology/
EVASC = Endovascular Procedures
EXEYE = Extraocular Ophthalmic Surgery
GIXXX = Gastrointestinal Procedures
GYNXX = Gynecologic Procedures
INEYE = Intraocular Surgery
LAPXX = Laparoscopic Procedures
NERVE = Nerve Procedures
NSTIM = Neurostimulators
ORTHO = Orthopedic Surgery
PUMPS = Implantable Drug Delivery Systems
RADTX = Radiation Oncology
SCTXX = Stem Cell Transplant
UROXX = Urologic Procedures
VASCX = Vascular Procedures

WPMXX = Wireless PA Pressure Monitor

c. Calculation of Composite APC Criteria-Based Costs

As discussed in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66613), we believe it is important that the OPPS enhance incentives for hospitals to provide necessary, high-quality care as efficiently as possible. For CY 2008, we developed composite APCs to provide a single payment for groups of services that are typically performed together during a single clinical encounter and that result in the provision of a complete service. Combining payment for multiple, independent services into a single OPPS payment in this way enables hospitals to manage their resources with maximum flexibility by monitoring and adjusting the volume and efficiency of services themselves. An additional advantage to the composite APC model is that we can use data from correctly coded multiple procedure claims to calculate payment rates for the specified combinations of services, rather than relying upon single procedure claims which may be low in volume and/or incorrectly coded. Under the OPPS, we currently have composite policies for mental health services and multiple imaging services. We refer readers to the CY 2008 OPPS/ASC final rule with comment period (72 FR 66611 through 66614 and 66650 through 66652) for a full discussion of the development of the composite APC methodology, and the CY 2012 OPPS/ASC final rule with comment period (76 FR 74163) and the CY 2018 OPPS/ASC final rule with comment period (82 FR 59241, 59242, and 59246 through 52950) for further background.

(1) Mental Health Services Composite APC

For CY 2027, we proposed to continue our longstanding policy of limiting the aggregate payment for specified less resource intensive mental health services furnished on the same date to the payment for a day of partial hospitalization services provided by a hospital, which we consider to be the most resource-intensive of all outpatient mental health services (88 FR 49572). We refer readers to the April 7, 2000, OPPS final rule with comment period (65 FR 18452

through 18455) for the initial discussion of this longstanding policy and the CY 2012 OPPS/ASC final rule with comment period (76 FR 74168) for further background.

In the CY 2018 OPPS/ASC proposed rule and final rule with comment period (82 FR 33580 through 33581 and 82 FR 59246 through 59247), we proposed and finalized the policy for CY 2018 and subsequent years that, when the aggregate payment for specified mental health services provided by one hospital to a single beneficiary on a single date of service, based on the payment rates associated with the APCs for the individual services, exceeds the maximum per diem payment rate for partial hospitalization services provided by a hospital, those specified mental health services will be paid through composite APC 8010 (Mental Health Services Composite). In addition, we set the payment rate for composite APC 8010 for CY 2018 at the same payment rate for APC 5863, which was the maximum partial hospitalization per diem payment rate for a hospital, and finalized a policy that the hospital would continue to be paid the payment rate for composite APC 8010. This policy applied in CYs 2018 through 2023.

In the CY 2024 OPPS/ASC proposed rule, we stated that APC 5863 was no longer the maximum partial hospitalization per diem payment rate for a hospital due to the creation of APC 5864, which is four or more hospital-based partial hospitalization program (PHP) services per day (88 FR 49572). We solicited comment on whether APC 5864 would be appropriate to use as the daily mental health cap, as we have historically set the daily mental health cap for composite APC 8010 at the maximum partial hospitalization per diem payment rate for a hospital (88 FR 49572). Based on public comments received and our longstanding policy, in the CY 2024 OPPS/ASC final rule with comment period, we finalized APC 5864, four hospital-based PHP services per day, as the daily mental health cap (88 FR 81566).

We continue to believe that the costs associated with administering a PHP represent the most resource intensive of all outpatient mental health services. For CY 2027 and subsequent years, we proposed to continue this policy that when the aggregate payment for specified mental health services provided by one hospital to a single beneficiary on a single date of service, based

on the payment rates associated with the APCs for the individual services, exceeds the per diem payment rate for four partial hospitalization services provided in a day by a hospital (the payment amount for APC 5864), those specified mental health services would be paid through composite APC 8010 (91 FR 41752). In addition, we proposed to continue to set the payment rate for composite APC 8010 at the same payment rate that we proposed for APC 5864, which is a partial hospitalization per diem payment rate for four partial hospitalization services furnished in a day by a hospital.

Under the proposed policy, the Integrated OCE (I/OCE) would continue to determine whether to pay for these specified mental health services individually, or to make a single payment at the same payment rate established for APC 5864 for all the specified mental health services furnished by the hospital on that single date of service by paying for the services through composite APC 8010.

Comment: Commenters expressed concerns regarding the Mental Health Services Composite APC policy and requested that CMS evaluate the effects and adequacy of the policy. One commenter stated that because the payment rate for APC 8010 is based on the payment rate for the highest PHP APC, the PHP service-count tier effectively establishes a payment ceiling for other hospital outpatient mental health services. The commenter expressed concern that the policy may discourage hospitals from furnishing multiple clinically appropriate mental health services on the same date of service, including for beneficiaries in rural areas who may travel significant distances for care and for whom consolidation of services may be appropriate. The commenter requested that CMS analyze how frequently the composite payment applies and whether it disproportionately affects beneficiaries receiving consolidated same-day care or those traveling significant distances to receive care.

Another commenter requested that CMS evaluate whether APC 8010 appropriately recognizes and pays for hospital outpatient services furnished to beneficiaries with substance use disorder (SUD). The commenter stated that it is unclear to what extent addiction treatment

services are included in determining whether the Mental Health Services Composite APC payment applies or are reflected in the utilization and cost data underlying the payment rate. The commenter also recommended that CMS evaluate other APCs that may include addiction treatment services.

Response: We thank the commenters for their recommendations regarding the Mental Health Services Composite APC policy. As discussed in prior rulemaking, the Mental Health Services Composite APC policy establishes a payment limit for specified less resource-intensive mental health services furnished to a beneficiary on the same date of service (90 FR 53475). When the aggregate payment for those specified services exceeds the payment rate for the highest-paying PHP APC, payment is made through APC 8010 at the rate for the highest-paying PHP APC. We continue to believe it is appropriate to apply this payment limit because a day of care under a PHP represents a highly intensive level of outpatient mental health care, and we do not believe that payment for the specified individual mental health services furnished on the same date of service should exceed payment for such a day of care.

We appreciate the commenters' recommendations that we further evaluate how the Mental Health Services Composite APC policy operates in practice. As part of our ongoing review of OPPS payment policies, we can examine how frequently payment through APC 8010 occurs and the combinations of services to which it applies. We will consider what the available data show about same-day care for beneficiaries in rural areas and the treatment of services furnished to beneficiaries with SUD under this policy. We will consider whether the findings warrant further discussion or proposals in future rulemaking.

We are finalizing our proposal regarding APC 8010 without modification. When the aggregate payment for specified mental health services provided by one hospital to a single beneficiary on a single date of service, based on the payment rates associated with the APCs for the individual services, exceeds the maximum per diem payment rate for four partial hospitalization services provided in a day by a hospital (the payment amount for APC 5864),

those specified mental health services would be paid through composite APC 8010 for CY 2027. In addition, we are finalizing setting the payment rate for composite APC 8010 for CY 2027 at the same payment rate that we set for APC 5864, which is the maximum partial hospitalization per diem payment rate for a hospital.

(2) Multiple Imaging Composite APCs (APCs 8004, 8005, 8006, 8007, and 8008)

In the CY 2009 OPPS/ASC final rule with comment period (73 FR 68559 through 68569) we finalized a policy that effective January 1, 2009, we would provide a single payment each time a hospital submitted a claim for more than one imaging procedure within an imaging family on the same date of service, to reflect and promote the efficiencies hospitals can achieve when performing multiple imaging procedures during a single session. We utilize three imaging families based on imaging modality for purposes of this methodology: (1) ultrasound; (2) computed tomography (CT) and computed tomographic angiography (CTA); and (3) magnetic resonance imaging (MRI) and magnetic resonance angiography (MRA). The HCPCS codes subject to the multiple imaging composite policy and their respective families are listed in Table 5.

While there are three imaging families, there are five multiple imaging composite APCs due to the statutory requirement under section 1833(t)(2)(G) of the Act that we differentiate payment for OPPS imaging services provided with and without contrast. While the ultrasound procedures included under the policy do not involve contrast, both CT/CTA and MRI/MRA scans can be provided either with or without contrast. The five multiple imaging composite APCs established in CY 2009 are:

- APC 8004 (Ultrasound Composite);
- APC 8005 (CT and CTA without Contrast Composite);
- APC 8006 (CT and CTA with Contrast Composite);
- APC 8007 (MRI and MRA without Contrast Composite); and
- APC 8008 (MRI and MRA with Contrast Composite).

We define the single imaging session for the "with contrast" composite APCs as having at least one or more imaging procedures from the same family performed with contrast on the same date of service. For example, if the hospital performs an MRI without contrast during the same session as at least one other MRI with contrast, the hospital will receive payment based on the payment rate for APC 8008, the "with contrast" composite APC.

We make a single payment for those imaging procedures that qualify for payment based on the composite APC payment rate, which includes any packaged services furnished on the same date of service. The standard (noncomposite) APC assignments continue to apply for single imaging procedures and multiple imaging procedures performed across families. For a full discussion of the development of the multiple imaging composite APC methodology, we refer readers to the CY 2009 OPPS/ASC final rule with comment period (73 FR 68559 through 68569).

For CY 2027, we proposed to continue to pay for all multiple imaging procedures within an imaging family performed on the same date of service using the multiple imaging composite APC payment methodology (91 FR 41753). We continue to believe that this policy would reflect and promote the efficiencies hospitals can achieve when performing multiple imaging procedures during a single session.

For CY 2027, except where otherwise indicated, we proposed to use the costs derived from CY 2025 claims data to set the proposed CY 2027 payment rates. Therefore, for CY 2027, the proposed payment rates for the five multiple imaging composite APCs (APCs 8004, 8005, 8006, 8007, and 8008) were based on proposed geometric mean costs calculated from CY 2025 claims available for the CY 2027 OPPS/ASC proposed rule that qualify for composite payment under the current policy (that is, those claims reporting more than one procedure within the same family on a single date of service) (91 FR 41753). To calculate the proposed geometric mean costs, we used the same methodology that we used to calculate the geometric mean costs for these composite APCs since CY 2014, as described in the CY 2014 OPPS/ASC final rule with

comment period (78 FR 74918). The imaging HCPCS codes referred to as "overlap bypass codes" that we removed from the bypass list for purposes of calculating the proposed multiple imaging composite APC geometric mean costs, in accordance with our established methodology as stated in the CY 2014 OPPS/ASC final rule with comment period (78 FR 74918), are identified by asterisks in Addendum N to this final rule with comment period (which is available via the Internet on the CMS website *https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices*) and are discussed in more detail in section II.A.1.a. of this final rule with comment period.

We did not receive public comments on this policy. We are finalizing without modification our proposal to continue the use of multiple imaging composite APCs to pay for the provision of more than one imaging procedure from the same imaging family on the same date. Table 5 lists the final HCPCS codes that would be subject to the multiple imaging composite APC policy and their respective families and approximate composite APC final geometric mean costs for CY 2027.

TABLE 5: OPPS IMAGING FAMILIES AND MULTIPLE IMAGING PROCEDURE COMPOSITE APCS

Family 1 – Ultrasound	
CY 2027 APC 8004 (Ultrasound Composite)	**CY 2027 Approximate APC Geometric Mean Cost = $299.79**
76700	Us exam, abdom, complete
76705	Echo exam of abdomen
76770	Us exam abdo back wall, comp
76776	Us exam k transpl w/Doppler
76831	Echo exam, uterus
76856	Us exam, pelvic, complete
76857	Us exam, pelvic, limited
76981	Us parenchyma
76982	Us 1st target lesion
Family 2 - CT and CTA with and without Contrast	
CY 2027 APC 8005 (CT and CTA without Contrast Composite) *	**CY 2027 Approximate APC Geometric Mean Cost = $230.01**
0633T	Ct breast w/3d uni c-
0636T	Ct breast w/3d bi c-
70450	Ct head/brain w/o dye

70480	Ct orbit/ear/fossa w/o dye
70486	Ct maxillofacial w/o dye
70490	Ct soft tissue neck w/o dye
71250	Ct thorax w/o dye
72125	Ct neck spine w/o dye
72128	Ct chest spine w/o dye
72131	Ct lumbar spine w/o dye
72192	Ct pelvis w/o dye
73200	Ct upper extremity w/o dye
73700	Ct lower extremity w/o dye
74150	Ct abdomen w/o dye
74176	Ct angio abd & pelvis
74261	Ct colonography, w/o dye
CY 2027 APC 8006 (CT and CTA with Contrast Composite)	**CY 2027 Approximate APC Geometric Mean Cost = $451.13**
0634T	Ct breast w/3d uni c+
0635T	Ct breast w/3d uni c-/c+
0637T	Ct breast w/3d bi c+
0638T	Ct breast w/3d bi c-/c+
70460	Ct head/brain w/dye
70470	Ct head/brain w/o & w/dye
70481	Ct orbit/ear/fossa w/dye
70482	Ct orbit/ear/fossa w/o & w/dye
70487	Ct maxillofacial w/dye
70488	Ct maxillofacial w/o & w/dye
70491	Ct soft tissue neck w/dye
70492	Ct sft tsue nck w/o & w/dye
70496	Ct angiography, head
70498	Ct angiography, neck
71260	Ct thorax w/dye
70471	Cta h&n c+ w/noncontrast img
70473	Ct cere prfu aly c+wo ct/cta
71270	Ct thorax w/o & w/dye
71275	Ct angiography, chest
72126	Ct neck spine w/dye
72127	Ct neck spine w/o & w/dye
72129	Ct chest spine w/dye
72130	Ct chest spine w/o & w/dye
72132	Ct lumbar spine w/dye
72133	Ct lumbar spine w/o & w/dye
72191	Ct angiograph pelv w/o & w/dye
72193	Ct pelvis w/dye
72194	Ct pelvis w/o & w/dye
73201	Ct upper extremity w/dye

73202	Ct uppr extremity w/o & w/dye
73206	Ct angio upr extrm w/o & w/dye
73701	Ct lower extremity w/dye
73702	Ct lwr extremity w/o & w/dye
73706	Ct angio lwr extr w/o & w/dye
74160	Ct abdomen w/dye
74170	Ct abdomen w/o & w/dye
74175	Ct angio abdom w/o & w/dye
74177	Ct angio abd & pelv w/contrast
74178	Ct angio abd & pelv 1+ regns
74262	Ct colonography, w/dye
75635	Ct angio abdominal arteries
* If a "without contrast" CT or CTA procedure is performed during the same session as a "with contrast" CT or CTA procedure, the I/OCE assigns the procedure to APC 8006 rather than APC 8005.	
Family 3 - MRI and MRA with and without Contrast	
CY 2027 APC 8007 (MRI and MRA without Contrast Composite) *	**CY 2027 Approximate APC Geometric Mean Cost = $546.85**
0609T	Mrs disc pain acquisj data
70336	Magnetic image, jaw joint
70540	Mri orbit/face/neck w/o dye
70544	Mr angiography head w/o dye
70547	Mr angiography neck w/o dye
70551	Mri brain w/o dye
70554	Fmri brain by tech
71550	Mri chest w/o dye
72141	Mri neck spine w/o dye
72146	Mri chest spine w/o dye
72148	Mri lumbar spine w/o dye
72195	Mri pelvis w/o dye
73218	Mri upper extremity w/o dye
73221	Mri joint upr extrem w/o dye
73718	Mri lower extremity w/o dye
73721	Mri jnt of lwr extre w/o dye
74181	Mri abdomen w/o dye
75557	Cardiac mri for morph
75559	Cardiac mri w/stress img
76391	Mr elastography
77046	Mri breast c- unilateral
77047	Mri breast c- bilateral
C8901	MRA w/o cont, abd
C8910	MRA w/o cont, chest
C8913	MRA w/o cont, lwr ext
C8919	MRA w/o cont, pelvis
C8932	MRA, w/o dye, spinal canal
C8935	MRA, w/o dye, upper extr

C9762	Cardiac MRI seg dys strain
C9763	Cardiac MRI seg dys stress
CY 2027 APC 8008 (MRI and MRA with Contrast Composite)	**CY 2027 Approximate APC Geometric Mean Cost = $885.44**
70542	Mri orbit/face/neck w/dye
70543	Mri orbt/fac/nck w/o & w/dye
70545	Mr angiography head w/dye
70546	Mr angiograph head w/o & w/dye
70547	Mr angiography neck w/o dye
70548	Mr angiography neck w/dye
70549	Mr angiograph neck w/o & w/dye
70552	Mri brain w/dye
70553	Mri brain w/o & w/dye
71551	Mri chest w/dye
71552	Mri chest w/o & w/dye
72142	Mri neck spine w/dye
72147	Mri chest spine w/dye
72149	Mri lumbar spine w/dye
72156	Mri neck spine w/o & w/dye
72157	Mri chest spine w/o & w/dye
72158	Mri lumbar spine w/o & w/dye
72196	Mri pelvis w/dye
72197	Mri pelvis w/o & w/dye
73219	Mri upper extremity w/dye
73220	Mri uppr extremity w/o & w/dye
73222	Mri joint upr extrem w/dye
73223	Mri joint upr extr w/o & w/dye
73719	Mri lower extremity w/dye
73720	Mri lwr extremity w/o & w/dye
73722	Mri joint of lwr extr w/dye
73723	Mri joint lwr extr w/o & w/dye
74182	Mri abdomen w/dye
74183	Mri abdomen w/o & w/dye
75561	Cardiac mri for morph w/dye
75563	Card mri w/stress img & dye
C8900	MRA w/cont, abd
C8902	MRA w/o fol w/cont, abd
C8903	MRI w/cont, breast, uni
C8905	MRI w/o fol w/cont, brst, un
C8906	MRI w/cont, breast, bi
C8908	MRI w/o fol w/cont, breast,
C8909	MRA w/cont, chest
C8911	MRA w/o fol w/cont, chest
C8912	MRA w/cont, lwr ext

C8914	MRA w/o fol w/cont, lwr ext
C8918	MRA w/cont, pelvis
C8920	MRA w/o fol w/cont, pelvis
C8931	MRA, w/dye, spinal canal
C8933	MRA, w/o&w/dye, spinal canal
C8934	MRA, w/dye, upper extremity
C8936	MRA, w/o&w/dye, upper extr

* If a “without contrast” MRI or MRA procedure is performed during the same session as a “with contrast” MRI or MRA procedure, the I/OCE assigns the procedure to APC 8008 rather than APC 8007.

3. Changes to Packaged Items and Services

a. Background and Rationale for Packaging in the OPPS

Like other prospective payment systems, the OPPS relies on the concept of averaging to establish a payment rate for services. The payment may be more or less than the estimated cost of providing a specific service or a bundle of specific services for a particular beneficiary. The OPPS packages payments for multiple interrelated items and services into a single payment to create incentives for hospitals to furnish services most efficiently and to manage their resources with maximum flexibility. Our packaging policies support our strategic goal of using larger payment bundles in the OPPS to maximize hospitals' incentives to provide care in the most efficient manner. For example, where there are a variety of devices, drugs, items, and supplies that could be used to furnish a service, some of which are more costly than others, packaging encourages hospitals to use the most cost-efficient item that meets the patient's needs, rather than to routinely use a more expensive item, which may occur if separate payment is provided for the item.

Packaging also encourages hospitals to effectively negotiate with manufacturers and suppliers to reduce the purchase price of items and services or to explore alternative group purchasing arrangements, thereby encouraging the most economical health care delivery. Similarly, packaging encourages hospitals to establish protocols that ensure that necessary services are furnished, while scrutinizing the services ordered by practitioners to maximize the efficient use of hospital resources. Packaging our payments into larger bundles promotes predictability and accuracy. Finally, packaging may reduce the importance of refining service-specific payments because packaged payments include costs associated with higher cost cases requiring many ancillary items and services and lower cost cases requiring fewer ancillary items and services. Packaging encourages efficiency and is an essential component of a prospective payment system; therefore, packaging payments for items and services that are typically integral, ancillary, supportive, dependent, or adjunctive to a primary service has been a fundamental part

of the OPPS since its implementation in August 2000. As we continue to develop larger payment groups that more broadly reflect services provided in an encounter or episode of care, we have expanded the OPPS packaging policies. Most, but not necessarily all, categories of items and services currently packaged in the OPPS are listed in 42 CFR 419.2(b). Our overarching goal is to make payments under the OPPS more consistent with a prospective payment system and less like a per-service fee schedule, which pays separately for each coded item. As a part of this effort, we have continued to examine the payment for items and services provided under the OPPS to determine which OPPS services can be packaged to further achieve the objective of advancing the OPPS toward a more prospective payment system.

b. Final CY 2027 Policy on Packaged Items and Services

For CY 2027, we examined the items and services currently provided under the OPPS, reviewing categories of integral, ancillary, supportive, dependent, or adjunctive items and services for which we believe payment would be appropriately packaged into payment for the primary service that they support. Specifically, we examined the HCPCS code definitions (including CPT code descriptors) and hospital outpatient department billing patterns to determine whether there were categories of codes for which packaging would be appropriate according to existing OPPS packaging policies or a logical expansion of those existing OPPS packaging policies.

For CY 2027, we did not propose any changes to the current overall packaging policy discussed previously in section II.A.3.a. of this final rule with comment period. We proposed to continue to conditionally package the costs of selected newly identified ancillary services into payment for a primary service where we believe that the packaged item or service is integral, ancillary, supportive, dependent, or adjunctive to the provision of care that was reported by the primary service HCPCS code (91 FR 41758).

We received public comments on our proposal to continue conditionally packaging selected newly identified ancillary services. The following is a summary of the comments we received and our responses.

Comment: Several commenters requested that CMS unpackage payments in certain scenarios. For example, several commenters stated that unpackaging payment could support patient access and innovations, including increased access to certain drugs, biologicals, and services. A commenter, a manufacturer of a contrast agent, suggested that CMS consider unpackaging their product, a contrast agent, and believed CMS should unpackage high cost and low volume cancer drugs. This commenter believed CMS's historic reasoning for unpackaging and paying separately for diagnostic radiopharmaceuticals applies equally or even more to their product, since the cost of their product is significantly greater than the amount reported for the policy packaged drugs offset associated with the assigned APC for the procedure used to administer the contrast agent. The commenter believed lack of separate payment was a barrier to beneficiary access and recommended CMS pay for products like theirs when the product costs exceeded a certain threshold. The commenter cited recent proposed FDA changes to increase patient access to this diagnostic agent and associated diagnostic test, as well as the recent introduction of the Facilitating Access to Innovation in Cancer Care (FAIC) Act, as support for their recommendation.

Response: We thank the commenters for their perspectives on packaging within the OPPS, including specific examples showing that a product's cost, such as a drug, may exceed the offset amount associated with the procedure in which the product is utilized. We note that our decision to unpackage certain diagnostic radiopharmaceuticals was based on evidence that packaged payment was creating an access barrier for a narrow set of high-cost, low-utilization products. We continue to believe that packaging is a fundamental component of a prospective payment system, which distinguishes it from a fee schedule. In general, packaging the costs of supportive items and services into the payment for the primary procedure or service with which

they are associated encourages hospital efficiencies and enables hospitals to manage their resources with maximum flexibility. We, therefore, do not find it appropriate to revise our longstanding "policy" packaged drug policies or our comprehensive-APC payment policies to facilitate separate payment for these products. We appreciate the input from commenters, and we will continue to monitor our packaging policies.

Additionally, we received specific recommendations regarding C–APC packaging, including the C-APC packaging of certain cancer treatments and of Cell and Gene Therapies and associated products. We address these recommendations in section II.A.2.b.(4) of this final rule with comment period. The packaging of non-opioid treatments for pain relief is addressed in section XIII.F. of this final rule with comment period.

Commenters also made recommendations on our packaging policies in the context of our diagnostic radiopharmaceutical proposal, which is discussed in the next section.

After consideration of public comments, we are finalizing our proposal to continue to conditionally package the costs of selected newly identified ancillary services into payment for a primary service where we believe that the packaged item or service is integral, ancillary, supportive, dependent, or adjunctive to the provision of care that was reported by the primary service HCPCS code.

c. Final Payment for Diagnostic Radiopharmaceuticals

(1) Background on OPPS Packaging Policy for Diagnostic Radiopharmaceuticals

Under the OPPS, we package several categories of non-passthrough drugs, biologicals, and radiopharmaceuticals, regardless of the cost of the products. Because the products are packaged according to the policies in § 419.2(b), we refer to them as "policy-packaged" drugs, biologicals, and radiopharmaceuticals. In particular, under § 419.2(b)(15), payment for drugs, biologicals, and, prior to CY 2025, all radiopharmaceuticals that function as supplies when used in a diagnostic test or procedure are packaged with the payment for the related procedure or service.

In the CY 2008 OPPS/ASC final rule with comment period, we finalized the packaging status of diagnostic radiopharmaceuticals as part of our overall enhanced packaging approach for the CY 2008 OPPS and subsequent years (72 FR 66635 through 66641). Importantly, we noted that we believe diagnostic radiopharmaceuticals are always intended to be used with a diagnostic nuclear medicine procedure and function as supplies when used in a diagnostic test or procedure, making it appropriate to package the payment for the diagnostic radiopharmaceutical into the payment for the related nuclear medicine procedure. Accordingly, prior to CY 2025, diagnostic radiopharmaceuticals were policy packaged under § 419.2(b)(15), regardless of cost, including higher-cost products.

In the CY 2025 OPPS/ASC proposed rule (89 FR 59213 through 59222) and CY 2025 OPPS/ASC final rule with comment period (89 FR 93950), we stated that we continue to believe diagnostic radiopharmaceuticals are always intended to be used with a diagnostic nuclear medicine procedure and function as supplies when used in a diagnostic test or procedure, generally making it appropriate to package payment for them with payment for the related nuclear medicine procedure. However, we stated there are certain situations in which the packaged payment amount attributed to the diagnostic radiopharmaceutical used in an imaging procedure assigned to a nuclear medicine APC may not adequately account for the cost of a diagnostic radiopharmaceutical that has a significantly higher cost, but lower utilization relative to the other diagnostic radiopharmaceuticals that may be used with the procedure.

Additionally, in the CY 2025 OPPS/ASC final rule with comment period (89 FR 93948 through 93963) we finalized a policy to pay separately for any diagnostic radiopharmaceutical with a per day cost greater than $630 for CY 2025. To calculate those per-day costs, we also finalized, for CY 2026 and subsequent years, a policy of applying a methodology similar to that used to determine the per day costs of drugs and biologicals (89 FR 93953 through 93955). We noted that any diagnostic radiopharmaceutical with a per day cost at or below that threshold will continue to be policy packaged under our longstanding policy at § 419.2(b)(15) (89 FR 93962

through 93963). Additionally, we finalized the policy that starting in CY 2026 and for subsequent years, we will update the threshold amount of $630 by a forecast of the Producer Price Index (PPI) for Pharmaceuticals for Human Use, Prescription (Bureau of Labor Statistics (BLS) series code WPUSI07003) from IHS Global, Inc (IGI) (89 FR 93955).

In the CY 2025 OPPS/ASC final rule with comment period, we also finalized that, for non-passthrough, separately payable diagnostic radiopharmaceuticals with per day costs above the designated threshold, payment would be determined based on our authority under section 1833(t)(14)(A)(iii)(II) of the Act. Because we found that the ASP data we had was not usable for the purpose of paying for diagnostic radiopharmaceuticals, we finalized a policy to use mean unit cost data derived from hospital claims to determine the payment amount for qualifying non-passthrough diagnostic radiopharmaceuticals. Additionally, we finalized corresponding modifications to the regulation text at § 419.2(b)(15) and § 419.41 to codify our finalized payment policy for diagnostic radiopharmaceuticals and our existing policy for therapeutic radiopharmaceuticals. In the CY 2026 OPPS/ASC final rule with comment period, we finalized a technical refinement to the diagnostic radiopharmaceutical packaging threshold methodology and finalized the CY 2026 diagnostic radiopharmaceutical packaging threshold of $655. For additional information regarding the policy finalized, please reference the CY 2025 OPPS/ASC final rule with comment period (89 FR 93948 through 93963) and the CY 2026 OPPS/ASC final rule with comment period (90 FR 53482 through 53488).

(2) Final Diagnostic Radiopharmaceutical Packaging Threshold

For CY 2027, we proposed to continue the policy finalized in CY 2025 OPPS/ASC final rule with comment period (89 FR 93948 through 93963). Specifically, we proposed to continue to calculate the per day cost of diagnostic radiopharmaceuticals based on the methodology described in section V.B.1.b. of this final rule with comment period, which relies on the methodology finalized in the CY 2006 OPPS final rule with comment period (70 FR 68636 through 68638).

As finalized in the CY 2025 OPPS/ASC final rule with comment period (89 FR 93955), starting in the OPPS/ASC rulemaking for CY 2026 and for subsequent years, we stated we would update the proposed threshold amount of $630 by a forecast of the PPI for Pharmaceuticals for Human Use, Prescription (BLS series code WPUSI07003) from IHS Global, Inc (IGI) by using most recently available four-quarter moving average PPI levels to trend from the third quarter of the year 2 years prior to the applicable calendar year to the third quarter of the year prior to the applicable calendar year (for example, from the third quarter of 2024 to the third quarter of 2025 for CY 2026). In the CY 2026 OPPS/ASC final rule with comment period, we finalized a technical refinement to this policy to use the most recently available four-quarter moving average PPI levels to trend the CY 2025 final threshold forward from the third quarter of the CY 2025 to the third quarter of the payment year (CY 2026) and round the resulting dollar amount to the nearest $5 increment (90 FR 53482 through 53483). We believed using the most recently available four-quarter moving average PPI levels more appropriately updated the packaging threshold from CY 2025 for payment in CY 2026. For CY 2026 and subsequent updates, we finalized to trend the CY 2025 threshold of $630 forward using the four-quarter moving average PPI levels for Pharmaceuticals for Human Use, Prescription for CY 2025 (third quarter) forward using the PPI for Pharmaceuticals for Human Use, Prescription for the applicable payment year (third quarter) (90 FR 53482 through 53488). This is the same as the update factor used for the OPPS drug packaging threshold, where we originally used the four-quarter moving average PPI levels for Pharmaceutical Preparations, Prescription (BLS series code WPUSI07003, formerly BLS series code 32541DRX) to trend the $50 threshold forward from the third quarter of CY 2005 (when the Pub. L. 108–173 mandated threshold became effective) to the third quarter of the applicable payment year (71 FR 68085 and 68086).

Therefore, for CY 2027, we proposed to update the CY 2025 $630 threshold amount by the four-quarter moving average PPI levels for Pharmaceuticals for Human Use, Prescription to trend the $630 threshold forward (91 FR 41759). Specifically, we proposed using the most

recently available forecast of the four-quarter moving average PPI levels for Pharmaceutical for Human Use, Prescription from the third quarter of 2025 to the third quarter of 2027, and to round the resulting dollar amount to the nearest $5 increment. Based on this methodology, we trended the $630 threshold forward and rounded the resulting dollar amount ($667.44) to the nearest $5 increment, which yielded a proposed figure of $665 per day for CY 2027. Consistent with our methodology and practices listed in section V.B.1.b. of this final rule with comment, we also proposed that if more recent data subsequently became available (for example, a more recent estimate of the PPI for Pharmaceuticals for Human Use, Prescription), we would use such data, if appropriate, to determine the CY 2027 diagnostic radiopharmaceutical packaging threshold in the final rule.

We received public comments on these proposals. The following is a summary of the comments received and our responses.

Comment: Most comments were supportive of continued separate payment for diagnostic radiopharmaceuticals above a certain per day cost threshold. Most commenters were supportive of the proposed update methodology and the corresponding updated per day cost threshold of $665. Some commenters also recommended CMS continue to monitor the effects of this policy.

Response: We thank the commenters for their support of our proposal. We will continue to consider updates to this policy as necessary.

After consideration of public comments, we are finalizing our policy as proposed. We are finalizing our proposal to update the CY 2025 $630 threshold amount by the four-quarter moving average PPI levels for Pharmaceuticals for Human Use, Prescription to trend the threshold forward. Specifically, we are using the most recently available forecast of the four-quarter moving average PPI levels for Pharmaceutical for Human Use, from the third quarter of 2025 to the third quarter of 2027, and to round the resulting dollar amount to the nearest $5 increment. We also proposed, and are now finalizing, a policy that if more recent data were to subsequently become available (for example, a more recent estimate of the PPI for

Pharmaceuticals for Human Use, Prescription), we would use such data, if appropriate, to determine the CY 2027 diagnostic radiopharmaceutical packaging threshold in the final rule. Based on this methodology, using the most recent data available for this final rule with comment period, we trended the $630 threshold forward and rounded the resulting dollar amount ($634.80) to the nearest $5 increment, which yields a final diagnostic radiopharmaceutical packaging threshold figure of $635 per day for CY 2027.

(3) Amount of Separate Payment for Diagnostic Radiopharmaceuticals Exceeding the Threshold

As discussed in the CY 2025 OPPS/ASC final rule with comment period (89 FR 93955 through 93959), once we determine that the per day cost of a non-passthrough diagnostic radiopharmaceutical exceeds the cost threshold, proposed to be $665 per day for CY 2027, we will then assign that radiopharmaceutical to an APC, making it a specified covered outpatient drug (SCOD) per section 1833(t)(14)(B) of the Act. We proposed to continue our current policy for CY 2027 and proposed to pay for those non-passthrough, separately payable diagnostic radiopharmaceuticals based on our authority under section 1833(t)(14)(A)(iii)(II) of the Act. While, under this authority, we would ordinarily use the ASP methodology under section 1847A of the Act, we continue to find that the ASP data we had was not usable for payment purposes. We continue to believe that arithmetic mean unit cost (MUC) would be an appropriate proxy for the average price for a diagnostic radiopharmaceutical for a given year, as it is calculated based on the average costs for a particular year and is directly reflective of the actual cost data that hospitals submit to CMS. Therefore, we proposed to continue our current policy and propose for CY 2027 to pay for qualifying diagnostic radiopharmaceuticals with per day costs above the diagnostic radiopharmaceutical packaging threshold based on their arithmetic MUC, which would be derived from calendar year 2025 claims data.

Although we proposed to base payment for qualifying radiopharmaceuticals on their arithmetic MUC for CY 2027, we continue to encourage manufacturers to submit ASP information for diagnostic radiopharmaceuticals, if possible. While we proposed to continue to

use MUC to pay for separately payable diagnostic radiopharmaceuticals in CY 2027, we note that manufacturers can begin, or continue, to report ASP data for potential future use in paying for diagnostic radiopharmaceuticals. For CY 2027, ASP reporting is voluntary for diagnostic radiopharmaceuticals paid under the OPPS. We encouraged interested parties to submit comments regarding potential issues that may arise that prevent appropriate ASP reporting for diagnostic radiopharmaceuticals. We referred readers to the CY 2025 OPPS/ASC final rule with comment period as it discusses some of the known concerns regarding ASP reporting for diagnostic radiopharmaceuticals (89 FR 93948 through 93963) as well as the CY 2026 OPPS/ASC final rule with comment period (90 FR 53482 through 53488). We reiterated our stance from the CY 2025 OPPS/ASC final rule with comment period, that if we were to use average sales price as the basis of calculating a payment, we believe there must be more consistent, validated, and universal reporting in order for ASP to be a viable payment methodology (89 FR 93961).

As we stated in the CY 2025 and CY 2026 OPPS/ASC final rules with comment period (89 FR 93957 and 90 FR 53484), there could be potential value in the use of ASP data for payment purposes for diagnostic radiopharmaceuticals when reported correctly and by all manufacturers who manufacture a product that is described by a given HCPCS code. We continue to believe that the use of ASP information for OPPS payment could provide an opportunity to improve payment accuracy for separately payable diagnostic radiopharmaceuticals by applying an established methodology that has already been successfully implemented under the OPPS for other separately payable drugs and biologicals, as well as for therapeutic radiopharmaceuticals. Previously, to facilitate potential future payment for diagnostic radiopharmaceuticals based on ASP, we sought comment from interested parties on how CMS could ensure more consistent, validated, and universal reporting in order for ASP to be a viable payment methodology utilized in future rulemaking. For example, we sought comment on how CMS could update its past guidance, *Submission of OPPS ASP Data for Non-*

passthrough Separately Payable Therapeutic Radiopharmaceuticals and Radiopharmaceuticals with Pass-Through Status[6], to reflect current clinical practices and to reflect ASP reporting for diagnostic radiopharmaceuticals.

Additionally, as discussed in section V.B.5. of the proposed rule (Proposed Payment for Non-passthrough Drugs, Biologicals, and Radiopharmaceuticals with HCPCS Codes but Without OPPS Hospital Claims Data), we proposed to continue our policy for determining the payment rate for new diagnostic radiopharmaceuticals that exceed the diagnostic radiopharmaceutical packaging threshold and have HCPCS codes, but which do not have pass-through status and are without claims data. Under this policy, we proposed to pay these products at ASP plus 6 percent (91 FR 41868). If ASP data for these diagnostic radiopharmaceuticals are not available, we proposed to pay WAC plus 3 percent during the product's initial sales period, consistent with our policy described in section V.B.2. of the proposed rule (91 FR 41865). If the WAC also is unavailable, we proposed to make payment for new diagnostic radiopharmaceuticals at 95 percent of the products' most recent AWP (91 FR 41867). Following the initial sales period, a payment rate of WAC plus 6 percent would apply if ASP data for these diagnostic radiopharmaceuticals remained unavailable. We continue to believe the volume of products in this category would typically be very low; however, in these rare situations, we continue to believe it would continue to be appropriate to use ASP plus 6 percent, WAC plus 3 or 6 percent, or 95 percent of AWP until a MUC is available. As we stated in the CY 2025 OPPS/ASC final rule with comment period (89 FR 93955 through 93962), it is appropriate to use this payment hierarchy until a MUC is available. There is typically only one manufacturer for a diagnostic radiopharmaceutical that is new and described by a HCPCS code, but without claims data, so CMS does not have to ensure all manufacturers are reporting ASP for that particular HCPCS code prior to establishing a separate payment amount based on ASP.

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[6] *https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitaloutpatientpps/downloads/opps_asp_radiopharm_guidance10302009.pdf.*

Additionally, although reporting of ASP is not a condition of CMS approving a HCPCS application, CMS has the opportunity to actively engage with the manufacturer, or sponsor of a HCPCS application, during the HCPCS application process. This allows for ongoing dialogue and education regarding the unique ASP reporting requirements that may be associated with a particular product, including how to ensure the reported ASP aligns with the dose descriptor for the newly assigned HCPCS code (89 FR 93958). We continue to believe the hierarchy previously specified is appropriate to determine the payment for a diagnostic radiopharmaceutical that is new and described by a HCPCS code, but without claims data, as it is consistent with the typical hierarchy associated with payment for drugs and biologicals paid under the OPPS as discussed in sections V.A. and V.B. of this final rule with comment period.

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: Commenters were generally in favor of separate payment for diagnostic radiopharmaceuticals. Commenters supported the separate payment, rather than packaged payment, to ensure patient access to these products. Many commenters were appreciative of the transitionary MUC based payment approach, but recommended CMS promptly move to an ASP based payment either for CY 2027 or CY 2028.

Commenters discussed a variety of reasons why MUC is less preferred over ASP based payments. For example, commenters explained that MUC is dependent on individual hospital reporting and that reporting practices may vary from hospital to hospital. Additionally, commenters explained that cost to charge ratios, charge compression, and varied revenue code use, among other concerns, may inappropriately lower a diagnostic radiopharmaceutical's MUC, thus leading to inadequate payment in their view. Many commenters explained how volatile MUC is relative to ASP, and many of these same commenters discussed that ASP data is much more current than MUC data.

A few commenters presented research comparing MUC to ASP amounts for certain products based on the commenters' calculations. According to the commenters' analyses, several of these products had MUCs below the ASP, and a smaller number of these products had MUCs above ASP. Commenters believed that the volatility of MUC made it an inferior payment methodology compared to ASP. These commenters recommended CMS transition to the more accurate ASP based payment methodology for these products. Further, commenters explained additional benefits of ASP over MUC in their view.

Several commenters stated that they already report ASP, they might have received ASP based payments while on OPPS pass-through status, and that they recommended that CMS continue to pay those products based on ASP. These commenters also contended that MUC put their products at a competitive disadvantage once off of pass-through status, compared to products paid under OPPS pass-through status. These commenters stated that ASP is the correct methodology for diagnostic radiopharmaceuticals, and that MUC should not be used as a proxy for ASP. In addition, other commenters contended that MUC is not a methodology that the statute contemplated for payment of these products and that the best reading of the law requires CMS to use ASP for these products. Commenters also suggested that CMS can use its authority to require ASP to be reported for diagnostic radiopharmaceuticals, while other commenters believed ASP was already required to be reported.

A few commenters also recommended compendia-based payment methodologies, such as WAC, as an alternative payment methodology to MUC if CMS found that ASP was unavailable.

Response: We thank commenters for their support of our proposal to continue to pay diagnostic radiopharmaceuticals separately. We appreciate those comments that explained the value of ASP-based payment rates rather than MUC-based payment rates, including data comparing the two payment methodologies for certain products. As we have stated in previous rulemaking cycles, we recognize the complexities of ASP reporting for radiopharmaceuticals given the unique nature of the products. CMS will continue to assess the appropriateness of an

ASP based payment methodology; however, we continue to believe that there must be more consistent, validated, and universal reporting of ASP data for diagnostic radiopharmaceuticals. For those currently reporting ASP, we encourage continued reporting. We encourage manufacturers to share their best practices for ASP reporting to facilitate industry-wide adoption of consistent ASP reporting.

As we have stated in prior rulemaking, while the number of products reporting ASP has slightly increased, we continue to have concerns regarding the accuracy of the reported data. For several diagnostic radiopharmaceuticals that have reported their ASP, their reported ASP exceeds the calculated arithmetic MUCs by several thousand percent. One of these radiopharmaceuticals would be estimated to be among the top 10 highest paid HCPCS codes in all of the OPPS if CMS adopted this payment rate. Based on the claims data and claims volume for these diagnostic radiopharmaceuticals, these extremely high ASP data appear to be erroneously reported. Of the non-passthrough diagnostic radiopharmaceuticals, including those above and below the threshold, we estimate that currently less than 20 percent of diagnostic radiopharmaceuticals are submitting ASP to CMS. As previously mentioned, even when the ASP is reported, in some instances CMS strongly questions the validity of the data and the ability to use it to inform payment in certain instances. Based on this, among other factors, we continue to believe that an ASP-based methodology is inappropriate for setting CY 2027 payment for separately paid diagnostic radiopharmaceuticals.

We find that the ASP data we have are not usable for the purpose of paying for diagnostic radiopharmaceuticals. Instead, we are paying based on mean unit cost data derived from hospital claims, which we believe would appropriately pay for the average price of non-passthrough separately payable diagnostic radiopharmaceuticals for the applicable year under section 1833(t)(14)(A)(iii)(II). We believe MUC is an appropriate proxy for the average price and average cost for a diagnostic radiopharmaceutical for a given year, as it is calculated based on the average costs for a particular year and is directly reflective of the actual cost data that

hospitals submit to CMS. Historic hospital claims data is used as the basis for the vast majority of OPPS payments, making payment for diagnostic radiopharmaceuticals based on cost data consistent with the rest of the OPPS. This approach is also consistent with our authority under section 1833(t)(14)(A)(iii)(II) of the Act to calculate and adjust the average price as necessary, particularly when, as previously discussed, we continue to find that the ASP data available to us is not usable for payment purposes for diagnostic radiopharmaceuticals. We will continue to explore our authority regarding requiring ASP reporting for diagnostic radiopharmaceuticals under the OPPS.

In response to comments suggesting we adopt WAC or AWP based payment methodologies, we continue to believe that neither WAC nor AWP is an appropriate proxy to provide OPPS payment for average radiopharmaceutical acquisition costs and associated handling costs when manufacturers are not required to submit ASP data. This is because payment based on WAC or AWP for separately payable drugs and biologicals is usually temporary for a calendar quarter until a manufacturer is able to submit the required ASP data in accordance with the quarterly ASP submission timeframes for reporting under section 1847A of the Act. WAC and AWP reported to compendia may not be reflective of a patient ready dose.

The absence of an ASP reporting requirement and inappropriate or no reporting of ASP could result in payment for a separately payable diagnostic radiopharmaceutical based on WAC or AWP indefinitely, a result which we believe would be inappropriate, as these pricing metrics do not capture all of the pricing discounts that may be reflected in the ASP.

We appreciate the insight from commenters regarding their concerns with CMS continuing to use arithmetic MUC as the payment methodology for diagnostic radiopharmaceuticals. We are taking these comments into consideration for future rulemaking and for future guidance development.

In regard to concerns regarding the MUC data received by CMS, we remind readers that we rely on providers to accurately report the use of HCPCS codes in accordance with code

descriptors and CPT and CMS instructions, to report services accurately on claims, and to report charges and costs accurately for the services on their Medicare hospital cost reports.

Comment: Some commenters expressed hesitations with using ASP based payments for diagnostic radiopharmaceuticals. A commenter stated that manufacturers do not universally report ASP currently because they are not required to do so. A commenter suggested that voluntary ASP reporting may not capture complete market dynamics and could result in payment rates that do not accurately reflect acquisition costs, particularly if the data are incomplete, inconsistently reported, or from a limited subset of manufacturers. Some commenters recommended CMS maintain MUC as a payment option for diagnostic radiopharmaceuticals, as it is difficult, or impossible, for some forms of diagnostic radiopharmaceuticals to report ASP for reasons outside of the manufacturer's control. For example, diagnostic radiopharmaceuticals from multi-dose generators and multi-dose vial cold kits could be products in which a manufacturer is unable to report ASP.

Response: We appreciate the information presented by these commenters. The information in these comments will be used to help inform any potential changes in future policy and any additional ASP reporting guidance. These comments reinforce our concerns regarding the use of ASP for all diagnostic radiopharmaceuticals. For CY 2027, non-passthrough diagnostic radiopharmaceuticals with claims data will continue to be paid based on arithmetic MUC.

Comments: Many commenters appreciated the CMS mention of an ASP Reporting Framework for Diagnostic Radiopharmaceuticals and encouraged CMS to release such guidance prior to the end of CY 2026. Many commenters offered to collaborate with CMS on such guidance and welcomed the opportunity to provide feedback.

Response: We thank the commenters for their support. We will continue to consider additional ASP reporting guidance for diagnostic radiopharmaceuticals and we welcome input from interested parties on the framework's content.

After consideration of public comments, we are finalizing our proposal without modification. In summary, for CY 2027 we are paying separately for any diagnostic radiopharmaceutical with a per-day cost greater than $635 using the methodology described. Any diagnostic radiopharmaceutical with a per-day cost at or below that threshold would continue to be policy packaged under our longstanding policy codified at § 419.2(b)(15).

As discussed in section V.B.5. of this final rule with comment period, we proposed and are finalizing a policy to set the payment rate for new diagnostic radiopharmaceuticals with HCPCS codes that exceed the diagnostic radiopharmaceutical packaging threshold, but which do not have pass-through status and are without claims data, at ASP plus 6 percent. If ASP data for these diagnostic radiopharmaceuticals are not available, we are finalizing a policy to pay WAC plus 3 percent during the product's initial sales period, consistent with our policy described in section V.B.2. of this final rule with comment period. If the WAC also is unavailable, we are finalizing a policy to make payment for new diagnostic radiopharmaceuticals at 95 percent of the products' most recent AWP. Following the initial sales period, we are finalizing a payment rate of WAC plus 6 percent would apply, if ASP data for these diagnostic radiopharmaceuticals remain unavailable.

Additionally, we refer readers to section V.B.8. of this final rule with comment period for discussion of payment for 340B drugs, including diagnostic radiopharmaceuticals acquired through the 340B program.

(4) Qualifying Diagnostic Radiopharmaceuticals Above the Diagnostic Radiopharmaceutical Packaging Threshold

The HCPCS codes that describe diagnostic radiopharmaceuticals with per day costs that exceed the proposed diagnostic radiopharmaceutical packaging threshold were proposed to be assigned to a status indicator of "K", indicating separate payment to be paid based on that HCPCS code's arithmetic MUC. The proposed APC and the proposed payment rate were assigned as shown in Addendum B to the proposed rule. HCPCS codes that describe diagnostic

radiopharmaceuticals with per day costs that are at or below the proposed diagnostic radiopharmaceutical packaging threshold were proposed to continue to be assigned to a status indicator of "N", indicating packaged payment.

The proposed list of diagnostic radiopharmaceuticals that we calculated as having per day costs that exceeded $665 and their proposed status indicators can be found in Table 6.

TABLE 6: PROPOSED QUALIFYING DIAGNOSTIC RADIOPHARMACEUTICALS WITH PER DAY COSTS EXCEEDING $665

HCPCS Code	Short Descriptor	Proposed CY 2027 Status Indicator Assignment
A4642	In111 satumomab	K
A9507	In111 capromab	K
A9508	I131 iodobenguate, dx	K
A9515	Choline C 11, diagnostic	K
A9521	Tc99m exametazime	E1*
A9532	I125 serum albumin, dx	K
A9547	In111 oxyquinoline	K
A9548	In111 pentetate	K
A9551	Tc99m succimer	K
A9554	I125 iothalamate, dx	K
A9557	Tc99m bicisate	K
A9569	Technetium TC-99m auto WBC	K
A9570	Indium In-111 auto WBC	K
A9572	Indium In-111 pentetreotide	K
A9582	Iodine I-123 iobenguane	K
A9584	Iodine I-123 ioflupane	K
A9586	Florbetapir F18	K
A9587	Gallium Ga-68	K
A9588	Fluciclovine F-18	K
A9591	Fluoroestradiol F 18	K
A9592	Copper cu 64 dotatate diag	K
A9593	Gallium ga-68 psma-11 ucsf	K
A9594	Gallium ga-68 psma-11, ucla	K
A9595	Piflu f-18, dia 1 millicurie	K
A9596	Gallium illuccix 1 millicure	K
A9601	Flortaucipir inj 1 millicuri	K
A9602	Fluorodopa f-18 diag per mci	K
A9608	Flotufolastat f18 diag 1 mci	K
A9800	Gallium locametz 1 millicuri	K
C9067	Gallium ga-68 Dotatoc	K
Q9982	Flutemetamol F18	K
Q9983	Florbetaben F18	K

*Proposed Status Indicator assignment is E1 until compliance with the Medicaid National Drug Rebate Agreement occurs. Once compliance is met, status indicator K would apply.

The proposed definitions of status indicators can be found in Addendum D1 to the proposed rule. Addenda to the proposed rule can be found on the CMS OPPS webpage at

https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-regulations-and-notices/cms-1850-p?utm.

Based on the policy finalized in this section to continue paying separately at arithmetic MUC for non-passthrough diagnostic radiopharmaceutical with a HCPCS code and claims data, and with a per day cost greater than $635 using the methodology previously described, the HCPCS codes that describe diagnostic radiopharmaceuticals with per day costs that exceed the finalized diagnostic radiopharmaceutical packaging threshold are assigned to a status indicator of ''K'', indicating separate payment to be paid based on that HCPCS code's arithmetic MUC. A final APC and payment rate are assigned as shown in Addendum B to this final rule with comment period. HCPCS codes that describe diagnostic radiopharmaceuticals with per day costs that are at or below the proposed diagnostic radiopharmaceutical packaging threshold are assigned to a status indicator of ''N'', indicating packaged payment. The finalized list of diagnostic radiopharmaceuticals that we calculated as having per day costs that exceed $635 and their final status indicators can be found in Table 7.

TABLE 7: FINAL QUALIFYING DIAGNOSTIC RADIOPHARMACEUTICALS WITH PER DAY COSTS EXCEEDING $635

HCPCS Code	Short Descriptor	Final CY 2027 Status Indicator Assignment
A4642	In111 satumomab	K
A9507	In111 capromab	K
A9508	I131 iodobenguate, dx	K
A9515	Choline C 11, diagnostic	K
A9521	Tc99m exametazime	K
A9532	I125 serum albumin, dx	K
A9547	In111 oxyquinoline	K
A9548	In111 pentetate	K
A9551	Tc99m succimer	K
A9554	I125 iothalamate, dx	K
A9557	Tc99m bicisate	K
A9569	Technetium TC-99m auto WBC	K
A9570	Indium In-111 auto WBC	K
A9572	Indium In-111 pentetreotide	K
A9582	Iodine I-123 iobenguane	K
A9584	Iodine I-123 ioflupane	K
A9586	Florbetapir F18	K
A9587	Gallium Ga-68	K
A9588	Fluciclovine F-18	K
A9591	Fluoroestradiol F 18	K
A9592	Copper cu 64 dotatate diag	K
A9593	Gallium ga-68 psma-11 ucsf	K

HCPCS Code	Short Descriptor	Final CY 2027 Status Indicator Assignment
A9594	Gallium ga-68 psma-11, ucla	K
A9595	Piflu f-18, dia 1 millicurie	K
A9596	Gallium illuccix 1 millicure	K
A9601	Flortaucipir inj 1 millicuri	K
A9602	Fluorodopa f-18 diag per mci	K
A9608	Flotufolastat f18 diag 1 mci	K
A9800	Gallium locametz 1 millicuri	K
C9067	Gallium ga-68 Dotatoc	K
Q9982	Flutemetamol F18	K
Q9983	Florbetaben F18	K

Finalized definitions of status indicators can be found in Addendum D1 to this final rule with comment period. Addenda to this rule can be found on the CMS OPPS web page.

4. Implementation of Section 4135 of the Consolidated Appropriations Act (CAA), 2023

The Consolidated Appropriations Act (CAA), 2023 (Pub. L. 117–328), was signed into law on December 29, 2022. Section 4135(a) and (b) of the CAA, 2023, titled Access to Non-Opioid Treatments for Pain Relief, amended sections 1833(t)(16) and 1833(i) of the Act, respectively, to provide for temporary additional payments for non-opioid treatments for pain relief (as that term is defined in section 1833(t)(16)(G)(iv) of the Act). In particular, section 1833(t)(16)(G) of the Act provides that with respect to a non-opioid treatment for pain relief furnished on or after January 1, 2025, and before January 1, 2028, the Secretary shall not package payment for the non-opioid treatment for pain relief into payment for a covered OPD service (or group of services) and shall make an additional payment for the non-opioid treatment for pain relief as specified in clause (ii) of that section. Clauses (ii) and (iii) of section 1833(t)(16)(G) of the Act provide for the amount of additional payment and set a limitation on that amount, respectively.

The additional payments required under section 1833(t)(16)(G) of the Act began on January 1, 2025, based on the policy finalized in the CY 2025 OPPS/ASC final rule with comment period (89 FR 94343 through 94361). In section XIII.E. of this final rule with comment period, we are finalizing our proposal to continue the payment policy finalized in the CY 2025 OPPS/ASC final rule with comment period for CY 2027. We are also finalizing non-

opioid treatments for pain relief that would qualify under this policy for CY 2027 and responded to public comments on the proposed rule.

We refer readers to section XIII.E. of this final rule with comment period for a summary of the finalized policy.

5. Calculation of OPPS Scaled Payment Weights

We established a policy in the CY 2013 OPPS/ASC final rule with comment period (77 FR 68283) using geometric mean-based APC costs to calculate relative payment weights under the OPPS. In the CY 2026 OPPS/ASC final rule with comment period (90 FR 53489 through 53490), we applied this policy and calculated the relative payment weights for each APC for CY 2026 that were shown in Addenda A and B of the CY 2026 OPPS/ASC final rule with comment period (which were made available via the Internet on the CMS website) using the APC costs discussed in sections II.A.1. and II.A.2. of the CY 2026 OPPS/ASC final rule with comment period (90 FR 53455 through 53480). For CY 2027, as we did for CY 2026, we proposed to continue to apply the policy established in CY 2013 and calculate relative payment weights for each APC for CY 2027 using geometric mean-based APC costs (91 FR 41762).

For CY 2012 and CY 2013, outpatient clinic visits were assigned to one of five levels of clinic visit APCs, with APC 0606 representing a mid-level clinic visit. In the CY 2014 OPPS/ASC final rule with comment period (78 FR 75036 through 75043), we finalized a policy that created alphanumeric HCPCS code G0463 (Hospital outpatient clinic visit for assessment and management of a patient), representing all clinic visits under the OPPS. HCPCS code G0463 was assigned to APC 0634 (Hospital Clinic Visits). We also finalized a policy to use CY 2012 claims data to develop the CY 2014 OPPS payment rates for HCPCS code G0463 based on the total geometric mean cost of the levels one through five CPT Evaluation or Assessment and Management (E/M) codes for clinic visits previously recognized under the OPPS (CPT codes 99201 through 99205 and 99211 through 99215). In addition, we finalized a policy to no longer recognize a distinction between new and established patient clinic visits.

For CY 2016, we deleted APC 0634 and reassigned the outpatient clinic visit HCPCS code G0463 to APC 5012 (Level 2 Examinations and Related Services) (80 FR 70372). For CY 2027, as we did for CY 2026, we proposed to continue to standardize all the relative payment weights to APC 5012. We believe that standardizing relative payment weights to the geometric mean of the APC to which HCPCS code G0463 is assigned maintains consistency in calculating unscaled weights that represent the cost of some of the most frequently provided OPPS services. For CY 2027, as we did for CY 2026, we proposed to assign APC 5012 a relative payment weight of 1.00 and to divide the geometric mean cost of each APC by the geometric mean cost for APC 5012 to derive the unscaled relative payment weight for each APC. The choice of the APC on which to standardize the relative payment weights does not affect payments made under the OPPS because we scale the weights for budget neutrality.

Section 1833(t)(9)(B) of the Act requires that APC reclassification and recalibration changes, wage index changes, and other adjustments be made in a budget neutral manner. Budget neutrality ensures that the estimated aggregate weight under the OPPS for CY 2027 is neither greater than nor less than the estimated aggregate weight that would have been calculated without the changes. To comply with this requirement concerning the APC changes, we proposed to compare the estimated aggregate weight using the CY 2026 scaled relative payment weights to the estimated aggregate weight using the proposed CY 2027 unscaled relative payment weights.

For CY 2026, we multiplied the CY 2026 scaled APC relative payment weight applicable to a service paid under the OPPS by the volume of that service from CY 2025 claims to calculate the total relative payment weight for each service (90 FR 53489). We then added together the total relative payment weight for each of these services to calculate an estimated aggregate weight for the year. For CY 2027, we proposed to apply the same process using the estimated CY 2027 unscaled relative payment weights rather than scaled relative payment weights. We

proposed to calculate the weight scalar by dividing the CY 2026 estimated aggregate weight by the unscaled CY 2027 estimated aggregate weight.

For a detailed discussion of the weight scalar calculation, we refer readers to the OPPS claims accounting document available on the CMS website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices*. Click on the link labeled "Hospital Outpatient Prospective Payment – Notice of Proposed Rulemaking" for 2027, which can be found under the heading "Hospital Outpatient Regulations and Notices" and open the claims accounting document link, which is labeled "2027 Proposed Rule OPPS Claims Accounting."

We proposed to compare the estimated unscaled relative payment weights in CY 2027 to the estimated total relative payment weights in CY 2026 using CY 2025 claims data, holding all other components of the payment system constant to isolate changes in total weight. Based on this comparison, we proposed to adjust the calculated CY 2027 unscaled relative payment weights for purposes of budget neutrality. We proposed to adjust the estimated CY 2027 unscaled relative payment weights by multiplying them by a proposed weight scalar of 1.4582 to ensure that the proposed CY 2027 relative payment weights are scaled to be budget neutral. The proposed CY 2027 relative payment weights listed in Addenda A and B to the CY 2027 OPPS/ASC proposed rule (which are available via the Internet on the CMS website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices*) are scaled and include the recalibration adjustments discussed in sections II.A.1. and II.A.2. of the CY 2027 OPPS/ASC proposed rule.

Section 1833(t)(14) of the Act provides the methodology for payment rates for certain specified covered outpatient drugs (SCODs). Section 1833(t)(14)(H) of the Act provides that additional expenditures resulting from this paragraph shall not be taken into account in establishing the conversion factor, weighting, and other adjustment factors for 2004 and 2005 under section 1833(t)(9) of the Act but shall be taken into account for subsequent years.

Therefore, the cost of those SCODs (as discussed in section V.B.2. of this final rule with comment period) is included in the budget neutrality calculations for the CY 2027 OPPS.

We did not receive any public comments on the proposed weight scalar calculation, and we are finalizing our proposal to use the calculation process described in the CY 2027 OPPS/ASC proposed rule, without modification, for CY 2027. For CY 2027, as we did for CY 2026, we will continue to apply the policy established in CY 2013 and calculate relative payment weights for each APC for CY 2027 using geometric mean-based APC costs. For CY 2027, as we did for CY 2026, we will assign APC 5012 a relative payment weight of 1.00; and we will divide the geometric mean cost of each APC by the geometric mean cost for APC 5012 to derive the unscaled relative payment weight for each APC. To comply with this requirement concerning the APC changes, we will compare the estimated aggregate weight using the CY 2026 scaled relative payment weights to the estimated aggregate weight using the CY 2027 unscaled relative payment weights.

Using updated final rule claims data, we are updating the estimated CY 2027 unscaled relative payment weights by multiplying them by a weight scalar of 1.4614 to ensure that the final CY 2027 relative payment weights are scaled to be budget neutral. The final CY 2027 relative payment weights listed in Addenda A and B of this final rule with comment period (available via the internet on the CMS website) were scaled and include the recalibration adjustments discussed in sections II.A.1 and II.A.2. of this final rule with comment period.

B. Final Conversion Factor Update

1. OPD Fee Schedule Increase Factor

Section 1833(t)(3)(C)(ii) of the Act requires the Secretary to update the conversion factor used to determine the payment rates under the OPPS on an annual basis by applying the OPD fee schedule increase factor. For purposes of section 1833(t)(3)(C)(iv) of the Act, subject to sections 1833(t)(17) and 1833(t)(3)(F) of the Act, the OPD fee schedule increase factor is equal to the hospital inpatient market basket percentage increase applicable to hospital discharges of the Act (or an amount that is computed and applied with respect to covered OPD services). In the FY 2027 IPPS/Long Term Care Hospital (LTCH) proposed rule (91 FR 19496), consistent with current law, based on IHS Global, Inc.'s (IGI's) fourth quarter 2025 forecast, the proposed FY 2027 IPPS market basket percentage increase was 3.2 percent. We noted that under our regular process for the CY 2027 OPPS/ASC final rule with comment period, we would use the market basket update for the FY 2027 IPPS/LTCH PPS final rule. If that forecast is different than the IPPS market basket percentage increase used for this final rule with comment period, the CY 2027 OPPS/ASC final rule with comment period OPD fee schedule increase factor would reflect that updated forecast of the market basket percentage increase.

For CY 2027, we proposed to use the estimate of the hospital inpatient market basket percentage increase of 3.2 percent as one component to calculate the OPD fee schedule increase factor (91 FR 41763).

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: A commenter supported the proposed CY 2027 OPD fee schedule increase factor. Another commenter appreciated the proposed positive update while requesting that CMS monitor the combined effects of the conversion factor, APC assignments, site-neutral policies, and other payment changes on particular services.

Response: We thank the commenters for their support.

Comment: Several commenters stated that the proposed OPD fee schedule increase factor would not keep pace with the cost of furnishing hospital outpatient care. Commenters cited increase costs in labor, pharmaceuticals, supplies, technology, infrastructure, regulatory compliance, and other operating expenses, and stated that the effect is particularly acute for rural hospitals, safety-net providers, academic medical centers, and hospitals furnishing complex or high-acuity services. Some commenters stated that forecast-based market basket data lag actual cost growth and requested that CMS use more current or alternative data, correct for prior forecast error, conduct a broader review of the rate-setting methodology, or provide an update of at least 3.2 percent.

Response: We acknowledge the commenters' concerns regarding the proposed CY 2027 market basket update, including the challenging financial circumstances commenters described for rural hospitals, safety-net providers, academic medical centers, and other hospitals furnishing complex services. Section 1833(t)(3)(C)(iv) of the Act requires the OPD fee schedule increase factor for a year to be equal to the IPPS market basket percentage increase factor applicable under section 1886(b)(3)(B)(iii) of the Act to hospital discharges in the fiscal year ending in that year. Therefore, we are unable to adopt a final OPD fee schedule increase factor different from the IPPS market basket percentage increase factor finalized in the FY 2027 IPPS/LTCH PPS final rule. We refer commenters to the FY 2027 IPPS/LTCH PPS final rule for responses regarding the market basket issues commenters raised (91 FR 49835 through 49838).

2. Productivity Adjustment

Section 1833(t)(3)(F)(i) of the Act requires that, for 2012 and subsequent years, the OPD fee schedule increase factor under subparagraph (C)(iv) be reduced by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act. Section 1886(b)(3)(B)(xi)(II) of the Act defines the productivity adjustment as equal to the 10-year moving average of changes in annual economy-wide, private nonfarm business multifactor productivity (MFP) (as projected by the Secretary for the 10-year period ending with the applicable fiscal year, year, cost reporting

period, or other annual period). The U.S. Department of Labor's Bureau of Labor Statistics (BLS) publishes the official measures of private nonfarm business productivity for the U.S. economy. The productivity measure referenced in section 1886(b)(3)(B)(xi)(II) of the Act is now published by BLS as private nonfarm business total factor productivity ((TFP) previously referred to as multifactor productivity)[7]. Please see *https://www.bls.gov/productivity/* for the BLS historical published TFP data. A complete description of IGI's TFP projection methodology is available on the CMS website at *https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-program-rates-statistics/market-basket-research-and-information*. In the FY 2027 IPPS/LTCH PPS proposed rule (91 FR 19496), the proposed productivity adjustment for FY 2027 was 0.8 percentage point.

Therefore, we proposed that the productivity adjustment for the CY 2027 OPPS/ASC proposed rule would be a reduction of 0.8 percentage point. We also proposed that if more recent data subsequently become available after the publication of the CY 2027 OPPS/ASC proposed rule (for example, a more recent estimate of the market basket percentage increase and/or the productivity adjustment), we would use such data, if appropriate, to determine the CY 2027 hospital inpatient market basket update and the productivity adjustment for the final rule with comment period, which are components in calculating the OPD fee schedule increase factor under sections 1833(t)(3)(C)(iv) and 1833(t)(3)(F) of the Act (91 FR 41763).

We note that section 1833(t)(3)(F) of the Act provides that application of this subparagraph may result in the OPD fee schedule increase factor under section 1833(t)(3)(C)(iv) of the Act being less than 0.0 percent for a year and may result in OPPS payment rates being less than rates for the preceding year. As described in further detail later in this section, we proposed for CY 2027 an OPD fee schedule increase factor of 2.4 percent for the CY 2027 OPPS/ASC (which is the proposed estimate of the hospital inpatient market basket percentage increase of 3.2 percent, less the proposed 0.8 percentage point productivity adjustment).

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[7] *https://www.bls.gov/productivity/notices/2021/mfp-to-tfp-term-change.htm.*

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: Some commenters objected to the proposed 0.8 percentage point productivity adjustment or requested that it be modified. Commenters stated that hospital care is labor intensive and hospitals, therefore, must be in a constant state of readiness; meet staffing and regulatory requirements; and treat patients with complex conditions; and that hospitals could not achieve productivity gains across the economy the same way other private nonfarm businesses did. Commenters also noted that the proposed adjustment was higher than those made in recent years and requested that CMS provide further explanation or reevaluate the data and methodology. Some suggestions included removing the adjustment, capping it to between 0.2 and 0.3 percentage point, using a hospital-specific productivity index, or creating hardship exceptions for safety-net and academic medical centers.

Response: We acknowledge the commenters' concerns. Section 1833(t)(3)(F)(i) of the Act requires that after determining the OPD fee schedule increase factor under subparagraph (C)(iv), the Secretary shall reduce such increase factor by the productivity adjustment described in section 1886(b)(3)(B)(xi) of the Act. As required by statute, the FY 2027 productivity adjustment is derived based on the 10-year moving average growth in economy-wide productivity for the period ending FY 2027. Accordingly, CMS does not have discretion under these provisions to eliminate the adjustment, cap it at a different level, substitute a hospital-specific productivity index, or establish provider-specific hardship exceptions.

We thank the commenters for their comments. After consideration of the comments received and consistent with our proposal, we are finalizing an OPD fee schedule increase factor with modification of 2.3 percent for CY 2027, which consists of the IPPS market basket increase factor of 3.2 percent, less a 0.9 percentage point productivity adjustment calculated using more recent data.

3. Other Conversion Factor Adjustments

To set the OPPS conversion factor for 2027, we proposed to increase the CY 2026 conversion factor of $91.415 by 2.4 percent (91 FR 41763). In accordance with section 1833(t)(9)(B) of the Act, we proposed to further adjust the conversion factor for CY 2027 to ensure that any revisions made to the wage index and rural adjustment are made on a budget neutral basis. We proposed to apply an overall budget neutrality factor of 1.0098 for wage index changes by comparing proposed total estimated payments from our simulation model using the FY 2027 IPPS wage indexes to those payments using the CY 2026 OPPS wage indexes. We further proposed to calculate an additional budget neutrality factor of 0.9951 to account for our policy to cap wage index reductions for hospitals at 5 percent on an annual basis and the CY 2027 proposed transitional exception for low-wage index hospitals.

For CY 2027, we proposed to maintain the current rural adjustment policy, as discussed in section II.E. of this final rule with comment period. Therefore, the proposed budget neutrality factor for the rural adjustment is 1.0000 (91 FR 41763).

We proposed to calculate a CY 2027 budget neutrality adjustment factor for the cancer hospital payment adjustment. We finalized transitioning from the target PCR of 0.89 for CYs 2020 through 2023 (which included the 1.0 percentage point reduction as required by section 16002(b) of the 21st Century Cures Act) and incrementally reducing the target PCR by an additional 1.0 percentage point for each calendar year, beginning with CY 2024, until the target PCR equals the PCR of non-cancer hospitals calculated using the most recent data minus 1.0 percentage point as required by section 16002(b) of the 21st Century Cures Act. We proposed a CY 2027 target PCR equal to 0.88 for the cancer hospital payment adjustment, which includes the 1.0 percentage point reduction as required by section 16002(b) of the 21st Century Cures Act. The proposed CY 2027 estimated payments applying the proposed CY 2027 cancer hospital payment adjustment are greater than the estimated payments applying the CY 2026 final cancer hospital payment adjustment. Therefore, we proposed to apply a budget neutrality

adjustment factor of 0.9994 to the conversion factor for the cancer hospital payment adjustment (91 FR 41763).

We proposed to establish a cost-of-living adjustment (COLA) for hospitals in Alaska and Hawaii in the CY 2027 OPPS. We proposed a budget neutrality factor of 0.9993 to account for the CY 2027 COLA by comparing proposed total estimated payments from our simulation model without a COLA policy to those with the proposed CY 2027 COLA (91 FR 41763).

For the CY 2027 OPPS/ASC proposed rule, we estimated that proposed pass-through spending for drugs, biologicals, and devices for CY 2027 would equal approximately $195.3 million, which represents 0.18 percent of total projected CY 2027 OPPS spending. Therefore, we stated that the proposed conversion factor would be adjusted by the difference between the 0.30 percent estimate of pass-through spending for CY 2026 and the 0.18 percent estimate of proposed pass-through spending for CY 2027, resulting in a proposed increase to the conversion factor for CY 2027 of 0.12 percentage point (91 FR 41763).

We proposed that estimated payments for outliers would be 1.0 percent of total OPPS payments for CY 2027. We estimated in the proposed rule that outlier payments would be approximately 1.19 percent of total OPPS payments in CY 2026; the 1.00 percent for proposed outlier payments in CY 2027 would constitute a 0.19 percentage point decrease in payment in CY 2027 relative to CY 2026 (91 FR 41763).

In the CY 2027 OPPS/ASC proposed rule, we estimated an 8.44 percent increase to nondrug OPPS payment rates as a budget neutral adjustment for the $4.85 billion reduction in OPPS drug payment as a result of the proposed 340B drug payment policy. As part of that proposed policy, we noted that our adjustment in the final rule could potentially change as a result of changes such as updated data, modifications to the estimate methodology, and other factors. For additional discussion of the proposed 340B drug payment policy, please see section V.B.7. of this final rule with comment period.

For CY 2027, we proposed to use a conversion factor of $102.004 in the calculation of the national unadjusted payment rates for those items and services for which payment rates are calculated using geometric mean costs; that is, the proposed OPD fee schedule increase factor of 1.024 (2.4 percent for CY 2027), the required proposed wage index budget neutrality adjustment of approximately 1.0098, the proposed 5 percent annual cap for individual hospital wage index reductions adjustment and the proposed transitional exception of approximately 0.9951, the proposed cost-of-living adjustment of 0.9993, the proposed cancer hospital payment adjustment of 0.9994, the adjustment for drugs purchased under the 340B Program of 1.0844, and the proposed adjustment factor of 1.0012 (an increase of 0.12 percentage point) for the difference in pass-through spending, which resulted in a proposed conversion factor for CY 2027 of $102.004 (91 FR 41764).

For CY 2027, we also proposed that hospitals that fail to meet the reporting requirements of the Hospital OQR Program would continue to be subject to a further reduction of 2.0 percentage points to the OPD fee schedule increase factor. For hospitals that fail to meet the requirements of the Hospital OQR Program, we proposed to make all other adjustments discussed previously in this section and apply an adjustment factor to further reduce the update factor by 2.0 percentage points. We proposed that the hospitals that fail to meet the requirements of the Hospital OQR Program would use a reduced OPD fee schedule update factor of 0.4 percent (that is, the proposed OPD fee schedule increase factor of 2.4 percent reduced by 2.0 percentage points) (91 FR 41764).

For CY 2027, as discussed in section V.B.7. of the CY 2027 OPPS/ASC proposed rule, we proposed to reduce payments for non-drug items and services for hospitals for whom the annual reduction to payment amounts under § 419.32(b)(1)(iv)(B)(12) applies with a 3 percentage point reduction to the OPD fee schedule increase factor. This would result in a proposed reduced conversion factor for CY 2027 of approximately $99.015 for this group of hospitals (91 FR 41764).

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: Commenters stated that CMS should evaluate the combined effect of the conversion-factor adjustments and other proposed payment policies rather than evaluating each policy in isolation. Commenters noted that the proposed OPD update could be offset by other adjustments and that the resulting payment effects would vary across providers and services, including 340B hospitals, academic medical centers, and advanced cardiovascular imaging programs.

Response: We acknowledge commenters' concerns regarding the combined effect of the conversion-factor adjustments and other payment policies on different providers and services. The OPD fee schedule increase factor is only one component of the OPPS payment-rate calculation. The impact analysis in section XXVII. of this final rule with comment period presents the estimated combined effects of the finalized OPPS policies by hospital category. Actual payment effects for particular hospitals and services may vary based on factors such as service mix, wage-index adjustments, and other applicable payment policies. However, several conversion-factor components are required by statute or calculated to maintain budget neutrality for specific policies. Accordingly, we calculate each component under the applicable statutory and methodological requirements and apply the resulting adjustments in determining the final conversion factor. We address comments concerning the underlying payment policies in the relevant sections of this final rule with comment period.

Comment: A few commenters supported the proposed CY 2027 budget neutrality adjustment factor for the cancer hospital payment adjustment. One of the commenters requested that CMS retain flexibility to reinstate a gradual transition if future recalculations result in significant or unexpected changes to the target PCR, to avoid abrupt reductions in reimbursement for cancer hospitals.

Response: We thank the commenters for their support. We address the CY 2027 cancer hospital payment adjustment, including the target payment-to-cost ratio and commenters' request concerning a possible future transition, in section II.F. of this final rule with comment period.

Comment: Several commenters opposed CMS's proposed reduction in payment for drugs acquired under the 340B program and the associated 8.44 percent budget-neutral increase to the OPPS conversion factor for non-drug items and services. Commenters characterized the adjustment as a redistribution of payments from 340B hospitals to non-340B and for-profit hospitals and stated that it would disproportionately disadvantage safety-net, rural, teaching, and academic hospitals, particularly those furnishing substantial volumes of high-cost oncology and specialty drugs. Commenters also opposed the proposed treatment of nonexcepted off-campus provider-based departments, including the application of the drug-payment reduction without a corresponding budget-neutral payment increase. A commenter requested that CMS disclose the data and methodology used to calculate the aggregate drug payment reduction and conversion factor adjustment, including its methods for identifying 340B hospitals and determining the providers and claims included in the calculation. That commenter also requested that CMS recalculate the budget neutrality adjustment annually, citing CMS's use of an unchanged 3.19 percent adjustment from CY 2018 through CY 2022 despite subsequent increases in the amount of the drug payment reductions.

Response: We address comments on the payment rate for drugs acquired under the 340B program and the associated budget-neutrality adjustment, including comments on the affected hospital groups, claims methodology, and nonexcepted off-campus provider-based departments, in section V.B.7. of this final rule with comment period.

For this CY 2027 OPPS/ASC final rule with comment period, based on more recent data available, the OPD fee schedule increase factor for the CY 2027 OPPS is 2.3 percent (which reflects the 3.2 percent final estimate of the hospital inpatient market basket percentage increase with a - 0.9 percentage point productivity adjustment). For CY 2027, we are using a conversion

factor of $99.970 in the calculation of the national unadjusted payment rates for those items and services for which payment rates are calculated using geometric mean costs; that is, the OPD fee schedule increase factor of 2.3 percent for CY 2027, the required wage index budget neutrality adjustment of 0.9952, the 5 percent annual cap for individual hospital wage index reductions of 0.9996, the budget neutrality adjustment of 0.9992 for the COLA, the cancer hospital payment adjustment of 0.9996, the budget neutrality adjustment of 1.075 for the final 340B-drug payment adjustment, and the adjustment of 0.07 (or 0.30 less 0.23) percentage point of projected OPPS spending for the difference in pass-through spending that results in a conversion factor for CY 2027 of $99.970. We are also finalizing a reduced conversion factor of $98.011 in the calculation of payments for hospitals that fail to meet the Hospital OQR Program requirements (a difference of -1.959 in the conversion factor relative to hospitals that met the requirements). The calculations we performed to determine the CY 2027 final conversion factor are shown in Table 8.

TABLE 8: CALCULATION OF CY 2027 FINAL OPPS CONVERSION FACTOR

Start: CY 2026 Final OPPS Conversion Factor = **$91.415**
Step 1a: Adjust the conversion factor to temporarily account for additional drug and device pass-through spending and outlier spending in CY 2026. This action causes an increase in the conversion factor. So, the amount of both drug and device pass-through spending (0.0030), the percentage of outlier spending (0.01) and the percentage of domestic NIOSH/N95 policy (0.0001) as a share of total OPPS outpatient hospital spending is subtracted from 1.0000, which represents total OPPS outpatient hospital spending for CY 2026. ➢ 1.0000 – (0.0030 + 0.01 + 0.0001) = 0.9869
Step 1b: Divide $91.415 by 0.9869 ➢ $91.415/0.9869 = **$92.628**
Step 2: Adjust the conversion factor by the required wage index budget neutrality adjustment of approximately 0.9952. This adjustment increases the amount of OPPS outpatient hospital spending and is multiplied with $92.628. ➢ $92.628* 0.9952 = **$92.184**
Step 3: Adjust the conversion factor by the 5 percent annual cap for individual hospital wage index reductions adjustment of approximately 0.9996. This adjustment reduces the amount of OPPS outpatient hospital spending and is multiplied with $92.184. ➢ $92.184* 0.9996 = **$92.147**
Step 4: Adjust the conversion factor by cost-of-living adjustment (COLA) of 0.9992. This adjustment reduces the amount of OPPS outpatient hospital spending and is multiplied with $92.147.

➢ $92.147*0.9992 = **$92.073**
Step 5: Adjust the conversion factor by the cancer hospital payment adjustment of 0.9996. This adjustment reduces the amount of OPPS outpatient hospital spending and is multiplied with $92.073. ➢ $92.073*0.9996 = **$92.036**
Step 6: Adjust the conversion factor by rural SCH adjustment policy of 1.0000. Since we maintain our current policy, there is no impact on the conversion factor by this policy. ➢ $92.036*1.0000 = **$92.036**
Step 7: Adjust the conversion factor by the final 340B drug payment budget neutrality adjustment policy of 1.0750. This adjustment increases the amount of OPPS outpatient hospital spending and is multiplied with $92.036. $92.036*1.0750 = **$98.939**
Step 8a: Adjust the conversion factor by the OPD fee schedule increase factor of 0.023 for CY 2027. The OPD fee schedule increase factor increases outpatient hospital spending in CY 2027 over CY 2026 and is added to 1.0000 which represents total outpatient hospital OPPS spending in CY 2026. ➢ 1.0000+0.023 = 1.0230
Step 8b: Multiply $98.939 by 1.0230. ➢ $98.939*1.0230 = **$101.215**
Step 9a: Adjust the conversion factor to remove additional drug and device pass-through spending and outlier spending for CY 2027. This action causes a decrease in the conversion factor. So, the amount of both drug and device pass-through spending (0.0023) and the percentage of outlier spending (0.01) as a share of total OPPS outpatient hospital spending is subtracted from 1.0000, which represents total OPPS outpatient hospital spending for CY 2027. ➢ 1.0000 – (0.0023+0.01) = 0.9877
Step 9b: Multiply $101.215 by 0.9877 to get the CY 2027 final OPPS conversion factor. $101.215*0.9877 = **$99.970**
Finish: **CY 2027 final OPPS Conversion Factor = $99.970**
* *Reduction for Providers Subject to the 340B Remedy Offset* *Step 8:* Multiply $99.970 by 0.9804 to get the CY 2027 final OPPS conversion factor for the providers subject to the 340B remedy offset. $99.970*0.9804 = **$98.011**

Please note rounding may affect the numbers in the calculations above.

C. Final Wage Index Changes

Section 1833(t)(2)(D) of the Act requires the Secretary to determine a wage adjustment factor to adjust the portion of payment and coinsurance attributable to labor-related costs for

relative differences in labor and labor-related costs across geographic regions in a budget neutral manner (codified in regulation at 42 CFR 419.43(a)). This portion of the OPPS payment rate is called the OPPS labor-related portion or OPPS labor-related share. The scaled weight budget neutrality calculation methodology is discussed in section II.A.5. of this final rule with comment period.

The OPPS labor-related share is 60 percent of the national OPPS payment. This labor-related share is based on a regression analysis that determined that, for all hospitals, approximately 60 percent of the costs of services paid under the OPPS were attributable to wage costs. We confirmed that this labor-related share for outpatient services is appropriate during our regression analysis for the payment adjustment for rural hospitals in the CY 2006 OPPS final rule with comment period (70 FR 68553). We proposed to continue this policy for CY 2027. We refer readers to section II.C. of this final rule with comment period for a description and an example of how the wage index for a particular hospital is used to determine payment for the hospital.

As discussed in the claims accounting narrative included with the supporting documentation under "Downloads" for this final rule with comment period (which is available via the internet on the CMS website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices*), for estimating APC costs, we would standardize 60 percent of estimated claims costs for geographic area wage variation using the same FY 2027 pre-reclassified wage index that we use under the IPPS to standardize costs. This standardization process removes the effects of differences in area wage levels from the determination of a national unadjusted OPPS payment rate and copayment amount.

Under §§ 419.41(c)(1) and 419.43(c) (published in the OPPS April 7, 2000, final rule with comment period (65 FR 18495 and 18545)), the OPPS adopted the final fiscal year IPPS post-reclassified wage index as the calendar year wage index for adjusting the OPPS standard payment amounts for labor market differences. Therefore, the wage index that applies to a

particular acute care, short-stay hospital under the IPPS also applies to that hospital under the OPPS. As initially explained in the September 8, 1998, OPPS proposed rule (63 FR 47576), we believe that using the IPPS wage index as the source of an adjustment factor for the OPPS is reasonable and logical, given the inseparable, subordinate status of the HOPD within the hospital overall. In accordance with section 1886(d)(3)(E) of the Act, the IPPS wage index is updated annually.

The Affordable Care Act contained several provisions affecting the wage index. These provisions were discussed in the CY 2012 OPPS/ASC final rule with comment period (76 FR 74191). Section 10324 of the Affordable Care Act added section 1886(d)(3)(E)(iii)(II) to the Act, which defines a frontier State, and amended section 1833(t) of the Act to add paragraph (19), which requires a frontier State wage index floor of 1.00 in certain cases, and stipulates that the frontier State floor shall not be applied in a budget neutral manner. We codified these requirements at § 419.43(c)(2) and (3) of our regulations. For CY 2027, we proposed to implement this provision in the same manner as we have since CY 2011 (91 FR 41766). Under this policy, the frontier State hospitals would receive a wage index of 1.00 if the otherwise applicable wage index (including reclassification, the rural floor, and rural floor budget neutrality) is less than 1.00. Because the HOPD receives a wage index based on the geographic location of the specific inpatient hospital with which it is associated, the frontier State wage index adjustment applicable for the inpatient hospital also would apply for any associated HOPD. We refer readers to the FY 2011 through FY 2026 IPPS/LTCH PPS final rules for discussions regarding this provision, including our methodology for identifying which areas meet the definition of "frontier States" as provided for in section 1886(d)(3)(E)(iii)(II) of the Act: for FY 2011, 75 FR 50160 through 50161; for FY 2012, 76 FR 51793, 51795, and 51825; for FY 2013, 77 FR 53369 and 53370; for FY 2014, 78 FR 50590 to 50591; for FY 2015, 79 FR 49971; for FY 2016, 80 FR 49498; for FY 2017, 81 FR 56922; for FY 2018, 82 FR 38142; for FY 2019, 83 FR 41380; for FY 2020, 84 FR 42312; for FY 2021, 85 FR 58765; for FY 2022, 86 FR

45178; FY 2023, 87 FR 49006; FY 2024, 88 FR 58977; for FY 2025, 89 FR 69300; for FY 2026, 90 FR 36851, and for FY 2027, 91 FR 49806.

In addition to the changes required by the Affordable Care Act, we note that the proposed FY 2027 IPPS wage indexes continue to reflect a number of adjustments implemented in past years, including, but not limited to, an adjustment for occupational mix, reclassification of hospitals to different geographic areas, the rural floor provisions, the imputed floor wage index adjustment in all-urban States, an adjustment to the wage index based on commuting patterns of hospital employees (the out-migration adjustment), the 5 percent cap on any decrease to a hospital's wage index from its wage index in a prior FY, and the transitional payment exception for hospitals significantly impacted by the discontinuation of the low-wage index hospital policy. Beginning with FY 2024, we include hospitals with § 412.103 reclassification along with geographically rural hospitals in all rural wage index calculations, and we exclude "dual reclass" hospitals (hospitals with simultaneous § 412.103 and Medicare Geographic Classification Review Board (MGCRB) reclassifications) implicated by the hold harmless provision at section 1886(d)(8)(C)(ii) of the Act (88 FR 58971 through 58973). We refer readers to the FY 2027 IPPS/LTCH PPS proposed rule (91 FR 19459 through 19479) for a detailed discussion of all proposed changes to the FY 2027 IPPS wage indexes.

We note that in the FY 2023 IPPS/LTCH PPS final rule (87 FR 49018 through 49021), we finalized a permanent approach to smooth year-to-year decreases in hospitals' wage indexes. Specifically, for FY 2023 and subsequent years, we apply a 5 percent cap on any decrease to a hospital's wage index from its wage index in the prior FY, regardless of the circumstances causing the decline. That is, a hospital's wage index for FY 2027 would not be less than 95 percent of its final wage index for FY 2026. Except for newly opened hospitals, we apply the cap for a fiscal year using the final wage index applicable to the hospital on the last day of the prior fiscal year. A newly opened hospital would be paid the wage index for the area in which it is geographically located for its first full or partial fiscal year (subject to any reclassification),

and it would not receive a cap for that first year, because it would not have been assigned a wage index in the prior year (in accordance with 42 CFR 419.41(c)(1) and 419.43(c), as noted previously).

Consistent with the FY 2026 IPPS/LTCH PPS final rule (90 FR 36852 through 36854), we discontinued for CY 2026 and subsequent years the low-wage index hospital policy under the OPPS (90 FR 53495 through 53496). Under the low-wage index hospital policy that we previously adopted for the OPPS (84 FR 61186 through 61188), we increased the wage index for hospitals with a wage index value below the 25th percentile wage index value for a calendar year by half the difference between the otherwise applicable final wage index value for a year for that hospital and the 25th percentile wage index value for that year across all hospitals. We refer readers to the FY 2025 IFC (89 FR 80405 through 80421), FY 2026 IPPS/LTCH PPS final rule (90 FR 36852 through 36854) and CY 2026 OPPS/ASC final rule with comment period (90 FR 53495 through 53496) for a detailed discussion regarding the removal of the low-wage index hospital policy from the IPPS for FYs 2025 and 2026 and the OPPS for CY 2026.

Comment: A couple commenters supported the proposal to adopt the FY 2027 IPPS wage index post reclassification wages into the CY 2027 OPPS, and they also recommended that CMS continue to evaluate the impact of wage index changes across the IPPS and OPPS as well as potential refinements to the wage index to narrow geographic and rural-urban payment disparities in labor cost adjustments.

Response: We thank commenters for their support and note that we continue to review the wage index.

Comment: Several commenters opposed the proposal to adopt the IPPS wage index into the OPPS and requested that we evaluate the impact of the wage index on rural hospitals. Additionally, some commenters opposed the CY 2026 discontinuation of the low-wage index hospital policy, expressing concerns around the impact of the changes and urging CMS to restore the low-wage index policy in CY 2027 or develop a permanent alternative.

Response: We understand the commenters' concerns regarding the discontinuation of the low-wage index hospital policy for CY 2026. We continue to believe that it is appropriate for the IPPS wage index and the OPPS wage index to be aligned, which required discontinuation of the low-wage index policy in the OPPS for CY 2026. As initially explained in the September 8, 1998, OPPS/ASC proposed rule (63 FR 47576), we believe that using the IPPS wage index as the source of an adjustment factor for the OPPS is reasonable and logical, given the inseparable, subordinate status of the HOPD within the hospital overall. Finally, we note that we continue to review the impact of wage index changes on hospitals, and some of those impacts are included in the impact analysis in section XXVII. of this final rule with comment period as well as through the impact file made available online at *https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices*.

Comment: Multiple commenters supported CMS's policy to apply a 5 percent cap on any decrease to a hospital's wage index from its wage index in the prior FY. Commenters also requested that the proposed 5 percent cap policy be applied in a non-budget neutral manner.

Response: We appreciate the commenters' support of our policy to apply a 5 percent cap on any decrease to a hospital's wage index from its wage index in the prior FY. We stated in the FY 2023 IPPS/LTCH PPS final rule (87 FR 49021) that, under the IPPS, we apply the cap in a budget neutral manner through a national adjustment to the standardized amount each fiscal year. Specifically, we apply a budget neutrality adjustment to ensure that estimated aggregate payments under our wage index cap policy for hospitals that would have a decrease in their wage indexes for the upcoming fiscal year of more than 5 percent would equal what estimated aggregate payments would have been without the wage index cap policy. We have continued to apply a similar budget neutrality adjustment in the OPPS for each calendar year as well as in the CY 2027 OPPS proposed rule (91 FR 41763). For the OPPS, section 1833(t)(2)(D) of the Act requires the Secretary to determine a wage adjustment factor to adjust the portion of payment and coinsurance attributable to labor-related costs for relative differences in labor and labor-

related costs across geographic regions in a budget neutral manner, which is inconsistent with the commenters' request to exclude the wage index cap policy from budget neutrality.

After consideration of the public comments we received, we are finalizing our proposal without modification to use the FY 2027 IPPS post reclassified wage index for urban and rural areas as finalized in the FY 2027 IPPS final rule as the wage index for the OPPS. We are also finalizing our proposal without modification to apply a 5 percent cap on any decrease to a hospital's wage index from its wage index in the prior FY.

In the FY 2026 IPPS final rule (90 FR 36855 through 36857), using our authority under section 1886(d)(5)(I)(i) of the Act, we adopted a narrow transitional exception to the calculation of FY 2026 IPPS payments for low-wage index hospitals significantly impacted by the discontinuation of the low-wage index hospital policy. As indicated in that rule, we adopted this temporary payment exception "to mitigate short-term instability and payment fluctuations that can negatively impact hospitals consistent with principles of certainty and predictability under prospective payment systems." To address these same concerns under the OPPS, we correspondingly adopted a transitional payment exception for CY 2026 under the OPPS using our equitable adjustment authority under section 1833(t)(2)(E) of the Act (90 FR 53496 through 53497). This authority allows the Secretary to establish, in a budget neutral manner, adjustments as determined to be necessary to ensure equitable payments.

The CY 2026 transitional exception policy under the OPPS applied to hospitals that benefited from the CY 2024 low-wage index hospital policy. For those hospitals, we compared the hospital's proposed CY 2026 wage index to the hospital's CY 2024 wage index. If the hospital was significantly impacted by the discontinuation of the low-wage index hospital policy, meaning the hospital's proposed CY 2026 wage index was decreasing by more than 9.75 percent from the hospital's CY 2024 wage index, then the transitional payment exception for CY 2026 for that hospital was equal to the additional CY 2026 amount the hospital would be paid under the OPPS if its CY 2026 wage index were equal to 90.25 percent of its CY 2024 wage index.

This transitional payment exception was applied after the application of the 5 percent cap described at 42 CFR 412.64(h)(7). This policy was budget neutral under the OPPS through the second wage index budget neutrality adjustment applied to the OPPS conversion factor (which currently includes the 5 percent cap on wage index decreases policy).

In the FY 2027 IPPS/LTCH proposed rule (91 FR 19476 through 19478) we proposed, using our authority under section 1886(d)(5)(I)(i) of the Act, to continue to apply the narrow transitional payment exception to the calculation of FY 2027 IPPS payments for low-wage index hospitals significantly impacted by the discontinuation of the low-wage index hospital policy that we adopted in CY 2026. As indicated in that rule, we proposed to continue this temporary payment exception because "[s]ome hospitals that previously benefitted from the low-wage index hospital policy would continue to experience decreases of approximately 5 percent or more per year from their FY 2024 wage index (with the low-wage index hospital policy applied)" (91 FR 19477). To address these same concerns under the OPPS, we correspondingly proposed to continue the transitional payment exception for CY 2027 under the OPPS that we adopted in CY 2026 using our equitable adjustment authority under section 1833(t)(2)(E) of the Act (91 FR 41767).

Comment: Several commenters supported CMS's proposal to establish a transitional payment exception for CY 2027. Commenters also requested that the proposed transitional payment exception be applied in a non-budget neutral manner.

Response: We appreciate the commenters' support of our policy to establish a transitional payment exception for CY 2027. For the OPPS, section 1833(t)(2)(D) of the Act requires the Secretary to determine a wage adjustment factor to adjust the portion of payment and coinsurance attributable to labor-related costs for relative differences in labor and labor-related costs across geographic regions in a budget neutral manner. In addition, section 1833(t)(2)(E) of the Act requires adjustments under that provision to be established in a budget neutral manner. Commenters' request to exclude the proposed transitional payment exception

from budget neutrality is inconsistent with the budget neutrality requirement under 1833(t)(2)(D) and (E) of the Act.

Comment: A commenter requested specific detail on the calculation for how the transitional exception would apply under the CY 2027 OPPS. That commenter also requested that the budget neutrality for the transitional exception only apply to hospitals at or above the 75th percentile of wage indexes.

Response: With regard to the calculation of the transitional exception policy under the CY 2027 OPPS, it would mirror the calculation for the policy under the FY 2027 IPPS. That is, for hospitals that benefitted from the low-wage index policy in CY 2024, if their CY 2027 wage index decreased by more than 14.2625 percent from the hospital's CY 2024 wage index, then its CY 2027 transitional payment exception would be equal to the additional CY 2027 amount the hospital would be paid under the OPPS if its CY 2027 wage index were equal to 85.7375 percent of its CY 2024 wage index (91 FR 49808). This narrow transitional payment exception would be applied after the application of the 5 percent cap described at 42 CFR 412.64(h)(7). Similar to the policy in the CY 2026 OPPS, we proposed to make this policy budget neutral under the OPPS through the second wage index budget neutrality adjustment applied to the OPPS conversion factor, which currently includes the 5 percent cap on wage index decreases policy (91 FR 41767).

While we recognize the commenter's concern regarding the impact that wage index budget neutrality has with regard to payments through the rest of the OPPS, we do not believe that it is appropriate to budget neutralize specifically for hospitals with wage indexes above the 75th percentile. Developing wage index budget neutrality in this manner would result in different wage indexes between the IPPS and OPPS, and as discussed throughout this section, we believe it is important to maintain alignment of the IPPS and OPPS wage indexes.

After consideration of the public comments we received, we are finalizing our proposal without modification to adopt a transitional payment exception for CY 2027 under the OPPS using our equitable adjustment authority under section 1833(t)(2)(E) of the Act.

Core Based Statistical Areas (CBSAs) are made up of one or more constituent counties. Each CBSA and constituent county has its own unique identifying codes. The FY 2018 IPPS/LTCH PPS final rule (82 FR 38130) discussed the two different lists of codes to identify counties: Social Security Administration (SSA) codes and Federal Information Processing Standard (FIPS) codes. Historically, CMS listed and used SSA and FIPS county codes to identify and crosswalk counties to CBSA codes for purposes of the IPPS and OPPS wage indexes. However, the SSA county codes are no longer being maintained and updated, although the FIPS codes continue to be maintained by the U.S. Census Bureau. The Census Bureau's most current statistical area information is derived from ongoing census data received since 2010; the most recent data are from 2015. The Census Bureau maintains a complete list of changes to counties or county equivalent entities on the website at *https://www.census.gov/programs-surveys/geography/technical-documentation/county-changes.html*. In the FY 2018 IPPS/LTCH PPS final rule (82 FR 38130), for purposes of crosswalking counties to CBSAs for the IPPS wage index, we finalized our proposal to discontinue the use of the SSA county codes and begin using only the FIPS county codes. Similarly, for the purposes of crosswalking counties to CBSAs for the OPPS wage index, in the CY 2018 OPPS/ASC final rule with comment period (82 FR 59260), we finalized our proposal to discontinue the use of SSA county codes and begin using only the FIPS county codes. For CY 2027, under the OPPS, we are continuing to use only the FIPS county codes for purposes of crosswalking counties to CBSAs (91 FR 41768).

We proposed to use the FY 2027 IPPS post-reclassified wage index for urban and rural areas as the wage index for the OPPS to determine the wage adjustments for both the OPPS payment rate and the copayment rate for CY 2027. Therefore, any policies and adjustments that are finalized for the FY 2027 IPPS post-reclassified wage index would be reflected in the final

CY 2027 OPPS wage index beginning on January 1, 2027, if appropriate (91 FR 41768). We refer readers to the FY 2027 IPPS/LTCH PPS proposed rule (91 FR 19459 through 19479) and the proposed FY 2027 hospital wage index files posted on the CMS website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2027-ipps-proposed-rule-home-page.*

Regarding budget neutrality for the CY 2027 OPPS wage index, we refer readers to section II.C. of this final rule with comment period. We continue to believe that using the IPPS post-reclassified wage index as the source of an adjustment factor for the OPPS is reasonable and logical, given the inseparable, subordinate status of the HOPD within the hospital overall.

Hospitals that are paid under the OPPS, but not under the IPPS, do not have an assigned hospital wage index under the IPPS. Therefore, for non-IPPS hospitals paid under the OPPS, it is our longstanding (65 FR 18495 through 18498) policy to assign the wage index that would be applicable if the hospital was paid under the IPPS, based on its geographic location and any applicable wage index policies and adjustments. We proposed to continue this policy for CY 2027 (91 FR 41768). We refer readers to the FY 2027 IPPS/LTCH PPS proposed rule (91 FR 19459 through 19479) for a detailed discussion of the proposed changes to the FY 2027 IPPS wage indexes.

It has been our longstanding policy to allow non-IPPS hospitals paid under the OPPS to qualify for the out-migration adjustment if they are located in a "section 505 out-migration county" (that is, a county identified under section 505 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173)). Applying this adjustment is consistent with our policy of adopting IPPS wage index policies for hospitals paid under the OPPS. We note that, because non-IPPS hospitals cannot reclassify, they are eligible for the out-migration wage index adjustment if they are located in a section 505 out-migration county. This is the same out-migration adjustment policy that would apply if the hospital were paid under the IPPS. For CY 2027, we proposed to continue our policy of allowing non-IPPS

hospitals paid under the OPPS to qualify for the out-migration adjustment if they are located in a section 505 out-migration county (section 505 of the MMA) (88 FR 49585 through 49586). Furthermore, we proposed that the wage index that would apply for CY 2027 to non-IPPS hospitals paid under the OPPS would continue to include the rural floor adjustment and any other policies and adjustments applied to the IPPS wage index. In addition, we proposed that the wage index that would apply to non-IPPS hospitals paid under the OPPS would include the 5 percent cap on wage index decreases and the previously described proposed transitional payment exception for hospitals significantly impacted by the discontinuation of the low-wage index hospital policy.

For CMHCs, for CY 2027, we proposed to continue to calculate the wage index by using the post-reclassification IPPS wage index based on the CBSA where the CMHC is located. Furthermore, we proposed that the wage index that would apply to a CMHC for CY 2027 would continue to include the rural floor adjustment and any other policies and adjustments applied to the IPPS wage index. In addition, the wage index that would apply to CMHCs would include the 5 percent cap on wage index decreases and proposed transitional exception. Also, we proposed that the wage index that would apply to CMHCs would not include the out-migration adjustment because that adjustment only applies to hospitals (91 FR 41768).

We did not receive any public comments on these proposals, and, therefore, we are finalizing our proposals regarding CMHC wage index calculations without modification.

Table 4A associated with the FY 2027 IPPS/LTCH PPS final rule (available via the internet on the CMS website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2027-ipps-final-rule-home-page*) identifies counties that would be eligible for the out-migration adjustment. Table 2 associated with the FY 2027 IPPS/LTCH PPS final rule (available for download via the website noted previously) identifies IPPS hospitals that would receive the out-migration adjustment for FY 2027. We are including the out-migration adjustment information from Table 2 associated with the FY 2027 IPPS/LTCH PPS final rule as

Addendum L to this final rule with comment period, with the addition of non-IPPS hospitals that would receive the section 505 out-migration adjustment under this final rule with comment period. Addendum L is available via the internet on the CMS website. We refer readers to the CMS website for the OPPS at *https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices.* At this link, readers will find a link to the final FY 2027 IPPS wage index tables and Addendum L, associated with this final rule with comment period.

D. Final Statewide Average Default Cost-to-Charge Ratios (CCRs)

In addition to using CCRs to estimate costs from charges on claims for ratesetting, we use overall hospital-specific CCRs calculated from the hospital's most recent cost report (OMB control number 0938-0050 for Form CMS–2552–10) to determine outlier payments, payments for pass-through devices, and monthly interim transitional corridor payments under the OPPS during the PPS year. For certain hospitals, under the regulations at 42 CFR 419.43(d)(5)(iii), we use the statewide average CCRs to determine the payments mentioned earlier if it is not possible to determine an accurate CCR for a hospital in certain circumstances. This includes new hospitals, defined for this purpose as entities that have not accepted assignment of an existing hospital's provider agreement, and hospitals that have not yet submitted a cost report. We also use the statewide average default CCRs to determine payments for hospitals whose CCR falls outside the predetermined ceiling threshold for a valid CCR or for hospitals in which the most recent cost report reflects an all-inclusive rate status (Medicare Claims Processing Manual (Pub. 100-04), Chapter 4, Section 10.11).

We discussed our policy for using statewide average CCRs (also referred to as statewide average default CCRs), including setting the ceiling threshold for a valid CCR, in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68594 through 68599) in the context of our adoption of an outlier reconciliation policy for cost reports beginning on or after January 1, 2009. For details on our process for calculating the statewide average CCRs, we refer readers to the

Claims Accounting Narrative for this final rule with comment period, which is posted on the CMS website. We proposed to calculate the default ratios for CY 2027 using the most recent cost report data (91 FR 41769).

We did not receive any public comments on our proposal, and, therefore, we are finalizing our proposal without modification to calculate the default ratios for CY 2027 using the most recent cost report data, which are from a June 2026 HCRIS cost report extract.

The statewide average CCRs are available on our website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices*; click on the link on the left of the page titled ‘‘Annual Policy Files’’ and then select the relevant year to download the statewide CCRs and upper limits in the ‘‘Downloads’’ section of the web page.

E. Adjustment for Rural Sole Community Hospitals (SCHs) and Essential Access Community Hospitals (EACHs) under Section 1833(t)(13)(B) of the Act for CY 2027

In the CY 2006 OPPS final rule with comment period (70 FR 68556), we finalized a payment increase for rural sole community hospitals (SCHs) of 7.1 percent for all services and procedures paid under the OPPS, excluding separately payable drugs and biologicals, brachytherapy sources, items paid at charges reduced to costs, and devices paid under the pass-through payment policy, in accordance with section 1833(t)(13)(B) of the Act, as added by section 411 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173). Section 1833(t)(13) of the Act provides the Secretary the authority to make an adjustment to OPPS payments for rural hospitals, effective January 1, 2006, if justified by a study of the difference in costs by APC between hospitals in rural areas and hospitals in urban areas. Our analysis showed a difference in costs for rural SCHs. Therefore, for the CY 2006 OPPS, we finalized a payment adjustment for rural SCHs of 7.1 percent for all services and procedures paid under the OPPS, excluding separately payable drugs and biologicals, brachytherapy sources, items paid at charges reduced to costs, and devices paid under the pass-through payment policy, in accordance with section 1833(t)(13)(B) of the Act.

In the CY 2007 OPPS/ASC final rule with comment period (71 FR 68010 and 68227), for purposes of receiving this rural adjustment, we revised our regulations at § 419.43(g) to clarify that essential access community hospitals (EACHs) are also eligible to receive the rural SCH adjustment, assuming these entities otherwise meet the rural adjustment criteria. Currently, two hospitals are classified as EACHs, and as of CY 1998, under section 4201(c) of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105-33), a hospital can no longer become newly classified as an EACH.

This adjustment for rural SCHs is budget neutral and applied before calculating outlier payments and copayments. We stated in the CY 2006 OPPS final rule with comment period (70 FR 68560) that we would not reestablish the adjustment amount on an annual basis, but we

may review the adjustment in the future and, if appropriate, would revise the adjustment. As detailed in the CY 2026 OPPS/ASC final rule with comment period (90 FR 53499), we provided the same 7.1 percent adjustment to rural SCHs, including EACHs, again in CYs 2008 through 2026.

For CY 2027, we proposed to continue the current policy of a 7.1 percent payment adjustment for rural SCHs, including EACHs, for all services and procedures paid under the OPPS, excluding separately payable drugs and biologicals, brachytherapy sources, items paid at charges reduced to costs, and devices paid under the pass-through payment policy, applied in a budget neutral manner (91 FR 41769).

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: Multiple commenters supported our proposal to continue to apply the 7.1 percent payment adjustment for rural SCHs and EACHs in CY 2027.

Response: We thank the commenters for their support of our proposal.

Comment: Several commenters recommended extending the 7.1 percent payment adjustment to all SCHs, including urban SCHs, and conducting a study to determine if a similar adjustment is appropriate for Medicare dependent hospitals (MDHs); and one commenter requested a similar payment adjustment under OPPS for rural hospitals that are not SCHs.

Response: We note that our authority for an adjustment under section 1833(t)(13)(B) of the Act only applies to rural hospitals, so we would not have authority to expand the types of hospitals eligible for the payment adjustment to non-rural hospitals. With respect to rural hospitals that are not SCHs, we did not separately study this specific group during the CY 2027 rule cycle. However, the original study under section 1833(t)(13)(A) of the Act examined cost differences by APC for broader categories of rural hospitals and identified a significant difference only for rural SCHs. We will consider whether such a study is appropriate for future rulemaking.

After consideration of these public comments, we are finalizing our proposal, without modification, to continue our current policy of utilizing a budget neutral 7.1 percent payment adjustment for rural SCHs, including EACHs, for all services and procedures paid under the OPPS, excluding separately payable drugs and biologicals, brachytherapy sources, devices paid under the pass-through payment policy, and items paid at charges reduced to costs (91 FR 41769).

F. Payment Adjustment for Certain Cancer Hospitals for CY 2027

1. Background

Since the inception of the OPPS, which was authorized by the BBA, Medicare has paid the 11 hospitals that meet the criteria for cancer hospitals identified in section 1886(d)(1)(B)(v) of the Act under the OPPS for covered outpatient department services. These cancer hospitals are exempted from payment under the IPPS. With the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 (Pub. L. 106-113), Congress added section 1833(t)(7) of the Act, "Transitional Adjustment to Limit Decline in Payment," which requires the Secretary to determine OPPS payments to cancer and children's hospitals based on their pre-BBA payment amount (these hospitals are often referred to under this policy as "held harmless" and their payments are often referred to as "hold harmless" payments).

As required under section 1833(t)(7)(D)(ii) of the Act, a cancer hospital receives the full amount of the difference between payments for covered outpatient department services under the OPPS and a "pre-BBA amount." That is, cancer hospitals are permanently held harmless to their "pre-BBA amount," and they receive transitional outpatient payments (TOPs) or hold harmless payments to ensure that they do not receive a payment that is lower in amount under the OPPS than the payment amount they would have received before implementation of the OPPS, as set forth in section 1833(t)(7)(F) of the Act. The "pre-BBA amount" is the product of the hospital's reasonable costs for covered outpatient department services occurring in the current year and the base payment-to-cost ratio (PCR) for the hospital defined in section 1833(t)(7)(F)(ii) of the Act.

The "pre-BBA amount" and the determination of the base PCR are defined at § 419.70(f). TOPs are calculated on Worksheet E, Part B, of the Hospital Cost Report or the Hospital Health Care Complex Cost Report (Form CMS–2552–96 or Form CMS–2552–10 (OMB No. 0938-0050), respectively), as applicable each year. Section 1833(t)(7)(I) of the Act exempts TOPs from budget neutrality calculations.

Section 3138 of the Patient Protection and Affordable Care Act (Pub. L. 111-148) amended section 1833(t) of the Act by adding a new paragraph (18), which instructs the Secretary to conduct a study to determine if, under the OPPS, outpatient costs incurred by cancer hospitals described in section 1886(d)(1)(B)(v) of the Act with respect to APC groups exceed outpatient costs incurred by other hospitals furnishing services under section 1833(t) of the Act, as determined appropriate by the Secretary. Section 1833(t)(18)(A) of the Act requires the Secretary to take into consideration the cost of drugs and biologicals incurred by cancer hospitals and other hospitals. Section 1833(t)(18)(B) of the Act provides that, if the Secretary determines that cancer hospitals' costs are higher than those of other hospitals, the Secretary shall provide an appropriate adjustment under section 1833(t)(2)(E) of the Act to reflect these higher costs. In 2011, after conducting the study required by section 1833(t)(18)(A) of the Act, we determined that outpatient costs incurred by the 11 specified cancer hospitals were greater than the costs incurred by other OPPS hospitals. For a complete discussion regarding the cancer hospital cost study, we refer readers to the CY 2012 OPPS/ASC final rule with comment period (76 FR 74200 through 74201).

Based on these findings, we finalized a policy to provide a payment adjustment to the 11 specified cancer hospitals that reflects their higher outpatient costs, as discussed in the CY 2012 OPPS/ASC final rule with comment period (76 FR 74202 through 74206). Specifically, we adopted a policy to provide additional payments to the cancer hospitals so that each cancer hospital's final PCR for services provided in a given calendar year is equal to the weighted average PCR (which we refer to as the "target PCR") for other hospitals paid under the

OPPS. The target PCR is set in advance of the calendar year and is calculated using the most recently submitted or settled cost report data that are available at the time of final rulemaking for the calendar year. The amount of the payment adjustment is made on an aggregate basis at cost report settlement. We note that the changes made by section 1833(t)(18) of the Act do not affect the existing statutory provisions that provide for TOPs for cancer hospitals. The TOPs are assessed, as usual, after all payments, including the cancer hospital payment adjustment, have been made for a cost reporting period. Table 9 displays the target PCR for purposes of the cancer hospital adjustment for CY 2012 through CY 2026.

TABLE 9: CANCER HOSPITAL ADJUSTMENT TARGET PAYMENT-TO-COST RATIOS (PCRS), CY 2012 THROUGH CY 2026

Calendar Year	Target PCR
2012	0.91
2013	0.91
2014	0.90
2015	0.90
2016	0.92
2017	0.91
2018	0.88
2019	0.88
2020	0.89
2021	0.89
2022	0.89
2023	0.89
2024	0.88
2025	0.87
2026	0.87

2. Policy for CY 2027

Section 16002(b) of the 21st Century Cures Act (Pub. L. 114-255) amended section 1833(t)(18) of the Act by adding subparagraph (C), which requires that in applying § 419.43(i) (that is, the payment adjustment for certain cancer hospitals) for services furnished on or after January 1, 2018, the Secretary shall use a target PCR that is 1.0 percentage point less than the target PCR that would otherwise apply. Section 16002(b) of the 21st Century Cures Act also provides that, in addition to the percentage reduction, the Secretary may consider making an additional percentage point reduction to the target PCR that takes into account payment rates for applicable items and services described under section 1833(t)(21)(C) of the Act for hospitals that

are not cancer hospitals described under section 1886(d)(1)(B)(v) of the Act. Further, in making any budget neutrality adjustment under section 1833(t) of the Act, section 16002(b) of the 21st Century Cures Act provides that the Secretary shall not consider the reduced expenditures that result from application of section 1833(t)(18)(C) of the Act.

We proposed to provide additional payments to the 11 specified cancer hospitals so that each cancer hospital's proposed PCR is equal to the weighted average PCR (or "target PCR") for the other OPPS hospitals, generally using the most recent submitted or settled cost report data that are available, reduced by 1.0 percentage point, to comply with section 16002(b) of the 21st Century Cures Act (91 FR 41770). As discussed further later in this section of the preamble, we did not propose an additional reduction beyond the 1.0 percentage point reduction required by section 16002(b) of the 21st Century Cures Act for CY 2027.

To calculate the proposed CY 2027 target PCR, we proposed to use the same extract of cost report data from HCRIS used to estimate costs for the CY 2027 OPPS which, in most cases, would be the most recently available hospital cost reports (91 FR 41770). Using these cost report data, we included data from Worksheet E, Part B, for each hospital, using data from each hospital's most recent cost report, whether as submitted or settled.

We then limited the dataset to the hospitals with CY 2025 claims data that we used to model the impact of the proposed CY 2027 APC relative payment weights (3,374 hospitals) because we believe it is appropriate to use the same set of hospitals that are being used to calibrate the modeled CY 2027 OPPS. The cost report data for the hospitals in this dataset were from cost report periods with fiscal year ends ranging from 2023 to 2025; however, the cost reporting periods were predominantly from fiscal years ending in 2024 and 2025 (91 FR 41770). We then removed the cost report data of the 50 hospitals located in Puerto Rico from our dataset because we did not believe their cost structure reflected the costs of most hospitals paid under the OPPS, and, therefore, their inclusion may bias the calculation of hospital-weighted statistics. We also removed the cost report data of nine hospitals because these hospitals had cost report data

that were not complete (missing aggregate OPPS payments, missing aggregate cost data, or missing both), so that all cost reports in the study would have both the payment and cost data necessary to calculate a PCR for each hospital, leading to a proposed analytic file of 3,315 hospitals with cost report data (91 FR 41771).

Using this smaller dataset of cost report data, we estimated that, on average, the OPPS payments to other hospitals furnishing services under the OPPS were approximately 89 percent of reasonable cost (weighted average PCR of 0.89). Therefore, after applying the 1.0 percentage point reduction, as required by section 16002(b) of the 21st Century Cures Act, using our standard process the payment amount associated with the cancer hospital payment adjustment to be determined at cost report settlement would be the additional payment needed to result in a proposed target PCR equal to 0.88 for each cancer hospital (91 FR 41771).

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: Many commenters supported our cancer hospital payment adjustment methodology and our proposed target PCR of 0.88. Some commenters also recommended we reinstate our gradual transition policy in the future if changes in the underlying data yield a target PCR change of greater than 1 percentage point.

Response: We thank the commenters for their support of our cancer hospital payment methodology. With respect to their recommendation to reinstate the transition policy we finalized in the CY 2024 OPPS/ASC final rule with comment period (88 FR 81586 through 81589) for CYs 2024 and 2025, we did not propose such a policy but may take this comment into consideration in future rulemaking.

After consideration of public comments, we are finalizing without modification our proposal to calculate the target PCR based on our longstanding target PCR calculation methodology described in this final rule with comment period and then apply the 1.0 percentage point reduction as required by section 16002(b) of the 21st Century Cures Act. For this final rule

with comment period, we are using the most recent cost report data through June 30, 2026 to update the adjustment. We limited the dataset to hospitals with CY 2025 claims data that we used to model the impact of the CY 2027 APC relative payment weights (3,387 hospitals) because we believe it is appropriate to use the same set of hospitals that are being used to calibrate the modeled CY 2027 OPPS. The cost report data for the hospitals in this dataset were from cost report periods with fiscal year ends ranging from 2023 to 2025; however, the cost reporting periods were predominantly from fiscal years ending in 2024 and 2025. We then removed the cost report data of the 50 hospitals located in Puerto Rico from our dataset because we did not believe their cost structure reflected the costs of most hospitals paid under the OPPS, and, therefore, their inclusion may bias the calculation of hospital-weighted statistics. We also removed the cost report data of 10 hospitals because these hospitals had cost report data that were not complete (missing aggregate OPPS payments, missing aggregate cost data, or missing both), so that all cost reports in the study would have both the payment and cost data necessary to calculate a PCR for each hospital, leading to a proposed analytic file of 3,327 hospitals with cost report data.

Using this smaller dataset of cost report data, we estimated that, on average, the OPPS payments to other hospitals furnishing services under the OPPS were approximately 89 percent of reasonable cost (weighted average PCR of 0.89). Therefore, after applying the 1.0 percentage point reduction, as required by section 16002(b) of the 21st Century Cures Act, using our standard process the payment amount associated with the cancer hospital payment adjustment to be determined at cost report settlement would be the additional payment needed to result in a final target PCR equal to 0.88 for each cancer hospital.

Table 10 shows the estimated percentage increase in OPPS payments to each cancer hospital for CY 2027, due to the cancer hospital payment adjustment policy. The actual, final amount of the CY 2027 cancer hospital payment adjustment for each cancer hospital will be determined at cost report settlement and will depend on each hospital's CY 2027 payments and

costs from the settled CY 2027 cost report. We note that the requirements contained in section 1833(t)(18) of the Act do not affect the existing statutory provisions that provide for TOPs for cancer hospitals. The TOPs will be assessed, as usual, after all payments, including the cancer hospital payment adjustment, have been made for a cost reporting period.

TABLE 10: ESTIMATED CY 2027 HOSPITAL-SPECIFIC PAYMENT ADJUSTMENT FOR CANCER HOSPITALS TO BE PROVIDED AT COST REPORT SETTLEMENT

Provider Number	Hospital Name	Estimated Percentage Increase in OPPS Payments for CY 2027 due to Payment Adjustment
050146	City of Hope Comprehensive Cancer Center	35.2%
050660	USC Norris Cancer Hospital	19.8%
100079	Sylvester Comprehensive Cancer Center	31.3%
100271	H. Lee Moffitt Cancer Center & Research Institute	16.3%
220162	Dana-Farber Cancer Institute	45.4%
330154	Memorial Sloan-Kettering Cancer Center	39.5%
330354	Roswell Park Cancer Institute	7.8%
360242	James Cancer Hospital & Solove Research Institute	27.1%
390196	Fox Chase Cancer Center	5.3%
450076	M.D. Anderson Cancer Center	52.9%
500138	Seattle Cancer Care Alliance	41.8%

G. Hospital Outpatient Outlier Payments

1. Background

The OPPS provides outlier payments to hospitals to help mitigate the financial risk associated with high-cost and complex procedures, where a very costly service could present a hospital with significant financial loss. As explained in the CY 2015 OPPS/ASC final rule with comment period (79 FR 66832 through 66834), we set our projected target for aggregate outlier payments at 1.0 percent of the estimated aggregate total payments under the OPPS for the prospective year. Outlier payments are provided on a service-by-service basis when the cost of a service exceeds the APC payment amount multiplier threshold (the APC payment amount multiplied by a certain amount) as well as the APC payment amount plus a fixed-dollar amount threshold (the APC payment plus a certain dollar amount). In CY 2026, the outlier threshold was met when the hospital's cost of furnishing a service exceeded 1.75 times the APC payment

amount (the multiplier threshold) and exceeded the APC payment amount plus $6,225 (the fixed-dollar amount threshold) (90 FR 53502 through 53504). If the hospital's cost of furnishing a service exceeds both the multiplier threshold and the fixed-dollar threshold, the outlier payment is calculated as 50 percent of the amount by which the hospital's cost of furnishing the service exceeds 1.75 times the APC payment amount. Beginning with CY 2009 payments, outlier payments are subject to a reconciliation process similar to the IPPS outlier reconciliation process for cost reports, as discussed in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68594 through 68599).

It has been our policy to report the actual amount of outlier payments as a percent of total spending in the claims being used to model the OPPS. Our estimate of total outlier payments as a percent of total CY 2025 OPPS payments, using CY 2025 claims available for the CY 2027 OPPS/ASC proposed rule (91 FR 41772) was approximately 0.93 percent of the total aggregate OPPS payments. Using an updated claims dataset for this final rule with comment period, we estimate that we paid approximately 0.88 percent of the total aggregated OPPS payments in outliers for CY 2025. Therefore, for CY 2025, we estimate that we did not meet the outlier target by 0.12 percent of total aggregated OPPS payments.

For the CY 2027 OPPS/ASC proposed, using CY 2025 claims data and CY 2026 payment rates, we estimated that the aggregate outlier payments for CY 2026 would be approximately 1.21 percent of the total CY 2026 OPPS payments (91 FR 41772). We provided estimated CY 2027 outlier payments for hospitals and CMHCs with claims included in the claims data that we used to model impacts in the Hospital–Specific Impacts - Provider-Specific Data file on the CMS website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient.*

2. Outlier Calculation for CY 2027

For CY 2027, we proposed to continue our policy of estimating outlier payments to be 1.0 percent of the estimated aggregate total payments under the OPPS. We proposed that a

portion of that 1.0 percent, an amount equal to less than 0.01 percent of outlier payments (or 0.0001 percent of total OPPS payments), would be allocated to CMHCs for partial hospitalization program (PHP) and intensive outpatient program (IOP) outlier payments (91 FR 41772). This is the amount of estimated outlier payments that would result from the proposed CMHC outlier threshold as a proportion of total estimated OPPS outlier payments. We proposed to continue our outlier policy that if a CMHC's cost for PHP and IOP services exceeds 3.40 times the APC payment rate, the outlier payment would be calculated as 50 percent of the amount by which the cost exceeds 3.40 times the proposed APC payment rate (91 FR 41772).

For further discussion of CMHC outlier payments, we refer readers to section VIII.C. of this final rule with comment period.

To ensure that the estimated CY 2027 aggregate outlier payments would equal 1.0 percent of estimated aggregate total payments under the OPPS, we proposed that the hospital outlier threshold be set so that outlier payments would be triggered when a hospital's cost of furnishing a service exceeds 1.75 times the APC payment amount and exceeds the APC payment amount plus the fixed-dollar threshold (91 FR 41772).

We calculated the proposed fixed-dollar threshold using the standard methodology most recently used for CY 2026 (90 FR 53502 through 53504). For purposes of estimating outlier payments for CY 2027, we used the hospital-specific overall ancillary CCRs available in the April 2026 update to the Outpatient Provider-Specific File (OPSF). The OPSF contains provider-specific data, such as the most current CCRs, which are maintained by the MACs and used by the OPPS Pricer to pay claims. The claims that we generally use to model each OPPS update lag by 2 years.

To estimate CY 2027 hospital outlier payments, we inflated the charges on the CY 2025 claims using the same proposed charge inflation factor of 1.15154 that we used to estimate the IPPS fixed-loss cost threshold for the FY 2027 IPPS/LTCH PPS proposed rule (91 FR 19807 through 19809). We used an inflation factor of 1.07310 to estimate CY 2026 charges from the

CY 2025 charges reported on CY 2025 claims before applying CY 2026 CCRs to estimate the percent of outliers paid in CY 2026. The proposed methodology for determining these charge inflation factors is discussed in the FY 2027 IPPS/LTCH PPS proposed rule (91 FR 19807 through 19809). As we stated in the CY 2005 OPPS final rule with comment period (69 FR 65844 through 65846), we believe that the use of the same charge inflation factors is appropriate for the OPPS because, with the exception of the inpatient routine service cost centers, hospitals use the same ancillary and cost centers to capture costs and charges for inpatient and outpatient services.

As noted in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68011), we were concerned that we could systematically overestimate the OPPS hospital outlier threshold if we did not apply a CCR inflation adjustment factor. Therefore, we proposed to apply the same CCR adjustment factor that we proposed to apply for the FY 2027 IPPS outlier calculation to the CCRs used to simulate CY 2027 OPPS outlier payments to determine the fixed-dollar threshold. Specifically, for CY 2027, we proposed to apply an adjustment factor of 0.977497 to the CCRs that were in the April 2026 OPSF to trend them forward from CY 2026 to CY 2027 (91 FR 41772). The methodology for calculating the proposed CCR adjustment factor is discussed in the FY 2027 IPPS/LTCH PPS proposed rule (91 FR 19807 through 19809).

To model hospital outlier payments for this CY 2027 OPPS/ASC proposed rule, we applied the overall CCRs from the April 2026 OPSF after adjustment (using the proposed CCR inflation adjustment factor of 0.977497 to approximate CY 2027 CCRs) to charges on CY 2025 claims that were adjusted (using the proposed charge inflation factor of 1.15154 to approximate CY 2027 charges). We simulated aggregated CY 2027 hospital outlier payments using these costs for several different fixed-dollar thresholds, holding the 1.75 multiplier threshold constant and assuming that outlier payments would continue to be made at 50 percent of the amount by which the cost of furnishing the service would exceed 1.75 times the APC payment amount, until the total outlier payments equaled 1.0 percent of aggregated estimated total CY 2027 OPPS

payments. We estimate that a proposed fixed dollar- threshold of $7,100 combined with the proposed multiplier threshold of 1.75 times the APC payment rate, would allocate 1.0 percent of aggregated total OPPS payments to outlier payments for CY 2027. For CMHCs, we proposed that, if a CMHC's cost for partial hospitalization or intensive outpatient services exceeds 3.40 times the APC payment rate, the outlier payment would be calculated as 50 percent of the amount by which the cost exceeds 3.40 times the APC payment rate (91 FR 41772).

Section 1833(t)(17)(A) of the Act, which applies to hospitals, as defined under section 1886(d)(1)(B) of the Act, requires that hospitals that fail to report data required for the quality measures selected by the Secretary, in the form and manner required by the Secretary under section 1833(t)(17)(B) of the Act, incur a 2.0 percentage point reduction to their OPD fee schedule increase factor—that is, the annual payment update factor. The application of a reduced OPD fee schedule increase factor results in reduced national unadjusted payment rates that would apply to certain outpatient items and services furnished by hospitals that are required to report outpatient quality data and that fail to meet the Hospital Outpatient Quality Reporting (OQR) Program requirements. For hospitals that fail to meet the Hospital OQR Program requirements, we proposed to continue the policy that we implemented in CY 2010 that the hospitals' costs would be compared to the reduced payments for purposes of outlier eligibility and payment calculation (91 FR 41772). For more information on the Hospital OQR Program, we refer readers to section XV. of this final rule with comment period.

We received public comments on these proposals. The following is a summary of the comments we received and our response.

Comment: Commenters expressed concern regarding the proposed increase in the fixed-dollar loss threshold from $6,225 in CY 2026 to the proposed fixed-dollar loss threshold of $7,100 for CY 2027. Commenters were concerned that fewer cases would qualify for outlier payments under the increased threshold and recommended we freeze the CY 2026 fixed-dollar threshold for CY 2027. One commenter recommended we evaluate alternative trend factors for

determining charge inflation in a prospective year, such as a multi-year rolling average charge inflation factor or the hospital market basket update.

Response: We understand the commenters' concerns; however, we believe our current methodology, which allocates 1.0 percent of total OPPS spending to outlier payments, helps mitigate the financial risk to hospitals posed by high-cost cases. We do not believe an increase beyond 1.0 percent would be appropriate at this time as it would reduce OPPS payment rates by shifting dollars from standard OPPS APC payments to outlier OPPS payments under budget neutrality. Additionally, we do not believe using the CY 2026 fixed-dollar loss threshold of $6,225 would be appropriate as well as our modeling suggests we would exceed our 1.0 percent target and such excess expenditures would require recoupment in future ratesetting. As previously discussed, CY 2025 OPPS outlier payments were approximately 0.88 percent of total CY 2025 OPPS spending. Therefore, we believe the overall methodology (including using the most recent charge inflation factor) for calculating prospective OPPS outlier payments yields a high degree of accuracy, but we will take the commenters' suggestions into consideration to analyze and evaluate our existing methodology for calculating the OPPS outlier fixed-dollar loss for potential refinement in the future.

After consideration of public comments, we are finalizing our proposal, without modification, to continue our policy of estimating outlier payments to be 1.0 percent of the estimated aggregate total payments under the OPPS and to use our established methodology to set the OPPS outlier fixed-dollar loss threshold for CY 2027.

3. Final Outlier Calculation for CY 2027

Consistent with historical practice, we used updated data for this final rule with comment period for outlier calculations. For CY 2027, we are applying the overall ancillary CCRs from the July 2026 OPSF file after adjustment (using the CCR adjustment factor of 0.971037 to approximate CY 2027 CCRs) to charges on CY 2025 claims that were adjusted using a charge inflation factor of 1.15064 to approximate CY 2027 charges. These are the same CCR

adjustment and charge inflation factors that were used to set the IPPS fixed-dollar thresholds for the FY 2027 IPPS/LTCH PPS final rule (91 FR 50383 and 61333). We simulated aggregated CY 2027 hospital outlier payments using these costs for several different fixed-dollar thresholds, holding the 1.75 multiplier threshold constant and assuming that outlier payments would continue to be made at 50 percent of the amount by which the cost of furnishing the service would exceed 1.75 times the APC payment amount, until the total outlier payments equaled 1.0 percent of aggregated estimated total CY 2027 OPPS payments. We estimate that a final fixed dollar- threshold of $7,150 combined with the multiplier threshold of 1.75 times the APC payment rate, would allocate 1.0 percent of aggregated total OPPS payments to outlier payments for CY 2027.

For CMHCs, if a CMHC's cost for partial hospitalization or intensive outpatient services exceeds 3.40 times the APC payment rate, the outlier payment would be calculated as 50 percent of the amount by which the cost exceeds 3.40 times the APC payment rate.

H. Calculation of an Adjusted Medicare Payment from the National Unadjusted Medicare Payment

The national unadjusted payment rate is the payment rate for most APCs before accounting for the wage index adjustment or any applicable adjustments. The basic methodology for determining prospective payment rates for HOPD services under the OPPS is set forth in existing regulations at 42 CFR part 419, subparts C and D. For this final rule with comment period, the payment rate for most services and procedures for which payment is made under the OPPS is the product of the conversion factor calculated in accordance with section II.B. of this final rule with comment period and the relative payment weight described in section II.A. of this final rule with comment period. The national unadjusted payment rate for most APCs contained in Addendum A to this final rule with comment period (which is available on the CMS website at "*Hospital Outpatient Regulations and Notices*") and for most HCPCS codes to which separate payment under the OPPS has been assigned in Addendum B to this final rule with comment period (which is available on the CMS website, see previous link) is calculated by multiplying the final CY 2027 scaled weight for the APC by the CY 2027 conversion factor.

We note that section 1833(t)(17) of the Act, which applies to hospitals, as defined under section 1886(d)(1)(B) of the Act, requires that hospitals that fail to submit data required to be submitted on quality measures selected by the Secretary, in the form and manner and at a time specified by the Secretary, incur a reduction of 2.0 percentage points to their OPD fee schedule increase factor, that is, the annual payment update factor. The application of a reduced OPD fee schedule increase factor results in reduced national unadjusted payment rates that apply to certain outpatient items and services provided by hospitals that are required to report outpatient quality data and that fail to meet the Hospital Outpatient Quality Reporting (OQR) Program requirements. For further discussion of the payment reduction for hospitals that fail to meet the

requirements of the Hospital OQR Program, we refer readers to section XIV. of this final rule with comment period.

As discussed later in this section of the preamble, we demonstrate the steps used to determine the APC payments that will be made in a CY under the OPPS to a hospital that fulfills the Hospital OQR Program requirements and to a hospital that fails to meet the Hospital OQR Program requirements for a service that has any of the following status indicator assignments: "J1," "J2," "P," "Q1," "Q2," "Q3," "Q4," "R," "S," "T," "U," or "V" (as defined in Addendum D1 to the proposed rule, which is available via the Internet on the CMS website), in a circumstance in which the multiple procedure discount does not apply, the procedure is not bilateral, and conditionally packaged services (status indicator of "Q1" and "Q2") qualify for separate payment. We note that, although blood and blood products with status indicator "R" and brachytherapy sources with status indicator "U" are not subject to wage adjustment, they are subject to reduced payments when a hospital fails to meet the Hospital OQR Program requirements.

Individual providers interested in calculating the payment amount that they would receive for a specific service from the national unadjusted payment rates presented in Addenda A and B to this final rule (which are available via the Internet on the CMS website) should follow the formulas presented in the following steps. For purposes of the payment calculations below, we refer to the national unadjusted payment rate for hospitals that meet the requirements of the Hospital OQR Program as the "full" national unadjusted payment rate. We refer to the national unadjusted payment rate for hospitals that fail to meet the requirements of the Hospital OQR Program as the "reduced" national unadjusted payment rate. The reduced national unadjusted payment rate is calculated by multiplying the reporting ratio of 0.9804 times the "full" national unadjusted payment rate. The national unadjusted payment rate used in the calculations as discussed later in this section of the preamble is either the full national unadjusted payment rate or the reduced national unadjusted payment rate, depending on whether the hospital met its

Hospital OQR Program requirements to receive the full CY 2027 OPPS fee schedule increase factor.

Step 1. Calculate 60 percent (the labor-related portion) of the national unadjusted payment rate. Since the initial implementation of the OPPS, we have used 60 percent to represent our estimate of that portion of costs attributable, on average, to labor. We refer readers to the April 7, 2000 OPPS final rule with comment period (65 FR 18496 through 18497) for a detailed discussion of how we derived this percentage. During our regression analysis for the payment adjustment for rural hospitals in the CY 2006 OPPS final rule with comment period (70 FR 68553), we confirmed that this labor-related share for hospital outpatient services is appropriate.

The formula below is a mathematical representation of Step 1 and identifies the labor-related portion of a specific payment rate for a specific service.

X is the labor-related portion of the national unadjusted payment rate.

X = .60 * (national unadjusted payment rate).

Step 2. Determine the wage index area in which the hospital is located and identify the wage index level that applies to the specific hospital. The wage index values assigned to each area would reflect the geographic statistical areas (which are based upon OMB standards) to which hospitals are assigned for FY 2027 under the IPPS, reclassifications through the Medicare Geographic Classification Review Board (MGCRB), section 1886(d)(8)(B) "Lugar" hospitals, and reclassifications under section 1886(d)(8)(E) of the Act, as implemented in § 412.103 of the regulations. For CY 2027, we proposed to apply for the CY 2027 OPPS wage index any adjustments for the FY 2027 IPPS post-reclassified wage index, including, but not limited to, the rural floor adjustment and a wage index floor of 1.00 in frontier States, in accordance with section 10324 of the Affordable Care Act of 2010. For further discussion of the wage index we are applying for the CY 2027 OPPS, including the low wage index hospital policy, we refer readers to section II.C. of this final rule with comment period.

Step 3. Adjust the wage index of hospitals located in certain qualifying counties that have a relatively high percentage of hospital employees who reside in the county, but who work in a different county with a higher wage index, in accordance with section 505 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108-173). Addendum L to this final rule with comment period (which is available via the Internet on the CMS website) contains the qualifying counties and the associated wage index increase developed for the final FY 2027 IPPS wage index, which are listed in Table 3 associated with the FY 2027 IPPS final rule and available via the Internet on the CMS website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps*. (Click on the link on the left side of the screen titled "FY 2027 IPPS Final Rule Home Page" and select "FY 2027 Final Rule Tables".) This step is to be followed only if the hospital is not reclassified or redesignated under section 1886(d)(8) of the Act or section 1886(d)(10) of the Act.

Step 4. Multiply the applicable wage index determined under Steps 2 and 3 by the amount determined under Step 1 that represents the labor-related portion of the national unadjusted payment rate. The formula below is a mathematical representation of Step 4 and adjusts the labor-related portion of the national unadjusted payment rate for the specific service by the wage index.

X_a is the labor-related portion of the national unadjusted payment rate (wage adjusted).

X_a = labor-portion of the national unadjusted payment rate * applicable wage index.

Step 5. Calculate 40 percent (the nonlabor-related portion) of the national unadjusted payment rate and add that amount to the resulting product of Step 4. The result is the wage index adjusted payment rate for the relevant wage index area.

The formula below is a mathematical representation of Step 5 and calculates the remaining portion of the national payment rate, the amount not attributable to labor, and the adjusted payment for the specific service.

Y is the nonlabor-related portion of the national unadjusted payment rate.

$Y = 0.40 *$ (national unadjusted payment rate).

Step 6. If a provider is a sole community hospital (SCH), as set forth in the regulations at § 412.92, or an essential access community hospital (EACH), which is considered to be an SCH under section 1886(d)(5)(D)(iii)(III) of the Act, and located in a rural area, as defined in § 412.64(b), or is treated as being located in a rural area under § 412.103, multiply the wage index adjusted payment rate by 1.071 to calculate the total payment.

The formula below is a mathematical representation of Step 6 and applies the rural adjustment for rural SCHs.

Adjusted Medicare Payment (SCH or EACH) = Adjusted Medicare Payment * 1.071.

Step 7. The adjusted payment rate is the sum of the wage adjusted labor-related portion of the national unadjusted payment rate and the nonlabor-related portion of the national unadjusted payment rate.

X_a *is the labor-related portion of the national unadjusted payment rate (wage adjusted).*

Y is the nonlabor-related portion of the national unadjusted payment rate.

Adjusted Medicare Payment = $X_a + Y$

We are providing examples as discussed later in this section of the preamble, of the calculation of both the full and reduced national unadjusted payment rates that would apply to certain outpatient items and services performed by hospitals that meet and that fail to meet the Hospital OQR Program requirements, using the steps outlined previously. For purposes of this example, we are using a provider that is located in Brooklyn, New York that is assigned to CBSA 35614. This provider bills one service that is assigned to APC 5071 (Level 1 Excision/Biopsy/Incision and Drainage). The CY 2027 full national unadjusted payment rate for APC 5071 is $796.21. The reduced national adjusted payment rate for APC 5071 for a hospital that fails to meet the Hospital OQR Program requirements is $780.60. This reduced rate is

calculated by multiplying the reporting ratio of 0.9804 by the full unadjusted payment rate for APC 5071.

Step 1. The labor-related portion of the full national unadjusted payment is approximately $477.73 (0.60 * $796.21). The labor-related portion of the proposed reduced national adjusted payment is approximately $468.36 (0.60 * $780.60).

Step 2 & 3. The FY 2027 wage index for a provider located in CBSA 35614 in New York, which includes the adoption of the IPPS 2027 wage index policies, is 1.4267.

Step 4. The wage adjusted labor-related portion of the full national unadjusted payment is approximately $681.58 ($477.73 * 1.4267). The wage adjusted labor-related portion of the reduced national adjusted payment is approximately $668.21 ($468.36* 1.4267).

Step 5. The nonlabor-related portion of the full national unadjusted payment is approximately $318.48 (0.40 * $796.21). The nonlabor-related portion of the reduced national adjusted payment is approximately $312.24 (0.40 * $780.60).

Step 6. For this example of a provider located in Brooklyn, New York, the rural adjustment for rural SCHs does not apply.

Step 7. The sum of the labor-related and nonlabor-related portions of the proposed full national unadjusted payment is approximately $1,000.06 ($681.58 + $318.48). The sum of the portions of the reduced national adjusted payment is approximately $980.45 ($668.21 + $312.24) as shown in Table 11.

TABLE 11: FINAL FULL NATIONAL UNADJUSTED PAYMENT RATE AND FINAL REDUCED NATIONAL ADJUSTED PAYMENT RATE

Final Full national unadjusted payment rate	Final Reduced national adjusted payment rate
$1,000.06	$980.45

We did not receive public comments on these steps under the methodology that we included in the CY 2027 OPPS/ASC proposed rule to determine the APC payments for CY 2027. Therefore, we are using the steps in the methodology specified previously to demonstrate the

calculation of the final CY 2027 OPPS payments using the same parameters.

I. Beneficiary Copayments

1. Background

Section 1833(t)(3)(B) of the Act requires the Secretary to set rules for determining the unadjusted copayment amounts to be paid by beneficiaries for covered OPD services. Section 1833(t)(8)(C)(ii) of the Act specifies that the Secretary must reduce the national unadjusted copayment amount for a covered OPD service (or group of such services) furnished in a year in a manner so that the effective copayment rate (determined on a national unadjusted basis) for that service in the year does not exceed a specified percentage. As specified in section 1833(t)(8)(C)(ii)(V) of the Act, the effective copayment rate for a covered OPD service paid under the OPPS in CY 2006, and in CYs thereafter, shall not exceed 40 percent of the APC payment rate.

Section 1833(t)(3)(B)(ii) of the Act provides that, for a covered OPD service (or group of such services) furnished in a year, the national unadjusted copayment amount cannot be less than 20 percent of the OPD fee schedule amount. However, section 1833(t)(8)(C)(i) of the Act limits the amount of beneficiary copayment that may be collected for a procedure (including items such as drugs and biologicals) performed in a year to the amount of the inpatient hospital deductible for that year.

Section 4104 of the Affordable Care Act eliminated the Medicare Part B coinsurance for preventive services furnished on and after January 1, 2011, that meet certain requirements, including flexible sigmoidoscopies and screening colonoscopies, and waived the Part B deductible for screening colonoscopies that become diagnostic during the procedure. For a discussion of the changes made by the Affordable Care Act with regard to copayments for preventive services furnished on and after January 1, 2011, we refer readers to section XII.B. of the CY 2011 OPPS/ASC final rule with comment period (75 FR 72013).

Section 122 of the Consolidated Appropriations Act (CAA), 2021 (Pub. L. 116-260), Waiving Medicare Coinsurance for Certain Colorectal Cancer Screening Tests, amended section 1833(a) of the Act to offer a special coinsurance rule for screening flexible sigmoidoscopies and screening colonoscopies, regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure, that is furnished in connection with, as a result of, and in the same clinical encounter as the colorectal cancer screening test. We refer readers to section "X.B. Changes to Beneficiary Coinsurance for Certain Colorectal Cancer Screening Tests", of the CY 2022 OPPS/ASC final rule with comment period for the full discussion of this policy (86 FR 63740 through 63743). Under the regulation at 42 CFR 410.152(l)(5)(i)(C), the Medicare Part B payment percentage for colorectal cancer screening tests described in the regulation at § 410.37(j) that are furnished in CY 2027 through CY 2029 is 90 percent, with beneficiary coinsurance equal to 10 percent.

On August 16, 2022, the Inflation Reduction Act of 2022 (IRA) (Pub. L. 117-169) was signed into law. Section 11101(a) of the IRA amended section 1847A of the Act by adding a new subsection (i), which requires the payment of rebates into the Supplementary Medical Insurance Trust Fund for Part B rebatable drugs if the payment limit amount exceeds the inflation-adjusted payment amount, which is calculated as set forth in section 1847A(i)(3)(C) of the Act. The provisions of section 11101 of the IRA were initially implemented through program instruction, as permitted under section 1847A(c)(5)(C) of the Act. On February 9, 2023 and December 14, 2023, we issued initial[8] and revised[9] guidance, respectively, implementing the Medicare Part B Inflation Rebate Program, including the computation of inflation-adjusted beneficiary coinsurance under section 1847A(i)(5) of the Act and amounts paid under section 1833(a)(1)(EE) of the Act.[10] For additional information regarding implementation of section

[8] *https://www.cms.gov/files/document/medicare-part-b-inflation-rebate-program-initial-guidance.pdf*.
[9] *https://www.cms.gov/files/document/medicare-part-b-inflation-rebate-program-revised-guidance.pdf.*
[10] In addition, beginning with the April 2023 ASP Drug Pricing file, the file includes the coinsurance percentage for each drug and specifies "inflation-adjusted coinsurance" in the "Notes" column if the coinsurance for a drug is less than 20 percent of the Medicare Part B payment amount. Drug pricing files are available at *https://www.cms.gov/medicare/medicare-fee-for-service-part-b-drugs/mcrpartbdrugavgsalesprice*.

11101 of the IRA, please see the inflation rebates resources page at *https://www.cms.gov/inflation-reduction-act-and-medicare/inflation-rebates-medicare*.

Section 11101(b) of the IRA amended sections 1833(i) and 1833(t)(8) of the Act by adding a new paragraph (9) and subparagraph (F), respectively. Section 1833(i)(9) of the Act requires under the ASC payment system that, in the case of a Part B rebatable drug for which payment is not packaged into a payment for a service, in lieu of calculation of coinsurance that would otherwise apply under the ASC payment system, the provisions of section 1847A(i)(5) of the Act shall, as determined appropriate by the Secretary, apply for calculation of beneficiary coinsurance in the same manner as the provisions of section 1847A(i)(5) of the Act apply under that section. Similarly, section 1833(t)(8)(F) of the Act requires under the OPPS that in the case of a Part B rebatable drug (except for a drug that has no copayment applied under subparagraph (E) of such section or for which payment is packaged into the payment for a covered OPD service or group of services), in lieu of the calculation of the copayment amount that would otherwise apply under the OPPS, the provisions of section 1847A(i)(5) of the Act shall, as determined appropriate by the Secretary, apply in the same manner as the provisions of section 1847A(i)(5) of the Act apply under that section. Section 1847A(i)(5) of the Act requires that for Part B rebatable drugs, as defined in section 1847A(i)(2)(A) of the Act, furnished on or after April 1, 2023, in quarters in which the payment amount described in section 1847A(i)(3)(A)(ii)(I) of the Act (or, in the case of selected drugs described under section 1192(c) of the Act, the payment amount described in section 1847A(b)(1)(B) of the Act), exceeds the inflation-adjusted payment amount determined in accordance with section 1847A(i)(3)(C) of the Act, the coinsurance will be 20 percent of the inflation-adjusted payment amount for such quarter (hereafter, the inflation-adjusted coinsurance amount). This inflation-adjusted coinsurance amount is applied as a percent, as determined by the Secretary, to the payment amount that would otherwise apply for such calendar quarter in accordance with section

1847A(b)(1)(B) or (C) of the Act, as applicable, including in the case of a selected drug described under section 1192(c) of the Act.

Paragraph (9) of section 1833(i) of the Act and subparagraph (F) of section 1833(t)(8) of the Act, as added by section 11101(b) of the IRA, also provide that in lieu of the amounts of payment otherwise applicable under the ASC payment system and the OPPS, the provisions of paragraph (1)(EE) of subsection (a) of section 1833 of the Act shall apply, as determined appropriate by the Secretary. Section 11101(b) of the IRA amended section 1833(a)(1) of the Act by adding a new subparagraph (EE), which requires that if the payment amount under section 1847A(i)(3)(A)(ii)(I) of the Act or, in the case of a selected drug described under section 1192(c) of the Act, the payment amount described in section 1847A(b)(1)(B) of the Act, for that drug exceeds the inflation-adjusted payment amount for a Part B rebatable drug, the Part B payment amount would, subject to the Part B deductible and sequestration, equal the difference between such payment amount and the inflation-adjusted coinsurance amount. Consistent with the policy adopted in section 40 of the revised Medicare Part B Drug Inflation Rebate Guidance, the calculation to determine the applicable beneficiary coinsurance amount would not be adjusted for sequestration. CMS codified the Medicare payment for Part B rebatable drugs in the CY 2024 PFS final rule by adding new paragraph (m) to § 410.152 (88 FR 79043).

In the CY 2024 OPPS/ASC final rule with comment period (88 FR 81594), we codified the OPPS program payment and cost as required by section 1833(t)(8)(F) of the Act by adding a new paragraph (e) to § 419.41, which cross-references the regulations adopted in the CY 2024 PFS final rule (§§ 410.152(m) and 489.30(b)(6)). We also amended the regulation text to reflect our longstanding policies for calculating the Medicare program payment and cost sharing amounts for separately payable drugs and biologicals by adding a new paragraph (d) to § 419.41. Similarly, we codified the ASC cost sharing amounts for Part B rebatable drugs as required by section 1833(i)(9) of the Act by revising § 416.172(d) to include a cross-reference to 42 CFR

489.30(b)(6), which codified the cost sharing amounts for Part B rebatable drugs with prices increasing at a rate faster than inflation.

In the CY 2025 PFS final rule (89 FR 98228 through 98275), we codified regulations implementing section 11101 of the IRA in newly added 42 CFR part 427, chapter IV, including new provisions at §§ 427.200 and 427.201 to codify the policies regarding the computation of the inflation-adjusted beneficiary coinsurance, defined in § 427.200, for Part B rebatable drugs as required by section 1847A(i)(5) of the Act. As finalized, § 427.201(a) establishes that CMS will use the methodology established in such section to calculate the inflation-adjusted beneficiary coinsurance and associated adjusted Medicare payment percentage and includes references to the existing provisions at §§ 410.152(m), 419.41(e), and 489.30(b)(6). Section 427.201(c) provides that any category of products that is excluded from the identification of Part B rebatable drugs at § 427.101(b) is not subject to the inflation-adjusted beneficiary coinsurance. Examples of these excluded products include separately payable radiopharmaceuticals, skin substitute products, and qualifying biosimilar biological products.

Section 427.201(b) sets forth the calculation of the inflation-adjusted beneficiary coinsurance. We will compare the payment amount in paragraph (b)(3) of such section to the inflation-adjusted payment amount for an applicable calendar quarter; if the payment amount exceeds the inflation-adjusted payment amount, the inflation-adjusted beneficiary coinsurance is calculated by multiplying the inflation-adjusted payment amount by 0.20. Section 427.201(b)(3) specifies that CMS will use the published payment amount in quarterly pricing files[11,12,7,13] to determine if a Part B rebatable drug should have an adjusted beneficiary coinsurance. If so, such adjusted beneficiary coinsurance shall be equal to 20 percent of the inflation-adjusted payment amount as described in section 1847A(i)(3)(C) of the Act for a calendar quarter. This approach

[11] See *https://www.cms.gov/medicare/payment/part-b-drugs/asp-pricing-files.*
[12] See *https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/addendum-a-b-updates.*
[13] See *https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-payment-rates-addenda*.

deviates from the rebate calculation approach set forth in § 427.302, which relies on the specified amount defined at § 427.20 even when the specified amount and the published payment amount in quarterly pricing files differ.

We note that the cost sharing amounts of rebatable drugs paid under the OPPS published in the quarterly Addendum A and B updates reflect the inflation-adjusted coinsurance applied as a percent of the payment amount that would otherwise apply in accordance with section 1847A(b)(1)(B) or (C) of the Act, as determined by the Secretary pursuant to 1847A(i)(5) of the Act using the methodology in § 427.201. As we explained in the CY 2025 PFS final rule (89 FR 98237), this policy is intended to hold beneficiaries harmless in situations where the payment amount is calculated differently from the specified amount, and we believe this approach is consistent with the statutory language and appropriately reflects the differences in the statutory text of section 1847A(i)(5) of the Act, which sets forth the payment amount that is used to determine whether coinsurance should be adjusted, and section 1847A(i)(3)(A) of the Act, which sets forth the "specified amount" used to determine rebate amounts. We refer readers to the full discussion at 89 FR 98237 and 98238 for additional details.

2. OPPS Copayment Policy

For CY 2027, we proposed to determine copayment amounts for new and revised APCs using the same methodology that we implemented beginning in CY 2004. We refer readers to the November 7, 2003 OPPS final rule with comment period for a discussion of that methodology (68 FR 63458). In addition, we proposed to use the same standard rounding principles that we have historically used in instances where the application of our standard copayment methodology would result in a copayment amount that is less than 20 percent and cannot be rounded, under standard rounding principles, to 20 percent. We refer readers to the CY 2008 OPPS/ASC final rule with comment period (72 FR 66687) in which we discuss our rationale for applying these rounding principles. The final national unadjusted copayment amounts for services payable under the OPPS that would be effective January 1, 2027, are

included in Addenda A and B to this final rule with comment period (which are available via the Internet on the CMS website).

As discussed in section XIV.E. of this final rule with comment period, for CY 2027, the Medicare beneficiary's minimum unadjusted copayment and national unadjusted copayment for a service to which a reduced national unadjusted payment rate applies will equal the product of the reporting ratio and the national unadjusted copayment, or the product of the reporting ratio and the minimum unadjusted copayment, respectively, for the service.

We note that OPPS copayments may increase or decrease each year based on changes in the calculated APC payment rates, due to updated cost report and claims data, and any changes to the OPPS cost modeling process. However, as described in the CY 2004 OPPS final rule with comment period, the development of the copayment methodology generally moves beneficiary copayments closer to 20 percent of OPPS APC payments (68 FR 63458 through 63459).

In the CY 2004 OPPS final rule with comment period (68 FR 63459), we adopted a new methodology to calculate unadjusted copayment amounts in situations including reorganizing APCs, and we finalized the following rules to determine copayment amounts in CY 2004 and subsequent years.

- When an APC group consists solely of HCPCS codes that were not paid under the OPPS the prior year because they were packaged or excluded or are new codes, the unadjusted copayment amount would be 20 percent of the APC payment rate.

- If a new APC that did not exist during the prior year is created and consists of HCPCS codes previously assigned to other APCs, the copayment amount is calculated as the product of the APC payment rate and the lowest coinsurance percentage of the codes comprising the new APC.

- If no codes are added to or removed from an APC and, after recalibration of its relative payment weight, the new payment rate is equal to or *greater than* the prior year's rate, the

copayment amount remains constant (unless the resulting coinsurance percentage is less than 20 percent).

- If no codes are added to or removed from an APC and, after recalibration of its relative payment weight, the new payment rate is *less than* the prior year's rate, the copayment amount is calculated as the product of the new payment rate and the prior year's coinsurance percentage.

- If HCPCS codes are added to or deleted from an APC and, after recalibrating its relative payment weight, holding its unadjusted copayment amount constant results in a decrease in the coinsurance percentage for the reconfigured APC, the copayment amount would not change (unless retaining the copayment amount would result in a coinsurance rate less than 20 percent).

- If HCPCS codes are added to an APC and, after recalibrating its relative payment weight, holding its unadjusted copayment amount constant results in an increase in the coinsurance percentage for the reconfigured APC, the copayment amount would be calculated as the product of the payment rate of the reconfigured APC and the lowest coinsurance percentage of the codes being added to the reconfigured APC.

We noted in the CY 2004 OPPS final rule with comment period that we would seek to lower the copayment percentage for a service in an APC from the prior year if the copayment percentage was greater than 20 percent. We noted that this principle was consistent with section 1833(t)(8)(C)(ii) of the Act, which accelerates the reduction in the national unadjusted coinsurance rate so that beneficiary liability will eventually equal 20 percent of the OPPS payment rate for all OPPS services to which a copayment applies, and with section 1833(t)(3)(B) of the Act, which achieves a 20 percent copayment percentage when fully phased in and gives the Secretary the authority to set rules for determining copayment amounts for new services. We further noted that the use of this methodology would, in general, reduce the beneficiary coinsurance rate and copayment amount for APCs for which the payment rate changes as the result of the reconfiguration of APCs and/or recalibration of relative payment weights

(68 FR 63459).

We received a public comment on our proposals. The following is a summary of the comment we received and our response.

Comment: One commenter stated they appreciated CMS staying close to the 20 percent copayment amount and recommended finalizing our calculation.

Response: We thank the commenter for their support of our proposed methodology.

After consideration of the public comment we received, we are finalizing our proposal to determine copayment amounts for new and revised APCs using the same methodology that we implemented in CY 2004. In addition, we are finalizing the use of the same standard rounding principles that we have historically used in instances where the application of our standard copayment methodology would result in a copayment amount that is less than 20 percent and cannot be rounded, under standard rounding principles, to 20 percent. (We refer readers to the CY 2008 OPPS/ASC final rule with comment period (72 FR 66687) in which we discuss our rationale for applying these rounding principles.) The finalized national unadjusted copayment amounts for services payable under the OPPS that would be effective January 1, 2027 are included in Addenda A and B to this CY 2027 OPPS/ASC final rule with comment period (which are available on the CMS website.)

3. Calculation of an Adjusted Copayment Amount for an APC Group

Individuals interested in calculating the national copayment liability for a Medicare beneficiary for a given service provided by a hospital that met or failed to meet its Hospital OQR Program requirements should follow the formulas presented in the following steps.

Step 1. Calculate the beneficiary payment percentage for the APC by dividing the APC's national unadjusted copayment by its payment rate. For example, using APC 5071, $159.24 is 20 percent of the full national unadjusted payment rate of $796.21. For APCs with only a minimum unadjusted copayment in Addenda A and B to this final rule with comment period

(which are available via the Internet on the CMS website), the beneficiary payment percentage is 20 percent.

The formula as discussed later in this section of the preamble is a mathematical representation of Step 1 and calculates the national copayment as a percentage of national payment for a given service.

B is the beneficiary payment percentage.

B = National unadjusted copayment for APC/national unadjusted payment rate for APC.

Step 2. Calculate the appropriate wage-adjusted payment rate for the APC for the provider in question, as indicated in Steps 2 through 4 under section II.H. of this final rule with comment period. Calculate the rural adjustment for eligible providers, as indicated in Step 6 under section II.H. of this final rule with comment period.

Step 3. Multiply the percentage calculated in Step 1 by the payment rate calculated in Step 2. The result is the wage-adjusted copayment amount for the APC.

The formula below is a mathematical representation of Step 3 and applies the beneficiary payment percentage to the adjusted payment rate for a service calculated under section II.H. of this final rule with comment period, with and without the rural adjustment, to calculate the adjusted beneficiary copayment for a given service.

Wage-adjusted copayment amount for the APC = Adjusted Medicare Payment * *B*.

Wage-adjusted copayment amount for the APC (SCH or EACH) = (Adjusted Medicare Payment * 1.071) * *B*.

Step 4. For a hospital that failed to meet its Hospital OQR Program requirements, multiply the copayment calculated in Step 3 by the reporting ratio of 0.9804.

The unadjusted copayments for services payable under the OPPS that would be effective January 1, 2027, are shown in Addenda A and B to this final rule with comment period (which are available via the CMS website). We note that the final national unadjusted payment rates and copayment rates shown in Addenda A and B to this final rule with comment period reflect

the CY 2027 OPD fee schedule increase factor discussed in section II.B. of this final rule with comment period.

In addition, as noted earlier, section 1833(t)(8)(C)(i) of the Act limits the amount of beneficiary copayment that may be collected for a procedure performed in a year to the amount of the inpatient hospital deductible for that year.

We also note that the co-insurance for a separately payable drug under the OPPS shall not exceed the amount of inpatient hospital deductible for that year.

III. OPPS Ambulatory Payment Classification (APC) Group Policies

A. OPPS Treatment of New and Revised HCPCS Codes

Payments for OPPS procedures, services, and items are generally based on medical billing codes, specifically, Healthcare Common Procedure Coding System (HCPCS) codes, that are reported on hospital outpatient department (HOPD) claims. HCPCS codes are used to report surgical procedures, medical services, items, and supplies under the hospital OPPS. The HCPCS is divided into two principal subsystems, referred to as Level I and Level II of the HCPCS. Level I is comprised of CPT (Current Procedural Terminology) codes, a numeric and alphanumeric coding system that is established and maintained by the American Medical Association (AMA), and consists of Category I, II, III, MAAA, and PLA CPT codes. Level II, which is established and maintained by CMS, is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes. Together, Level I and II HCPCS codes are used to report procedures, services, items, and supplies under the OPPS payment system. Specifically, we recognize the following codes on OPPS claims:

- Category I CPT codes, which describe surgical procedures, diagnostic and therapeutic services, and vaccine codes;
- Category III CPT codes, which describe new and emerging technologies, services, and procedures;
- MAAA CPT codes, which describe laboratory multianalyte assays with algorithmic analyses (MAAA);
- PLA CPT codes, which describe proprietary laboratory analyses (PLA) services; and
- Level II HCPCS codes (also known as alpha-numeric codes), which are used primarily to identify drugs, devices, supplies, temporary procedures, and services not described by CPT codes.

The codes are updated and changed throughout the year. CPT and Level II HCPCS code changes that affect the OPPS are published through the annual rulemaking cycle and through the

OPPS quarterly update Change Requests (CRs). Generally, these code changes are effective January 1, April 1, July 1, or October 1. CPT code changes are released by the AMA (via their website) while Level II HCPCS code changes are released to the public via the CMS HCPCS website. CMS recognizes the release of new CPT and Level II HCPCS codes outside of the formal rulemaking process via OPPS quarterly update CRs. Based on our review, we assign the new codes to interim status indicators (SIs) and APCs. These interim assignments are finalized in the OPPS/ASC final rules. This quarterly process offers hospitals access to codes that more accurately describe the items or services furnished and provides payment for these items or services in a timelier manner than if we waited for the annual rulemaking process. We solicit public comments on the new CPT and Level II HCPCS codes, status indicators, and APC assignments through our annual rulemaking process.

We note that, under the OPPS, the APC assignment determines the payment rate for an item, procedure, or service. The items, procedures, or services not exclusively paid separately under the hospital OPPS are assigned to appropriate status indicators. Certain payment status indicators provide separate payment while other payment status indicators do not. In section X.I. "CY 2027 Payment Status and Comment Indicators" of this final rule with comment period, we discuss the various status indicators and comment indicators used under the OPPS. We also provide a complete list of the status indicators and their definitions in Addendum D1 to this final rule with comment period.

1. April 2026 HCPCS Codes Proposed Rule Comment Solicitation

For the April 2026 update, 61 new HCPCS codes were established and made effective on April 1, 2026. Through the April 2026 OPPS quarterly update CR (Transmittal 13686, Change Request 14380, dated March 13, 2026), we recognized several new HCPCS codes for payment and assigned them to appropriate interim OPPS status indicators and APCs. We solicited public comments on the proposed APC and status indicator assignments for the codes listed in Table 9 (New HCPCS Codes Effective April 1, 2026) of the CY 2027 OPPS/ASC proposed rule (91 FR

41779 through 41781), which are also displayed in Table 12.

We received some public comments on the proposed OPPS APC and SI assignments for the new Level II HCPCS codes that were effective on April 1, 2026. The comments and our responses are addressed in the applicable sections of this final rule with comment period, which include, but are not limited to sections III.C. (New Technology APCs), III.E. (OPPS APC-Specific Policies), and IV. (OPPS Payment for Devices). For those April 2026 codes for which we received no comments, we are finalizing the proposed APC and status indicator assignments as proposed. Additionally, in prior years we included the final OPPS status indicators and APC assignments in the coding preamble tables, however, because the same information can be found in Addendum B, we no longer include them in Table 12. Therefore, readers are advised to refer to the OPPS Addendum B for the final OPPS status indicators, APC assignments, and payment rates for all codes reportable under the hospital OPPS. These new codes that were effective April 1, 2026, were assigned comment indicator "NP" in Addendum B to the CY 2027 OPPS/ASC proposed rule to indicate that the codes are assigned to an interim APC assignment, and comments would be accepted on their interim APC assignments. The complete list of status indicators and definitions used under the OPPS can be found in Addendum D1 to this final rule with comment period, while the complete list of comment indicators and definitions can be found in Addendum D2 to this final rule with comment period. We note that OPPS Addendum B (OPPS payment file by HCPCS code), Addendum D1 (OPPS Status Indicators), and Addendum D2 (OPPS Comment Indicators) are available via the internet on the CMS website.

TABLE 12: NEW HCPCS CODES EFFECTIVE APRIL 1, 2026

CY 2026 HCPCS Code	CY 2027 HCPCS Code	CY 2027 Long Descriptor
C1743	C1743	Scaffold, endovascular non-coronary, resorbable drug eluting, with delivery system (implantable)
C8007 (retroactive to January 1, 2026)	C8007	Open implantation of hypoglossal nerve neurostimulator array and pulse generator, not requiring an insertion of a separate distal respiratory sensor electrode or electrode array
C8008 (retroactive to	C8008	Revision or replacement of hypoglossal nerve neurostimulator array including connection to existing pulse generator

CY 2026 HCPCS Code	CY 2027 HCPCS Code	CY 2027 Long Descriptor
January 1, 2026)		
C8009 (retroactive to January 1, 2026)	C8009	Removal of hypoglossal nerve neurostimulator array and pulse generator
C8010	1091T	Percutaneous placement of permanent common carotid embolic protection device, including all system components and imaging guidance; bilateral
C8011 (retroactive to January 1, 2026)	C8011	Open implantation of hypoglossal nerve(s) neurostimulator electrode array(s) and receiver, including external power source and all system components
C8012 (retroactive to January 1, 2026)	C8012	Revision or replacement of hypoglossal nerve(s) neurostimulator electrode array(s) and receiver
C8013 (retroactive to January 1, 2026)	C8013	Removal of hypoglossal nerve(s) neurostimulator electrode array(s) and receiver
C9309	C9309	Injection, onasemnogene abeparvovec-brve, per treatment
C9818 (effective January 23, 2026)	C9818	Suzetrigine, oral, 1 mg
G0680	G0680	Detection and quantification of coronary artery calcium and/or aortic valve calcification from algorithmic analysis of computed tomography of the chest with report
G0681	G0681	Application of a premarket approval (pma), 510(k), 361 human cells, tissues or cellular and tissue-based products (hct/p) non-sheet form skin substitute for a wound surface area up to 100 sq cm; first 25 sq cm or less of wound surface area
J0463	J0463	Injection, atropine sulfate (fresenius and therapeutically equivalent), 0.01 mg
J1164	J1164	Injection, diltiazem hydrochloride in 0.72% sodium chloride, 0.5 mg
J1553	J1553	Injection, immune globulin (yimmugo), 100 mg
J3404	J3404	Injection, zopapogene imadenovec-drba suspension, per therapeutic dose
C9145	J8502	Injection, aprepitant (aponvie), 1 mg
J9003	J9003	Leuprolide injectable (camcevi etm), 1 mg
J9183	J9183	Gemcitabine intravesical system, 225 mg
J9277	J9277	Injection, pembrolizumab, 1 mg and berahyaluronidase alfa-pmph
C9308	J9278	Injection, carboplatin (avyxa), 1 mg
C9307	J9601	Injection, linvoseltamab-gcpt, 1 mg
M0233	M0233	Intravenous infusion, tocilizumab-aazg, for hospitalized adult patients with covid-19 who are receiving systemic corticosteroids and require supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ecmo) only, includes infusion and post administration monitoring, first dose
M0234	M0234	Intravenous infusion, tocilizumab-aazg, for hospitalized adult patients with covid-19 who are receiving systemic corticosteroids and require supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ecmo) only, includes infusion and post administration monitoring, second dose
Q0238	Q0238	Injection, tocilizumab-aazg, for hospitalized adult patients with covid-19 who are receiving systemic corticosteroids and require supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ecmo) only, 1 mg

CY 2026 HCPCS Code	CY 2027 HCPCS Code	CY 2027 Long Descriptor
Q4418	Q4418	Biolab membrane wrap flow, per square centimeter (add-on, list separately in addition to primary procedure)
Q4419	Q4419	Biolab membrane wrap lite flow, per square centimeter (add-on, list separately in addition to primary procedure)
Q4421	Q4421	Biolab membrane wrap solo, per square centimeter (add-on, list separately in addition to primary procedure)
Q4422	Q4422	A/c wrap, per square centimeter (add-on, list separately in addition to primary procedure)
Q4423	Q4423	Biolab tri-membrane wrap flow, per square centimeter (add-on, list separately in addition to primary procedure)
Q4424	Q4424	Revive ft, per square centimeter (add-on, list separately in addition to primary procedure)
Q4425	Q4425	Revive tl, per square centimeter (add-on, list separately in addition to primary procedure)
Q4426	Q4426	Dermabind tl + or dermabind tl x, per square centimeter (add-on, list separately in addition to primary procedure)
Q4427	Q4427	Dermabind dl n or dermabind dl + or dermabind dl x, per square centimeter (add-on, list separately in addition to primary procedure)
Q4428	Q4428	Dermabind sl n or dermabind sl + or dermabind sl x, per square centimeter (add-on, list separately in addition to primary procedure)
Q4429	Q4429	Dermabind ch n or dermabind ch x, per square centimeter (add-on, list separately in addition to primary procedure)
Q4435	Q4435	Renati membrane, per square centimeter (add-on, list separately in addition to primary procedure)
Q4436	Q4436	Renati ac membrane, per square centimeter (add-on, list separately in addition to primary procedure)
Q4437	Q4437	Revival ac, per square centimeter (add-on, list separately in addition to primary procedure)
Q4438	Q4438	Pretect, per square centimeter (add-on, list separately in addition to primary procedure)
Q4439	Q4439	Instagraft, per square centimeter (add-on, list separately in addition to primary procedure)
Q4440	Q4440	Curamatrix, per square centimeter (add-on, list separately in addition to primary procedure)
Q5161	Q5161	Injection, denosumab-kyqq (aukelso/bosaya), biosimilar, 1 mg
Q5162	Q5162	Injection, denosumab-nxxp (bildyos/bilprevda), biosimilar, 1 mg
0614U	0614U	Inborn error of metabolism (primary mitochondrial disease), mitochondrial analysis of 4 enzyme complexes by stained blue native polyacrylamide gel electrophoresis (PAGE), frozen tissue (muscle, liver, heart, cultured skin fibroblasts), diagnostic qualitative result
0615U	0615U	Borrelia burgdorferi (Lyme disease), antibody detection of 26 recombinant protein groups, by immunoassay, IgM
0616U	0616U	Neurology (dementia), DNA methylation analysis of more than 30,000 sites, whole blood, algorithm reported as positive or negative risk
0617U	0617U	Cardiovascular (atherosclerotic cardiovascular disease [ASCVD]), DNA methylation analysis of more than 20,000 sites, whole blood, algorithm reported as positive or negative risk
0618U	0618U	Psychiatry (bipolar disorder), DNA methylation analysis of more than 10,000 sites, whole blood, algorithm reported as positive or negative risk
0619U	0619U	Pulmonary (chronic obstructive pulmonary disease [COPD]), DNA methylation analysis of more than 18,000 sites, whole blood, algorithm reported as positive or negative risk
0620U	0620U	Oncology (hepatocellular carcinoma), DNA methylation analysis of more than 5,000 sites, whole blood, algorithm reported as positive or negative risk
0621U	0621U	Infectious disease (Lyme borreliosis), DNA methylation analysis of more than 10,000 sites, whole blood, algorithm reported as positive or negative risk
0622U	0622U	Psychiatry (major depressive disorder), DNA methylation analysis of more than 20,000 sites, whole blood, algorithm reported as positive or negative risk

CY 2026 HCPCS Code	CY 2027 HCPCS Code	CY 2027 Long Descriptor
0623U	0623U	Autoimmune (multiple sclerosis), DNA methylation analysis of more than 5,000 sites, whole blood, algorithm reported as positive or negative risk
0624U	0624U	Hepatology (nonalcoholic steatohepatitis [NASH]), DNA methylation analysis of 5,000 sites, whole blood, algorithm reported as positive or negative risk
0625U	0625U	Endocrinology (osteoporosis), DNA methylation analysis of more than 5,000 sites, whole blood, algorithm reported as positive or negative risk
0626U	0626U	Neurology (Parkinson disease), DNA methylation analysis of more than 20,000 sites, whole blood, algorithm reported as positive or negative risk
0627U	0627U	Psychiatry (schizophrenia), DNA methylation analysis of more than 15,000 sites, whole blood, algorithm reported as positive or negative risk
0628U	0628U	Nephrology (kidney disease-related genetic conditions), genomic analysis, renal disease panel, saliva, DNA, next-generation sequencing of 449 genes, reported as pathogenic or likely pathogenic variants of uncertain significance or risk alleles
0629U	0629U	Infectious disease (tuberculosis), DNA, analysis of 1 target by PCR with clustered regularly interspaced short palindromic repeat (CRISPR)-based probe detection, plasma or serum, qualitative report as detected or not detected
0630U	0630U	Oncology (breast), mRNA, gene expression profiling by microarray of 80 genes (80 content and 465 housekeeping), utilizing formalin-fixed paraffin-embedded tissue (FFPE), algorithm reported as an index that is diagnostic of a molecular subtype (luminal, basal, Her2)

2. July 2026 HCPCS Codes Proposed Rule Comment Solicitation

For the July 2026 update, 98 new codes were established and made effective July 1, 2026. Through the July 2026 OPPS quarterly update CR (Transmittal R13832CP Change Request 14477, dated June 16, 2026) we recognized several new codes for payment and assigned them to appropriate interim OPPS status indicators and APCs. We solicited public comments on the proposed APC and status indicator assignments for the codes listed in Table 10 (New HCPCS Codes Effective July 1, 2026) of the CY 2027 OPPS/ASC proposed rule (91 FR 41782 through 41786), which are listed in Table 13.

We received some public comments on the proposed OPPS APC and SI assignments for the new Level II HCPCS codes implemented on July 1, 2026. The comments and our responses are addressed in pertinent sections of this final rule with comment period, which include, but are not limited to sections III.C (New Technology APCs), III.E (OPPS APC-Specific Policies), and IV (OPPS Payment for Devices). For those July 1, 2026, codes for which we received no comments, we are finalizing the proposed APC and status indicator assignments. Additionally, we note that in prior years we included the final OPPS status indicators and APC assignments in

the coding preamble tables, however, because the same information can be found in Addendum B, we no longer include them in Table 13. Therefore, readers are advised to refer to the OPPS Addendum B for the final OPPS status indicators, APC assignments, and payment rates for all codes reportable under the OPPS. These new codes that were effective July 1, 2026, were assigned to comment indicator "NP" in Addendum B to the CY 2027 OPPS/ASC proposed rule to indicate that the codes are assigned to an interim APC assignment, and comments would be accepted on their interim APC assignments. The complete list of status indicators and definitions used under the OPPS can be found in Addendum D1 to this final rule with comment period, while the complete list of comment indicators and definitions can be found in Addendum D2 to this final rule with comment period. We note that OPPS Addendum B (OPPS payment file by HCPCS code), Addendum D1 (OPPS Status Indicators), and Addendum D2 (OPPS Comment Indicators) are available via the internet on the CMS website.

TABLE 13: NEW HCPCS CODES EFFECTIVE JULY 1, 2026

CY 2026 HCPCS Code	CY 2027 HCPCS Code	CY 2027 Long Descriptor
A9574	A9574	Injection, ferumoxytol, 1 mg
C1609	C1609	Vertebral device, motion-preserving, with screw fixation
C8014	C8014	Cystourethroscopy, with ureteroscopy and/or pyeloscopy, with lithotripsy, including use of a suction enabled ureteral access sheath, with irrigation (if performed)
C9310	C9310	Injection, leucovorin calcium (avyxa), 1 mg
G0572	G0572	Management of new patient with dementia residing in an eligible memory care unit, for use only in a medicare-approved cmmi model (services must be furnished within a patient's eligible memory care unit, including specialized dementia care units within assisted living facilities or other qualifying memory care settings designed to provide specialized care for individuals with dementia and cognitive impairment)
G0573	G0573	Management of established patient with dementia residing in an eligible memory care unit, for use only in a medicare-approved cmmi model (services must be furnished within a patient's eligible memory care unit, including specialized dementia care units within assisted living facilities or other qualifying memory care settings designed to provide specialized care for individuals with dementia and cognitive impairment)
G0574	G0574	Management of new patient with dementia residing in an eligible residential care community, for use only in a medicare-approved cmmi model (services must be furnished within a patient's eligible residential care community, including assisted living facilities, board and care homes, or other qualifying residential settings where dementia care services are provided)
G0575	G0575	Management of established patient with dementia residing in an eligible residential care community, for use only in a medicare-approved cmmi model (services must be furnished within a patient's eligible residential care community, including assisted living facilities, board and care homes, or other qualifying residential settings where dementia care services are provided)

CY 2026 HCPCS Code	CY 2027 HCPCS Code	CY 2027 Long Descriptor
G0669	G0669	Outcome-Aligned Payment (OAP) for technology-enabled chronic care management of early cardio-kidney-metabolic (eCKM) conditions (hypertension, or two or more of: dyslipidemia, obesity/overweight with central obesity marker, prediabetes); initial 12-month period; per month.
G0670	G0670	Outcome-Aligned Payment (OAP) for technology-enabled chronic care management of early cardio-kidney-metabolic (eCKM) conditions (hypertension, or two or more of: dyslipidemia, obesity/overweight with central obesity marker, prediabetes); follow-on 12-month period; per month.
G0671	G0671	Outcome-Aligned Payment (OAP) for technology-enabled chronic care management of cardio-kidney-metabolic (CKM) conditions (one or more of: diabetes mellitus, chronic kidney disease Stage 3a or 3b, atherosclerotic cardiovascular disease); initial 12-month period; per month.
G0672	G0672	Outcome-Aligned Payment (OAP) for technology-enabled chronic care management of cardio-kidney-metabolic (CKM) conditions (one or more of: diabetes mellitus, chronic kidney disease Stage 3a or 3b, atherosclerotic cardiovascular disease); follow-on 12-month period; per month.
G0673	G0673	Outcome-Aligned Payment (OAP) for technology-enabled chronic care management of musculoskeletal (MSK) conditions (chronic musculoskeletal pain); initial 12-month treatment period; per month.
G0674	G0674	Outcome-Aligned Payment (OAP) for technology-enabled chronic care management of behavioral health conditions (BH) conditions (one or more of: depression, anxiety); initial 12-month period; per month.
G0675	G0675	Outcome-Aligned Payment (OAP) for behavioral health (BH) conditions (one or more of: depression, anxiety); follow-on 12-month period; per month.
G0676	G0676	Standard Co-Management service payment for documented review of clinical updates from ACCESS Participant managing cardio-kidney-metabolic conditions (early cardio-kidney-metabolic [eCKM] or cardio-kidney-metabolic [CKM] track); per review.
G0677	G0677	Standard Co-Management service payment for documented review of clinical updates from ACCESS Participant managing musculoskeletal (MSK) conditions; per review.
G0678	G0678	Standard Co-Management service payment for documented review of clinical updates from ACCESS Participant managing behavioral health (BH) conditions (depression, anxiety); per review.
G0685	G0685	Algorithmic analysis for identification of new lesions and determination of change of existing lesions for advanced metastatic cancer using data sets from 2 or more previously acquired pet or pet/ct studies
J0528	J0528	Injection, fosfomycin disodium, 20 mg
J1289	J1289	Injection, narsoplimab-wuug, 1 mg
J1577	J1577	Injection, immune globulin (qivigy), 100 mg
J2361	J2361	Injection, depemokimab-ulaa, 1 mg
J2374	J2374	Apraclonidine hydrochloride ophthalmic, 1% solution, 0.1 mL
J2789	J2789	Riboflavin 5'-phosphate, ophthalmic solution (epioxahd/epioxa), up to 2 mL
J3386	J3386	Injection, etuvetidigene autotemcel, per treatment
C9309	J3405	Injection, onasemnogene abeparvovec-brve, per treatment
J9062	J9062	Injection, amivantamab 5 mg and hyaluronidase-lpuj
J9232	J9232	Injection, docetaxel (hospira), not therapeutically equivalent to j9171, 1 mg
M0231	M0231	Intravenous infusion, tocilizumabbavi, for hospitalized adult patients with covid-19 who are receiving systemic corticosteroids and require supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation only, includes infusion and post administration monitoring, first dose

CY 2026 HCPCS Code	CY 2027 HCPCS Code	CY 2027 Long Descriptor
M0232	M0232	Intravenous infusion, tocilizumabbavi, for hospitalized adult patients with covid-19 who are receiving systemic corticosteroids and require supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation only, includes infusion and post administration monitoring, second dose
Q0234	Q0234	Injection, tocilizumab-bavi, for hospitalized adult patients with covid-19 who are receiving systemic corticosteroids and require supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation only, 1 mg
Q5164	Q5164	Injection, ustekinumab-hmny (starjemza), biosimilar, 1 mg
Q5165	Q5165	Injection, denosumab-mobz (oziltus), biosimilar, 1 mg
Q5166	Q5166	Injection, denosumab-desu (osvyrti/jubereq), biosimilar, 1 mg
Q5167	Q5167	Injection, denosumab-qbde (enoby/xtrenbo), biosimilar, 1 mg
Q5168	Q5168	Injection, ranibizumab-leyk (nufymco), biosimilar, 0.1 mg
Q5169	Q5169	Injection, pegfilgrastim-unne (armlupeg), biosimilar, 0.5 mg
Q5170	Q5170	Injection, aflibercept-boav (eydenzelt), biosimilar, 1 mg
Q5171	Q5171	Injection, denosumab-mobz (boncresa), biosimilar, 1 mg
1026T	1026T	Transvaginal laser photobiomodulation therapy of pelvis, provided by a physician or other qualified health care professional
1027T	1027T	Percutaneous insertion or replacement of neurostimulation catheter via left subclavian or left jugular vein into the superior vena cava, with verification of capture of phrenic nerves, mapping and programming, and delivery of transvenous phrenic neurostimulation therapy in ventilated patients, with repositioning when performed, including imaging guidance
1028T	1028T	Mapping and programming of neurostimulation catheter with delivery of transvenous phrenic neurostimulation therapy in ventilated patients, with repositioning and verification of left phrenic nerve capture, per session
1029T	1029T	Mapping and programming of neurostimulation catheter with delivery of transvenous phrenic neurostimulation therapy in ventilated patients, without catheter repositioning, per session
1030T	1030T	Creation of digital 3D model from surface mesh files of patient-specific anatomy (eg, final anatomic representation [FAR]), cumulative time for up to 30 days; initial 30 minutes
1031T	1031T	Creation of digital 3D model from surface mesh files of patient-specific anatomy (eg, final anatomic representation [FAR]), cumulative time for up to 30 days; each additional 30 minutes (List separately in addition to code for primary procedure)
1032T	1032T	Creation of digital 3D model from surface mesh files of patient-specific anatomy (eg, final anatomic representation [FAR]) and digital simulation, cumulative time for up to 30 days; initial 60 minutes
1033T	1033T	Creation of digital 3D model from surface mesh files of patient-specific anatomy (eg, final anatomic representation [FAR]), cumulative time for up to 30 days; each additional 30 minutes (List separately in addition to code for primary procedure)
1034T	1034T	Creation of digital 3D model from surface mesh files of patient-specific anatomy (eg, final anatomic representation [FAR]) digital simulation, and computational analyses (eg, computational fluid dynamics, finite element analysis), cumulative time for up to 30 days; initial 90 minutes
1035T	1035T	Creation of digital 3D model from surface mesh files of patient-specific anatomy (eg, final anatomic representation [FAR]), digital simulation, and computational analyses (eg, computational fluid dynamics, finite element analysis), cumulative time for up to 30 days; each additional 30 minutes (List separately in addition to code for primary procedure)
1036T	1036T	Noninvasive hemodynamic assessment with pulmonary pressures and ejection fraction when performed, including passive acquisition of acoustic and electrical signals, augmentative algorithmic analysis, and generation of a clinical report with review, interpretation, and clinical integration by a physician or other qualified health care professional

CY 2026 HCPCS Code	CY 2027 HCPCS Code	CY 2027 Long Descriptor
1037T	1037T	Histotripsy (ie, non-thermal ablation via acoustic energy delivery) of malignant pancreatic tissue, including imaging guidance
1038T	1038T	Autologous muscle cell therapy, injection(s) of muscle progenitor cells into the tongue, including esophagoscopy, when performed
1039T	1039T	Connectomic analysis of previously performed multi-modal brain magnetic resonance imaging (MRI) requiring physician or other qualified health care professional (QHP) analysis of software- and physician-generated structural and functional maps for integration of cortical grey matter correlation based on resting state functional MRI and mapping of white matter connectivity based on diffusion weighted MRI relative to brain regions, with physician or other QHP interpretation and report
1040T	1040T	Bronchoscopy, flexible, with bronchial cryotherapy, 1 lung, including trachea, when performed
1041T	1041T	Augmentative algorithmic analysis of encephalographic waveforms to identify the source and propagation of epileptiform activity, including artifact reduction with analysis of 3D localization of spike sources throughout the examination, 3D animations over time of high-amplitude event locations, high-frequency activity locations, and temporal relationships among locations, with interpretation and report by physician or other qualified health care professional, related to a previously performed electroencephalogram (EEG)
1042T	1042T	Implantation of absorbable urologic scaffold for prosthetic urethra restoration of reconstructed bladder neck and urethral anastomosis (List separately in addition to code for primary procedure)
1043T	1043T	Quantitative magnetic resonance, without imaging, for analysis of liver tissue, including assessment of 1 or more parameters (eg, proton density fat fraction [PDFF], water diffusion, T1-water relaxation time), with automatically generated report.
1044T	1044T	Harvest of full-thickness skin for autologous heterogeneous skin-construct graft, including direct closure of donor site; first 5 sq cm or less
1045T	1045T	Harvest of full-thickness skin for autologous heterogeneous skin-construct graft, including direct closure of donor site; each additional 5 sq cm, or part thereof (List separately in addition to code for primary procedure)
1046T	1046T	Autologous heterogeneous skin-construct graft application, trunk, arms, legs; first 50 sq cm or less, or 0.5% of body area of infants and children
1047T	1047T	Autologous heterogeneous skin-construct graft application, trunk, arms, legs; each additional 50 sq cm, or each additional 0.5% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)
1048T	1048T	Autologous heterogeneous skin-construct graft application, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 50 sq cm or less, or 0.5% of body area of infants and children
1049T	1049T	Autologous heterogeneous skin-construct graft application, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 50 sq cm, or each additional 0.5% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)
1050T	1050T	Insertion, subcutaneous heart failure decompensation monitor, containing sensors that measure, at a minimum, heart rate, impedance, respiration rate, physical activity, heart sounds
1051T	1051T	Removal of subcutaneous heart failure decompensation monitor
1052T	1052T	Interrogation device evaluation(s), (in person or remote) up to 30 days, insertable subcutaneous heart failure decompensation monitor, analysis of physiologic parameters, including, at a minimum, heart rate, impedance, respiration rate, physical activity, heart sounds, with generation of a report, review and interpretation by a physician or other qualified health care professional
1053T	1053T	Programming device evaluation (in person or remote) of subcutaneous heart failure decompensation monitor, with analysis of physiologic parameters, including, at a minimum, heart rate, impedance, respiration rate, physical activity, heart sounds, with generation of a report and review and interpretation by a physician or other qualified health care professional

CY 2026 HCPCS Code	CY 2027 HCPCS Code	CY 2027 Long Descriptor
0631U	0631U	Oncology (solid tumor), DNA, sequence analysis of 15 genes including BRCA1 and BRCA2 for identification of clonal hematopoiesis, blood, reported as tumor-derived or nontumor-derived
0632U	0632U	Red blood cell antigen (fetal RhD gene analysis), multiplex polymerase chain reaction (PCR) and next-generation sequencing (NGS) of circulating cell-free DNA (cfDNA), plasma from pregnant individuals known to be RhD negative, reported as detected or not detected
0633U	0633U	Obstetrics (single-gene noninvasive prenatal test), cell-free DNA (cfDNA), next-generation sequencing (NGS) analysis of 1 or more targets (eg, CFTR, SMN1, HBB, HBA1, HBA2) to identify paternally inherited pathogenic variants and to determine fetal inheritance of maternal mutation, using maternal blood sample, algorithm reported as a fetal risk score
0634U	0634U	Oncology (breast cancer), cell-free DNA (cfDNA), evaluation of 11 ESR1 variants (E380Q, S463P, L536R, Y537C, Y537N, Y537S, D538G, V422del, L536H, L536P, Y537D) using droplet digital PCR (ddPCR), plasma, reported as positive or negative
0635U	0635U	Autoimmune (atopic dermatitis), mRNA, next-generation sequencing (NGS), gene expression profiling of 487 genes, noninvasive skin-surface scraping, algorithm reported as likelihood of response to therapy
0636U	0636U	Babesia (Babesiosis), antibody detection of 20 recombinant protein groups, by immunoassay, IgG
0637U	0637U	Babesia (Babesiosis), antibody detection of 20 recombinant protein groups, by immunoassay, IgM
0638U	0638U	Bartonella (Bartonellosis), antibody detection of 32 recombinant protein groups, by immunoassay, IgG
0639U	0639U	Bartonella (Bartonellosis), antibody detection of 32 recombinant protein groups, by immunoassay, IgM
0640U	0640U	Oncology (leptomeningeal metastases), tumor cell selection, identification, detection and enumeration based on differential CD318(CDCP1), SUSD2, CD340(erbB2/HER2), HGFR/cMET, FOLR1, EGFR, N cadherin, MUC1, EpCAM, and TROP2 antibody biomarkers, cerebrospinal fluid, reported as detection and quantification of tumor cells
0641U	0641U	Oncology (minimal residual disease [MRD]), tumor DNA, next-generation sequencing (NGS), using formalin-fixed paraffin-embedded (FFPE) tissue and blood samples, initial (baseline) assessment
0642U	0642U	Oncology (minimal residual disease [MRD]), tumor DNA, next-generation sequencing (NGS), whole blood, comparison to previously performed analyses, reported as trend in circulating tumor DNA (ctDNA) level
0643U	0643U	Oncology (genitourinary cancer), cell-free circulating tumor DNA (ctDNA), 200 genes, next-generation sequencing (NGS), interrogation for single-nucleotide variants (SNVs), insertions/deletions, gene rearrangements, copy number alterations, and tumor mutation burden, using urine, identify and report mutations with clinical actionability
0644U	0644U	Oncology (leukemia), minimal residual disease (MRD) detection for rearrangements, blood or bone marrow, personalized assay design and baseline quantification
0645U	0645U	Oncology (leukemia), minimal residual disease (MRD) detection for rearrangements, based on digital PCR, blood or bone marrow, reported as not detected or detected with estimated abundance
0646U	0646U	Oncology (molecular residual disease), whole genome sequence analysis, cell-free DNA, whole blood, and formalin-fixed paraffin-embedded (FFPE) tumor tissue DNA, baseline assessment
0647U	0647U	Oncology (molecular residual disease), whole genome sequence analysis, cell-free DNA (cfDNA), whole blood, assessment utilizing patient-specific tumor information, reported as negative or percent circulating tumor DNA (ctDNA)
0648U	0648U	Oncology (solid tumor), targeted genomic sequencing analysis, to detect deletions, insertions, and substitutions in 42 genes, copy number amplifications in 10 genes, and fusions and splice variants in 18 driver genes from DNA and RNA extracted from formalin-fixed paraffin-embedded (FFPE) tissue

CY 2026 HCPCS Code	CY 2027 HCPCS Code	CY 2027 Long Descriptor
0649U	0649U	Neurology (Alzheimer disease), DNA, targeted next-generation sequencing (NGS) of AD-1 and AD-2 target regions, whole blood, prognostic algorithmic analysis, reported as categorization of cognitive status
0650U	0650U	Drug metabolism (adverse drug reactions and drug response), genotyping of 9 genes (ie, CYP2D6, CYP2C19, G6PD, SLCO1B1, HLA-B*58:01, NAT2, CYP2C9, VKORC1, ABCG2), reported as metabolizer status and transporter function
0651U	0651U	Oncology (hereditary cancer), genomic DNA, 55 hereditary cancer pre-dispositioned genes, next-generation sequencing (NGS) and digital multiplex ligation-dependent probe amplification for variants, small indels (<40 base pairs), using saliva, whole blood or nail clipping, interpretive clinical report with variant classification
0652U	0652U	Drug metabolism (adverse drug reactions), DNA analysis of 13 genes by targeted genotyping, using saliva or buccal swab, reported as diplotype and metabolizer status
0653U	0653U	Nephrology (inherited kidney disorders), DNA, analysis of approximately 700 genes associated with inherited kidney diseases by exome sequencing, using whole blood, saliva, or nail clipping, reported as an interpretive clinical report classifying pathogenic and likely pathogenic variants
0654U	0654U	Inborn error of metabolism (primary mitochondrial disease), mitochondrial analysis of 1 enzyme complex by western blot analysis, using cultured skin fibroblasts, diagnostic qualitative result
0655U	0655U	Inborn error of metabolism (primary mitochondrial disease), mitochondrial analysis of 1 enzyme complex by spectrophotometric kinetic assay, using cultured skin fibroblasts, diagnostic quantitative result
0656U	0656U	Inborn error of metabolism (primary mitochondrial disease), mitochondrial analysis of 1 enzyme complex by radioactive activity assay, using cultured skin fibroblasts, diagnostic quantitative result
0657U	0657U	Rare diseases (constitutional/heritable disorders), rapid whole genome sequence analysis of comparator nuclear and mitochondrial DNA by next-generation sequencing (NGS), using blood or buccal sample, relevant variants reported with proband results
0658U	0658U	Rare diseases (constitutional/heritable disorders), rapid whole genome sequence analysis of nuclear and mitochondrial DNA by next-generation sequencing (NGS) for single-nucleotide variants (SNVs), insertions/deletions, copy number variants, uniparental disomy, and repeat expansions, using blood or buccal sample, identification and categorization of genetic variants
0659U	0659U	Rare diseases (constitutional/heritable disorders), ultrarapid whole genome sequence analysis of nuclear and mitochondrial DNA by next-generation sequencing (NGS) for single-nucleotide variants (SNVs), insertions/deletions, copy number variants, uniparental disomy, and repeat expansions, using blood or buccal sample, identification and categorization of genetic variants
90616	90616	Influenza virus vaccine, trivalent (tIRV), mRNA, 37.5 mcg/0.38 mL dosage, for intramuscular use
90639	90639	Influenza virus vaccine, quadrivalent (qIRV), mRNA; 50 mcg/0.5 mL dosage, for intramuscular use

3. October 2026 HCPCS Codes Final Rule Comment Solicitation

For the October 2026 update, 144 codes were established and made effective October 1, 2026. Through the October 2026 OPPS quarterly update CR (Transmittal 13978, Change Request 14589, dated September 29, 2026), we recognized these new codes for separate payment and assigned them to appropriate interim OPPS status indicators and APCs. We note that

because the AMA revised their release/effective date schedule for Category III CPT codes, there were a number of Category III codes that became effective October 1, 2026 instead of January 1, 2027 as proposed.

For CY 2027, consistent with our established policy, we proposed in the CY 2027 OPPS/ASC proposed rule (91 FR 41787) that the HCPCS codes that would be effective October 1, 2026, would be flagged with comment indicator "N1" in Addendum B to the CY 2027 OPPS/ASC final rule with comment period to indicate that we have assigned the codes to interim OPPS status indicators for CY 2027. Table 14 lists the codes that were effective October 1, 2026. We note that several of the temporary C-codes have been replaced with permanent J-codes effective January 1, 2027. We are inviting public comments in this final rule with comment period on the interim payment indicators, which will be finalized in the CY 2028 OPPS/ASC final rule with comment period. We note the proposed APC assignments and status indicators for these same codes will be subject to comment in the CY 2028 OPPS/ASC proposed rule with comment period and will be finalized in the CY 2028 OPPS/ASC final rule with comment period.

TABLE 14: NEW HCPCS CODES EFFECTIVE OCTOBER 1, 2026

October 2026 HCPCS Code	CY 2027 HCPCS Code	CY 2027 Long Descriptor
87638	87638	Infectious agent detection by nucleic acid (DNA or RNA); rubeola (measles) virus
0660U	0660U	Human papillomavirus (HPV), genotypes 18, 31, 33, and 35, cell-free DNA (cfDNA), whole blood, multiplex digital droplet PCR (ddPCR), quantitative
0661U	0661U	Human papillomavirus (HPV), genotype 16, cell-free DNA (cfDNA), whole blood, digital droplet PCR (ddPCR), quantitative
0662U	0662U	Transplantation medicine (kidney allograft rejection), mRNA, gene-expression profiling by real-time quantitative PCR of 12 genes (11 content and 1 housekeeping), urine, algorithm reported as a rejection risk score
0663U	0663U	Obstetrics (fetal platelet antigen noninvasive prenatal test [NIPT]), cell-free DNA (cfDNA) sequence analysis for detection of fetal presence or absence of 1 human platelet antigen or more (HPA-1a, HPA-1b, HPA-3a, HPA-5b, and others) when performed, reported as maternal/fetal incompatibility detected or not detected per selected antigen
0664U	0664U	Transplantation medicine (kidney allograft failure), RNA expression transcriptome by next-generation sequencing (NGS), profiling of 13 genes, post-transplant peripheral blood, algorithm reported as a risk score for predicting progressive fibrosis in the kidney allograft
0665U	0665U	Hepatology (metabolic dysfunction-associated steatohepatitis [MASH]), enzyme-linked immunosorbent assay (ELISA) for YKL40 and

October 2026 HCPCS Code	CY 2027 HCPCS Code	CY 2027 Long Descriptor
		quantitative reverse transcription polymerase chain reaction (RT-qPCR) for miR34a-5p, serum, algorithm reported as a single score for MASH activity and fibrosis
0666U	0666U	Infectious disease (wound infection), DNA, multiplex real-time PCR, wound swab, detection of 27 microbial targets and 28 antibiotic resistance targets, reported as semiquantitative for bacterial and fungal targets, and qualitative for viral- and antibiotic-resistance targets
0667U	0667U	Inborn error of metabolism (primary mitochondrial disease), determination of fibroblast growth factor 21 (FGF21) concentration by enzyme-linked immunosorbent assay (ELISA), serum or plasma, diagnostic quantitative result
0668U	0668U	Oncology (pancreas), DNA, genome sequence with 5hydroxymethylcytosine (5hmC) enrichment and glycan biomarker analysis, whole blood or plasma, algorithm reported as cancer detected or not detected
0669U	0669U	Infectious disease (Bartonella species, Borrelia species, and Babesia species), multiplex digital PCR for detection of DNA at the genus level for each species, blood, qualitative reporting of presence or absence of each pathogen at the genus level
0670U	0670U	Rare diseases (constitutional/heritable disorders), whole genome sequence analysis combination of short and long reads for single-nucleotide variants, insertions/deletions and characterized intronic variants, copy number variants, duplications/deletions, mobile element insertions, runs of homozygosity, aneuploidy, and inversions, mitochondrial DNA sequence and deletions, short tandem repeat (STR) genes, methylation status of selected regions, blood, saliva, amniocentesis, chorionic villus sample or tissue, identification and categorization of genetic variant, proband and comparator
0671U	0671U	Rare diseases (constitutional/heritable disorders), whole genome sequence analysis combination of short and long reads for single-nucleotide variants, insertions/deletions and characterized intronic variants, copy number variants, duplications/deletions, mobile element insertions, runs of homozygosity, aneuploidy, and inversions, mitochondrial DNA sequence and deletions, short tandem repeat (STR) genes, methylation status of selected regions, blood, saliva, amniocentesis, chorionic villus sample or tissue, identification and categorization of genetic variant, proband and 2 comparators
0672U	0672U	Rare diseases (constitutional/heritable disorders), whole exome and mitochondrial DNA sequence analysis, including small sequence changes, deletions, duplications, short tandem repeat (STR) gene expansions, and variants in nonuniquely mappable regions, blood or saliva, identification and categorization of genetic variants, proband and comparator
0673U	0673U	Rare diseases (constitutional/heritable disorders), whole exome and mitochondrial DNA sequence analysis, including small sequence changes, deletions, duplications, short tandem repeat (STR) gene expansions, and variants in nonuniquely mappable regions, blood or saliva, identification and categorization of genetic variants, proband and 2 comparators
0674U	0674U	Rare diseases (constitutional/heritable disorders), whole genome and mitochondrial DNA sequence analysis, including small sequence changes, insertions/deletions, copy number variants, mobile element insertions, runs of homozygosity, aneuploidy, and inversions, short tandem repeat (STR) gene expansions, blood, saliva, or genomic DNA, identification and categorization of genetic variants, proband and comparator
0675U	0675U	Rare diseases (constitutional/heritable disorders), whole genome and mitochondrial DNA sequence analysis, including small sequence changes, insertions/deletions, copy number variants, duplications/deletions, mobile element insertions, runs of homozygosity, aneuploidy, and inversions, short tandem repeat (STR) gene expansions, blood, saliva, or genomic

October 2026 HCPCS Code	CY 2027 HCPCS Code	CY 2027 Long Descriptor
		DNA, identification and categorization of genetic variants proband and 2 comparators
0676U	0676U	Rare diseases (constitutional/heritable disorders), whole genome sequence analysis, including small sequence changes, copy number variants, deletions, duplications, mobile element insertions, uniparental disomy (UPD), inversions, aneuploidy, mitochondrial genome sequence analysis with heteroplasmy and large deletions, short tandem repeat (STR) gene expansions and maternal cell contamination, fetal sample, identification and categorization of genetic variants, proband and maternal comparator
0677U	0677U	Rare diseases (constitutional/heritable disorders), whole genome sequence analysis, including small sequence changes, copy number variants, deletions, duplications, mobile element insertions, uniparental disomy (UPD), inversions, aneuploidy, mitochondrial genome sequence analysis with heteroplasmy and large deletions, short tandem repeat (STR) gene expansions and maternal cell contamination, fetal sample, identification and categorization of genetic variants, proband and 2 comparators
0678U	0678U	Oncology (hereditary cancer), genome sequence for 117 genes (single-nucleotide variants, deletions/insertions, and characterized intronic variants), copy number variants, duplications/deletions, mobile element insertions and inversions, blood, saliva, cultured skin fibroblasts (skin biopsy) or extracted genomic DNA, diagnostic, identification and categorization of genetic variants
0679U	0679U	Oncology (hereditary hematologic cancer), genomic DNA, whole genome sequence (single-nucleotide variants, deletions/insertions, and characterized intronic variants), copy number variants, duplications/deletions, mobile element insertions and inversions, analysis of over 105 genes, genomic DNA isolated from blood, saliva, cultured skin fibroblasts (skin biopsy), identification and categorization of genetic variants
0680U	0680U	Tobacco use, DNA analysis of 1 methylation marker (cg05575921 [AHRR]), methylation-sensitive digital PCR, whole blood, algorithm reported as quantitative percentage methylation and estimated average cigarette use per day
0681U	0681U	Tobacco use, DNA analysis of 2 methylation markers (1 content: cg05575921 [AHRR] and 1 normalizing: cg08141395), methylation-sensitive digital PCR, saliva, algorithm reported as quantitative percent methylation and estimated average cigarette use per day
0682U	0682U	Oncology (lung cancer), DNA analysis of 1 methylation marker (cg05575921), methylation-sensitive digital PCR, whole blood, algorithm results reported as the 20-year-hazard ratio for lung cancer
0683U	0683U	Oncology (lung cancer), DNA analysis of 2 methylation markers (1 content: cg05575921 and 1 normalizing: cg08141395), methylation-sensitive digital PCR, saliva, algorithm results reported as the 20-year-hazard ratio for lung cancer
0684U	0684U	Alcohol use disorder, DNA analysis of 4 methylation markers (cg02583484, cg04987734, cg09935388, cg04583842), methylation-sensitive digital PCR, whole blood, algorithm reported as a summed T-score
0685U	0685U	Alcohol use disorder, DNA analysis of 5 methylation markers (4 content: cg02583484, cg04987734, cg09935388, cg04583842, and 1 normalizing: cg08141395), methylation-sensitive digital PCR, whole blood or saliva, algorithm reported as a summed T-score
0686U	0686U	Oncology (prostate), mRNA, next-generation sequencing (NGS) gene expression profiling of 22 genes, formalin-fixed paraffin-embedded (FFPE) tissue, algorithm reported as risk score
0687U	0687U	Comparative analysis using short tandem repeat (STR) markers, patient and comparative specimen, DNA, buccal swab and tissue, reported match or mismatch

October 2026 HCPCS Code	CY 2027 HCPCS Code	CY 2027 Long Descriptor
0688U	0688U	Oncology (colorectal cancer), analysis of minimal residual disease (MRD), next-generation sequencing (NGS), circulating tumor DNA (ctDNA) analysis in whole blood and tumor for baseline assessment to evaluate current MRD status and for comparisons to subsequent MRD assessments
0689U	0689U	Oncology (colorectal cancer), analysis of minimal residual disease (MRD) using patient-specific assays, reported as amount of circulating tumor DNA (ctDNA) detection and trend over time
0690U	0690U	Transplantation medicine (allograft rejection), quantification of donor-derived cell-free DNA (cfDNA) using digital PCR analysis of 45 single-nucleotide polymorphisms, plasma, reported as quantity of donor-derived cfDNA in plasma to determine the probability of allograft rejection
0691U	0691U	Carrier screening (cystic fibrosis, spinal muscular atrophy, beta hemoglobinopathies [including sickle cell disease], alpha thalassemia, and Duchenne muscular dystrophy), genomic sequence analysis panel, 6 genes (CFTR, SMN1, HBB, HBA1, HBA2, DMD) (Do not report 0691U in conjunction with 81443)
0692U	0692U	Cardiology (peripheral artery disease [PAD]), analysis of 3 proteins (midkine, angiopoietin-1, and kidney injury molecule-1 [KIM-1]), immunoassay, plasma, algorithm reported as a risk score for obstructive PAD
0693U	0693U	Oncology (head and neck), circulating tumor DNA (ctDNA), tumor-informed next-generation sequencing (NGS) analysis for 699 genes of patient-specific somatic variants identified from primary tumor tissue, postoperative lymphatic exudate specimen, algorithm reported as presence or absence of ctDNA
0694U	0694U	Oncology (monoclonal gammopathy), immunoprecipitation and matrix-assisted laser desorption/ionization time-of-flight (MALDI-TOF) mass spectrometry, identification of intact monoclonal immunoglobulin isotypes (IgG, IgA, IgM, kappa, lambda), and M-protein concentrations in conjunction with turbidimetry, blood, semiquantitative
0695U	0695U	Oncology (central nervous system), low-pass whole genome sequence analysis of cerebrospinal fluid, interrogation for chromosome arm-level and focal losses and gains
0696U	0696U	Oncology (solid organ), targeted genomic sequence analysis, formalin-fixed paraffin-embedded (FFPE) tumor tissue, RNA analysis, 350 or more genes for RNA alterations (eg, gene rearrangements and splice isoforms)
0697U	0697U	Focused non-shock wave ultrasonic propulsion of residual stone fragment(s) post-lithotripsy, unilateral, including ultrasound guidance, fragment(s) less than or equal to 5 mm
0698U	0698U	Intraoperative radiofrequency ablation of lumpectomy cavity, unilateral, including applicator placement and removal (List separately in addition to code for primary procedure)
1054T	1054T	Focused non-shock wave ultrasonic propulsion of residual stone fragment(s) post-lithotripsy, unilateral, including ultrasound guidance, fragment(s) less than or equal to 5 mm
1055T	1055T	Intraoperative radiofrequency ablation of lumpectomy cavity, unilateral, including applicator placement and removal (List separately in addition to code for primary procedure)
1056T	1056T	Cochlear infusion of pharmacologic agent (ie, gene therapy vector), including mastoidectomy, labyrinthotomy, and repair of fenestrations
1057T	1057T	Insertion or replacement of subcutaneous neurostimulator pulse generators, with tunneling of 4 electrode arrays, bilateral supraorbital and occipital nerves, including all interrogation, programming, and imaging guidance, when performed
1058T	1058T	Revision of implanted subcutaneous unilateral supraorbital and occipital neurostimulator system, including all interrogation, programming, and imaging guidance, when performed

October 2026 HCPCS Code	CY 2027 HCPCS Code	CY 2027 Long Descriptor
1059T	1059T	Removal of implanted subcutaneous unilateral supraorbital and occipital neurostimulator system
1060T	1060T	Electronic analysis of implanted subcutaneous supraorbital-occipital neurostimulator pulse generator (eg, frequency, amplitude, pulse width, leads, electrode configuration); with complex programming by physician or other qualified health care professional
1061T	1061T	Electronic analysis of implanted subcutaneous supraorbital-occipital neurostimulator pulse generator (eg, frequency, amplitude, pulse width, leads, electrode configuration); with simple programming by physician or other qualified health care professional
1062T	1062T	Artificial insemination, transcervical intratubal, unilateral or bilateral, including imaging guidance
1063T	1063T	Oncology (bladder), augmentative algorithmic analysis of histomorphologic features in digitized slides from formalin-fixed paraffin-embedded (FFPE) bladder cancer tissue (high-grade, non-muscle invasive), with clinicopathologic variables entered by the qualified health care professional; algorithm-derived parameters reported as prognostic of recurrence and progression, including hematoxylin and eosin staining of tissue sections, and digitization of glass microscope slides, when performed
1064T	1064T	Oncology (bladder), augmentative algorithmic analysis of histomorphologic features in digitized slides from formalin-fixed paraffin-embedded (FFPE) bladder cancer tissue (high-grade, non-muscle invasive), with clinicopathologic variables entered by the qualified health care professional; algorithm-derived parameters reported as predictive of response to Bacillus Calmette-Guérin (BCG) therapy, including hematoxylin and eosin staining of tissue sections, and digitization of glass microscope slides, when performed
1065T	1065T	Cystourethroscopy, with CO2 cryotherapy spray, in a gaseous bladder environment with pressure monitoring, for treatment of; minor bladder lesion(s) (total lesion[s] diameters less than 0.5 cm)
1066T	1066T	Cystourethroscopy, with CO2 cryotherapy spray, in a gaseous bladder environment with pressure monitoring, for treatment of; small bladder lesion(s) (total lesion[s] diameters greater than or equal to 0.5 cm and less than 2.0 cm)
1067T	1067T	Cystourethroscopy, with CO2 cryotherapy spray, in a gaseous bladder environment with pressure monitoring, for treatment of; medium bladder lesion(s) (total lesion[s] diameters greater than or equal to 2.0 cm and less than 5.0 cm)
1068T	1068T	Cystourethroscopy, with CO2 cryotherapy spray, in a gaseous bladder environment with pressure monitoring, for treatment of; large bladder lesion(s) (total lesion[s] diameters greater than or equal to 5.0 cm)
1069T	1069T	Mechanical extremity (ie, hands and feet) cryocompression; individual glove and boot supplies with initial measurement, fitting, and therapy education
1070T	1070T	Mechanical extremity (ie, hands and feet) cryocompression; individual glove and boot placement, initiation of cooling pre-chemotherapy and continuing through chemotherapy administration
1071T	1071T	Mechanical extremity (ie, hands and feet) cryocompression; post-chemotherapy treatment continuation, each 30 minutes (List separately in addition to code for primary procedure)
1072T	1072T	Liver allograft, normothermic machine perfusion; each additional hour of monitoring and management (List separately in addition to code for primary procedure)
1073T	1073T	Liver allograft, normothermic machine perfusion; decannulation
1074T	1074T	Liver allograft, hypothermic oxygenated perfusion; cannulation
1075T	1075T	Liver allograft, hypothermic oxygenated perfusion; connection to perfusion device

October 2026 HCPCS Code	CY 2027 HCPCS Code	CY 2027 Long Descriptor
1076T	1076T	Liver allograft, hypothermic oxygenated perfusion; monitoring and management, first 2 hours
1077T	1077T	Liver allograft, hypothermic oxygenated perfusion; each additional hour of monitoring and management (List separately in addition to code for primary procedure)
1078T	1078T	Liver allograft, hypothermic oxygenated perfusion; decannulation
1079T	1079T	3D quantitative transmission water bath volumetric ultrasound tomography, breast, with augmentative algorithmic derivation of breast tissue composition (ie, fibroglandular volume), bilateral, with physician or other qualified health care professional interpretation and report
1080T	1080T	Insertion, intracapsular magnifier, with attachment to previously placed intraocular lens
1081T	1081T	Microvascular anastomosis between a lymph node and a vein, including robot assistance, when performed; initial anastomosis
1082T	1082T	Microvascular anastomosis between a lymph node and a vein, including robot assistance, when performed; each additional anastomosis (List separately in addition to code for primary procedure)
1083T	1083T	Stereotactic placement of infusion catheter(s), brain, for delivery of therapeutic agent(s), including computerized stereotactic planning and burr hole(s)
1084T	1084T	Implantation of scaffolding allograft to reinforce the suprachoroidal space
1085T	1085T	Assistive algorithmic analysis for identification of new lesions and determination of inter-lesion heterogeneity of change in metabolic activity and volume for advanced metastatic cancer, data sets from 2 or more previously acquired positron emission tomography (PET) and/or PET computed tomography (CT) (PET/CT) studies
1086T	1086T	Intraprocedural estimate of coronary fractional flow derived by augmentative algorithmic analysis of data from real-time coronary angiography, with creation of functional map of coronary circulation, when performed, with review and interpretation (List separately in addition to code for primary procedure)
1087T	1087T	Estimate of coronary fractional flow derived by augmentative algorithmic analysis of data from previously acquired coronary angiogram, with creation of functional map of coronary circulation, when performed, with automated result
1088T	1088T	Percutaneous application of high-frequency neuromodulation signals using microneedle electrode array for the treatment of nociceptive or neuropathic pain, including electrode placement and patient training, per day
1089T	1089T	Intraoperative quantitative micro-elastography tissue characterization, including real-time imaging and physician assessment, per breast
1090T	1090T	Attachment and insertion of intraocular lens prosthesis–mounted drug-eluting implant (List separately in addition to code for primary procedure)
C8010	1091T	Placement of permanent common carotid artery filter, percutaneous, bilateral, including ultrasound guidance, when performed
1092T	1092T	Implantation of acellular scaffold (eg, hyaluronan), knee, single implant; into chondral defect, open
1093T	1093T	Implantation of acellular scaffold (eg, hyaluronan), knee, single implant; into a chondral or osteochondral defect, arthroscopic
1094T	1094T	Implantation of acellular scaffold (eg, hyaluronan), knee, single implant; each additional acellular scaffold implantation (List separately in addition to code for primary procedure)
1095T	1095T	Harvesting and processing of autologous bone marrow aspirate concentrate (BMAC), with application onto scaffold or injection into anatomical recipient site (eg, subchondral bone, joint space, chondral lesion), including imaging guidance, when performed, for therapeutic musculoskeletal treatment, excluding spinal procedures

October 2026 HCPCS Code	CY 2027 HCPCS Code	CY 2027 Long Descriptor
1096T	1096T	Injection(s) of thermoregulated multiphase suspension to demyelinate nerves innervating the knee joint, including imaging guidance, when performed
1097T	1097T	Oncology (pancreas), augmentative algorithmic analysis of histomorphologic features in digitized slides from formalin-fixed paraffin-embedded pancreatic cancer tissue, algorithm-derived parameters reported as prediction of response to fluorouracil backbone versus gemcitabine backbone chemotherapy, including hematoxylin and eosin staining of tissue sections and digitization of glass microscope slides, when performed
1098T	1098T	Placement of subretinal prosthesis, including vitrectomy
1099T	1099T	Ablation of incompetent vein(s), extremity, transcutaneous, high intensity–focused ultrasound (HIFU), inclusive of all imaging guidance and monitoring
1100T	1100T	Transcutaneous spinal neuromodulation programming, including history and physical examination, safety screening, selection and external placement of a multichannel spinal electrode pad, baseline spinal motor mapping, creation of individualized stimulation parameter sets for therapeutic activities, and patient and/or caregiver instruction, each 30 minutes
1101T	1101T	Transcutaneous spinal neuromodulation application in combination with therapeutic activities, direct (one-on-one) patient contact using dynamic activities to improve functional performance, including individualized external placement of a multichannel spinal electrode pad, optimization of stimulation parameters across multiple channels, and delivery of transcutaneous spinal neuromodulation during functional task performance, each 15 minutes
1102T	1102T	Intraoperative molecular assessment for lung tumor tissue, in-vivo (including assessment, when performed following lung resection), using computer-aided fluorescence imaging (List separately in addition to code for primary procedure)
1103T	1103T	Intraoperative molecular assessment for ovarian, tubal, or peritoneal tumor tissue, in-vivo (including assessment, when performed following ovarian, tubal, or peritoneal resection), using computer-aided fluorescence imaging (List separately in addition to code for primary procedure)
1104T	1104T	Noninvasive cardiopulmonary assessment, including quantitative parameters, respectively predictive of significant epicardial coronary artery disease, pulmonary hypertension, and/or elevated pulmonary capillary wedge pressure, derived by augmentative algorithmic analysis of orthogonal voltage gradient and photoplethysmography signals, with automated report
1105T	1105T	Personalized neurostimulation pulse rate derived by augmentative algorithmic analysis of data from electroencephalogram (EEG) and electrocardiogram (ECG), including acquisition of EEG and single-lead ECG, with automated report
1106T	1106T	Oncology (breast), augmentative algorithmic analysis of histomorphologic features in digitized hematoxylin and eosin stained slides from formalin-fixed paraffin-embedded (FFPE) breast cancer tissue, algorithm-derived parameters reported as 5-year and 10-year risks of distant metastasis, including digitization of glass microscope slides and hematoxylin and eosin staining of tissue sections, when performed
1107T	1107T	Oncology (prostate), augmentative algorithmic analysis of histomorphologic features in digitized hematoxylin and eosin stained slide(s) from formalin-fixed paraffin-embedded (FFPE) prostate cancer tissue, algorithm-derived parameters reported as 10-year risk of distant metastasis and prostate cancer specific mortality, including hematoxylin and eosin staining of tissue sections and digitization of glass microscope slides, when performed

October 2026 HCPCS Code	CY 2027 HCPCS Code	CY 2027 Long Descriptor
1108T	1108T	Stereotactic intracerebral implantation of therapeutic agent, unilateral, including cranial access and intraoperative imaging guidance, when performed; 1 or more injections along a single trajectory
1109T	1109T	Stereotactic intracerebral implantation of therapeutic agent, unilateral, including cranial access and intraoperative imaging guidance, when performed; 1 or more injections along multiple trajectories
1110T	1110T	Stereotactic intracerebral delivery of therapeutic agent, by controlled infusion, unilateral, including cranial access and intraoperative imaging guidance, when performed; single trajectory
1111T	1111T	Stereotactic intracerebral delivery of therapeutic agent, by controlled infusion, unilateral, including cranial access and intraoperative imaging guidance, when performed; multiple trajectories
A2046	A2046	Dermisphere hdrt, per square centimeter (add-on, list separately in addition to primary procedure)
A2047	A2047	Lacertamatrix, per square centimeter (add-on, list separately in addition to primary procedure)
A2048	A2048	Puraply mz, per milligram
A2049	A2049	Theracor, per square centimeter (add-on, list separately in addition to primary procedure)
A2050	A2050	Fibrillar collagen wound dressing, per milligram
A4228	A4228	Supplies for maintenance of non-insulin, device-drug combination infusion catheter, per week
A6614	A6614	Supplies and accessories for use with an external ocular negative pressure pump, any type, per month
A9613	A9613	Piflufolastat f 18 (pylarify truvu), diagnostic, 1 millicurie
C9311	C9311	Injection, eplontersen, 1 mg (code may be used for medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered)
C9312	C9312	Injection, trabectedin (apotex), not therapeutically equivalent to J9352, 0.01 mg
C9313	C9313	Injection, pivekimab sunirine-pvzy, 0.01 mg
E0788	E0788	Ambulatory infusion pump, specific device-drug combination, single or multiple channels, electric or battery operated, with administrative equipment, worn by patient
E2403	E2403	External ocular negative pressure pump, electric
G0577	G0577	Vascular embolization or occlusion procedure with use of a pressure-generating catheter (e.g., one-way valve, intermittently occluding), inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction performed in the non-facility setting
G0685	G0685	Algorithm-based assessment of likelihood of autism spectrum disorder (asd), derived from validated analysis of eye-gaze data or other technology
J0014	J0014	Cocaine hydrochloride nasal solution (goprelto), 1 mg
J0643	J0643	Injection, leucovorin calcium, not otherwise specified, 1 mg
C9310	J0644	Injection, leucovorin calcium (avyxa), 1 mg
J0871	J0871	Injection, daptomycin (endo), not therapeutically equivalent to j0878, 1 mg
J1757	J1757	Injection, tividenofusp alfa-eknm, 1 mg
J1818	J1818	Injection, pegzilarginase-nbln, 0.05 mg
J1946	J1946	Injection, furosemide (lasix onyu), 1 mg
J1947	J1947	Injection, furosemide (furoscix), 1 mg
J1957	J1957	Injection, levetiracetam, 5 mg
J1958	J1958	Injection, levetiracetam in sodium chloride, 5 mg
C9462	J3268	Injection, delafloxacin, 1 mg
J3406	J3406	Injection, omidubicel-onlv, per therapeutic dose

October 2026 HCPCS Code	CY 2027 HCPCS Code	CY 2027 Long Descriptor
J7524	J7524	Mycophenolate mofetil, oral, 5 mg
J7526	J7526	Injection, mycophenolate mofetil, 5 mg
J7529	J7529	Mycophenolate mofetil, for suspension, oral, 5 mg
J7530	J7530	Mycophenolate mofetil (myhibbin), oral suspension, 5 mg
J7531	J7531	Prednisolone sodium phosphate, orally disintegrating tablet, 1 mg
J9066	J9066	Injection, bendamustine hydrochloride (avyxa), 1 mg
J9186	J9186	Injection, etoposide (avyxa), 1 mg
J9187	J9187	Injection, etoposide, 1 mg
J9191	J9191	Injection, fluorouracil (avyxa), 10 mg
J9192	J9192	Injection, fluorouracil, 10 mg
J9362	J9362	Injection, trabectedin, 0.01 mg
L1330	L1330	Thoracic orthosis, sternal and/or sternocostal compression, may include anterior and/or posterior pads, panels, with or without frame, prefabricated, includes fitting and adjustment
L1972	L1972	Ankle foot orthosis, plastic or other material with ankle joint, with or without dorsiflexion assist, prefabricated, off-the shelf
L8697	L8697	External accessory for use with implantable phrenic nerve stimulation device, replacement, each
Q4207	Q4207	Carbon life, per square centimeter (add-on, list separately in addition to primary procedure)
Q4223	Q4223	Dermabind sl optic, per square centimeter (add-on, list separately in addition to primary procedure)
Q4243	Q4243	Amchomatrix, per square centimeter (add-on, list separately in addition to primary procedure)
Q5172	Q5172	Injection, filgrastim-laha (filkri), biosimilar, 1 microgram
Q5173	Q5173	Injection, denosumab-adet (ponlimsi), biosimilar, 1 mg

4. January 2027 HCPCS Codes

a. New Level II HCPCS Codes Final Rule Comment Solicitation

Consistent with past practice, we are soliciting comments on the new Level II HCPCS codes that will be effective January 1, 2027, in the CY 2027 OPPS/ASC final rule with comment period, thereby allowing us to finalize the status indicators and APC assignments for the codes in the CY 2028 OPPS/ASC final rule with comment period. Unlike the CPT codes that are effective January 1 and are included in the OPPS/ASC proposed rules, and except for the proposed new C-codes and G-codes listed in Addendum O of the proposed rule, most Level II HCPCS codes are not released until sometime around November to be effective January 1. Because these codes are not available until November, we are unable to include them in the OPPS/ASC proposed rules. Consequently, for CY 2027, we proposed to include the new Level II HCPCS codes effective January 1, 2027, in Addendum B to the CY 2027 OPPS/ASC final rule

with comment period, which would be included in the January 2027 OPPS quarterly update CR. Specifically, for CY 2027, we proposed to continue our established policy of assigning comment indicator "N1" in Addendum B to the OPPS/ASC final rule with comment period to the new HCPCS codes that will be effective January 1, 2027, to indicate that we are assigning them an interim status indicator, which is subject to public comment. We are inviting public comments in this final rule with comment period on the status indicator and APC assignments, which would then be finalized in the CY 2028 OPPS/ASC final rule with comment period. Similar to the codes effective October 1, 2026, the proposed APC assignments and status indicators for these new Level II HCPCS codes that will be effective January 1, 2027, will also be subject to comment in the CY 2028 OPPS/ASC proposed rule, and will be finalized in the CY 2028 OPPS/ASC final rule with comment period.

b. New CPT Codes Proposed Rule Comment Solicitation

In the CY 2015 OPPS/ASC final rule with comment period (79 FR 66841 through 66844), we finalized a revised process of assigning APC and status indicators for new and revised Category I and III CPT codes that would be effective January 1. Specifically, for the new/revised CPT codes that we receive in a timely manner from the AMA's CPT Editorial Panel, we finalized our proposal to include the codes that would be effective January 1 in the OPPS/ASC proposed rules, along with proposed APC and status indicator assignments for them, and to finalize the APC and status indicator assignments in the OPPS/ASC final rules beginning with the CY 2016 OPPS update. For those new/revised CPT codes that were received too late for inclusion in the OPPS/ASC proposed rule, we finalized our proposal to establish and use HCPCS G-codes that mirror the predecessor CPT codes and retain the current APC and status indicator assignments for a year until we can propose APC and status indicator assignments in the following year's rulemaking cycle. We note that even if we find that we need to create HCPCS G-codes in place of certain CPT codes for the PFS proposed rule, we do not anticipate that these HCPCS G-codes will always be necessary for OPPS purposes. We will make every

effort to include proposed APC and status indicator assignments for all new and revised CPT codes that the AMA makes publicly available in time for us to include them in the proposed rule, and to avoid resorting to use of HCPCS G-codes and the resulting delay in utilization of the most current CPT codes. Also, we finalized our proposal to make interim APC and status indicator assignments for CPT codes that are not available in time for the proposed rule and that describe wholly new services (such as new technologies or new surgical procedures), to solicit public comments in the final rule with comment period, and to finalize the specific APC and status indicator assignments for those codes in the following year's rule.

For the CY 2027 OPPS update, we received the CPT codes that will be effective January 1, 2027, from the AMA in time to be included in the CY 2027 OPPS/ASC proposed rule. We note, however, that in early August, the AMA revised their release and effective dates for the Category III CPT codes to a tri-annual schedule.[14] The Category III codes that were initially slated to be effective January 1, 2027, became effective October 1, 2027. The new, revised, and deleted CPT codes, including the new Category III codes that became effective October 1, can be found in Addendum B to the proposed rule (which is available via the internet on the CMS website). See *https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1850-p*.

We note that the new and revised CPT codes are assigned to comment indicator "NP" in Addendum B to the proposed rule to indicate that the code is new for the next calendar year or the code is an existing code with substantial revision to its code descriptor in the next calendar year as compared to the current calendar year with a proposed APC assignment, and that comments would be accepted on the proposed APC assignment and status indicator. Further, we noted that the CPT code descriptors that appeared in Addendum B were short descriptors and did not accurately describe the complete procedure, service, or item described by

[14] See the American Medical Association's website for the updated release and effective dates. *https://www.ama-assn.org/system/files/category-3-early-release.pdf*.

the CPT code (91 FR 41787). Therefore, we included the 5-digit placeholder codes and the long descriptors for the new and revised CY 2027 OPPS/ASC proposed rule (which is available via the internet on the CMS website) so that the public could adequately comment on the proposed APCs and SI assignments. The 5-digit placeholder codes were included in Addendum O to the "CY 2027 OPPS/ASC Proposed Rule 5-Digit AMA/CMS Placeholder Code." We noted that the final CPT code numbers would be included in this CY 2027 OPPS/ASC final rule with comment period. We also noted that not every code listed in Addendum O is subject to public comment. For the new and revised Category I and III CPT codes, we requested public comments on only those codes that are assigned comment indicator "NP". Finally, we would like to note that the CY 2027 OPPS/ASC proposed rule Addendum O contained two errors. First, we inadvertently included placeholder code 'C75X6', which should not have been included. Second, the long descriptor for C75X5 should have read, *"Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation, with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, with 3d echocardiographic imaging and postprocessing during transesophageal echocardiography, or during transthoracic echocardiography for congenital cardiac anomalies, for the assessment of cardiac structure(s) (eg, cardiac chambers and valves, left atrial appendage, interatrial septum, interventricular septum) and function, when performed".* These errors have been corrected in the CY 2027 OPPS/ASC final rule Addendum O.

In summary, in the CY 2027 OPPS/ASC proposed rule, we solicited public comments on the proposed CY 2027 status indicators and APC assignments for the new and revised CPT codes that would be effective January 1, 2027. The CPT codes listed in Addendum B to the CY 2027 OPPS/ASC proposed rule appear with short descriptors only. We listed them again, with long descriptors, in Addendum O to the CY 2027 OPPS/ASC proposed rule. We also proposed to finalize the status indicator and APC assignments for these codes (with their final CPT code

numbers) in the CY 2027 OPPS/ASC final rule with comment period. The proposed status indicator and APC assignments for these codes were included in Addendum B to the CY 2027 OPPS/ASC proposed rule (which is available via the internet on the CMS website). We received comments on several of the new CPT codes that were assigned to comment indicator "NP" in Addendum B to the CY 2027 OPPS/ASC proposed rule. We have responded to those public comments in sections III.C., III.E., and IV. of this final rule with comment period.

The final SIs, APC assignments, and payment rates for the new CPT codes that are effective January 1, 2027, can be found in Addendum B to this final rule with comment period. In addition, the SI definitions can be found Addendum D1 to this final rule with comment period. Addenda B and D1 are available via the internet on the CMS website.

Finally, Table 15, which is a reprint of Table 11 from the CY 2027 OPPS/ASC proposed rule (91 FR 41788), shows the comment timeframe for new and revised HCPCS codes. The table provides information on our current process for updating codes through our OPPS quarterly update CRs, seeking public comments, and finalizing the treatment of these codes under the OPPS.

TABLE 15: COMMENT AND FINALIZATION TIMEFRAMES FOR NEW AND REVISED OPPS-RELATED HCPCS CODES

OPPS Quarterly Update CR	Type of Code	Effective Date	Comments Sought	When Finalized
April 2026	HCPCS (CPT and Level II Codes)	April 1, 2026	CY 2027 OPPS/ASC proposed rule	CY 2027 OPPS/ASC final rule with comment period
July 2026	HCPCS (CPT and Level II Codes)	July 1, 2026	CY 2027 OPPS/ASC proposed rule	CY 2027 OPPS/ASC final rule with comment period
October 2026	HCPCS (CPT and Level II Codes)	October 1, 2026	CY 2027 OPPS/ASC final rule with comment period	CY 2028 OPPS/ASC final rule with comment period
January 2027	CPT codes	January 1, 2027	CY 2027 OPPS/ASC proposed rule	CY 2027 OPPS/ASC final rule with comment period
	Level II HCPCS Codes	January 1, 2027	CY 2027 OPPS/ASC final rule with comment period	CY 2028 OPPS/ASC final rule with comment period

B. OPPS Changes—Variations Within APCs

1. Background

Section 1833(t)(2)(A) of the Act requires the Secretary to develop a classification system for covered hospital outpatient department services. In addition, section 1833(t)(2)(B) of the Act provides that the Secretary may establish groups of covered OPD services within this classification system, so that services classified within each group are comparable clinically and with respect to the use of resources. In accordance with these provisions, we developed a grouping classification system, referred to as Ambulatory Payment Classifications (APCs), as set forth in regulations at 42 CFR 419.31. We use Level I (also known as CPT codes) and Level II HCPCS codes (also known as alphanumeric codes) to identify and group the services within each APC. The APCs are organized such that each group is homogeneous both clinically and in terms of resource use. Using this classification system, we have established distinct groups of similar services. We also have developed separate APC groups for certain medical devices, drugs, biologicals, therapeutic radiopharmaceuticals, and brachytherapy devices that are not packaged into the payment for the procedure.

We have packaged into the payment for each procedure or service within an APC group, the costs associated with those items and services that are typically ancillary and supportive to a primary diagnostic or therapeutic modality and, in those cases, are an integral part of the primary service they support. Therefore, we do not make separate payment for these packaged items or services. In general, packaged items and services include, but are not limited to, the items and services listed in regulations at 42 CFR 419.2(b). A further discussion of packaged services is included in section II.A.3. of this final rule with comment period.

Under the OPPS, we generally pay for covered hospital outpatient services on a rate-per-service basis, where the service may be reported with one or more HCPCS codes. Payment varies according to the APC group to which the independent service or combination of services

is assigned. For CY 2027, we proposed that each APC relative payment weight represents the hospital cost of the services included in that APC, relative to the hospital cost of the services included in APC 5012 (Clinic Visits and Related Services) (91 FR 41788). The APC relative payment weights are scaled to APC 5012 because it is the hospital clinic visit APC and clinic visits are among the most frequently furnished services in the hospital outpatient setting.

2. Application of the 2 Times Rule

Section 1833(t)(9)(A) of the Act requires the Secretary to review, not less often than annually, and revise the APC groups, the relative payment weights, and the wage and other adjustments described in section 1833(t)(2) of the Act to consider changes in medical practice, changes in technology, the addition of new services, new cost data, and other relevant information and factors. Section 1833(t)(9)(A) of the Act also requires the Secretary to consult with an expert outside advisory panel composed of an appropriate selection of representatives of providers to review (and advise the Secretary concerning) the clinical integrity of the APC groups and the relative payment weights. We note that the Advisory Panel on Hospital Outpatient Payment (also known as the HOP Panel or the Panel) recommendations for specific services for the CY 2027 OPPS update will be discussed in the relevant specific sections throughout the CY 2027 OPPS/ASC final rule with comment period.

In addition, section 1833(t)(2) of the Act provides that, subject to certain exceptions, the items and services within an APC group cannot be considered comparable regarding the use of resources if the highest cost for an item or service in the group is more than 2 times greater than the lowest median cost (or mean cost if so elected) for an item or service within the same group (referred to as the "2 times rule").

The statute authorizes the Secretary to make exceptions to the 2 times rule in unusual cases, such as for low-volume items and services (but the Secretary may not make such an exception in the case of a drug or biological that has been designated as an orphan drug under section 526 of the Federal Food, Drug, and Cosmetic Act). In determining the APCs with a 2

times rule violation, we consider only those HCPCS codes that are significant based on the number of claims. We note that, for purposes of identifying significant procedure codes for examination under the 2 times rule, we consider procedure codes that have more than 1,000 single major claims or procedure codes that both have more than 99 single major claims and contribute at least 2 percent of the single major claims used to establish the APC cost to be significant (75 FR 71832). This longstanding definition of when a procedure code is significant for purposes of the 2 times rule was selected because we believe that a subset of 1,000 or fewer claims is negligible within the set of approximately 100 million single procedure or single session claims we use for establishing costs. Similarly, a procedure code for which there are fewer than 99 single claims and that comprises less than 2 percent of the single major claims within an APC will have a negligible impact on the APC cost (75 FR 71832). In the CY 2027 OPPS/ASC proposed rule, we proposed to make exceptions to this limit on the variation of costs within each APC group in unusual cases, such as for certain low-volume items and services (91 FR 41789).

For the CY 2027 OPPS update, we identified the APCs with violations of the 2 times rule, and we proposed changes to the procedure codes assigned to these APCs (with the exception of those APCs for which we have proposed a 2 times rule exception) in Addendum B to CY 2027 OPPS/ASC proposed rule. We note that Addendum B does not appear in the printed version of the **Federal Register** as part of the proposed rule. Rather, it was published and made available via the internet on the CMS website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices.*

To eliminate a violation of the 2 times rule and improve clinical and resource homogeneity in the APCs for which we have not proposed a 2 times rule exception, we proposed to reassign these procedure codes to new APCs that contain services that are similar with regard to both their clinical and resource characteristics. In many cases, the proposed procedure code

reassignments and associated APC reconfigurations for CY 2027 included in the CY 2027 OPPS/ASC proposed rule are related to changes in costs of services that were observed in the CY 2025 claims data available for CY 2027 ratesetting. Addendum B to the CY 2027 OPPS/ASC proposed rule identifies with a comment indicator ''CH'' those procedure codes for which we proposed a change to the APC assignment or status indicator, or both, that were initially assigned in the July 1, 2026, OPPS Addendum B Update, which is available via the internet on the CMS website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient-pps/quarterly-addenda-updates.*

3. APC Exceptions to the 2 Times Rule

While considering the APC changes that we proposed for CY 2027, we reviewed all of the APCs for which we identified 2 times rule violations to determine whether any of the APCs would qualify for an exception. We used the following criteria to evaluate whether to propose exceptions to the 2 times rule for affected APCs:

- Resource homogeneity;
- Clinical homogeneity;
- Hospital outpatient setting utilization;
- Frequency of service (volume); and
- Opportunity for upcoding and code fragments.

For a detailed discussion of these criteria, we refer readers to the April 7, 2000 final rule (65 FR 18457 through 18458).

Based on the CY 2025 claims data available for the CY 2027 OPPS/ASC proposed rule, we found 27 APCs with violations of the 2 times rule. We applied the criteria as described previously in this section to identify the APCs for which we proposed to make exceptions under the 2 times rule for CY 2027 and found that all of the 27 APCs we identified meet the criteria for an exception to the 2 times rule based on the CY 2025 claims data available for the CY 2027 OPPS/ASC proposed rule. We note that, on an annual basis, based on our analysis of the latest

claims data, we identify violations to the 2 times rule and propose changes when appropriate. Those APCs that violate the 2 times rule are identified and appear in Table 16. In addition, we did not include in that determination those APCs where a 2 times rule violation was not a relevant concept, such as APC 5401 (Dialysis), which only has two HCPCS codes assigned to it that have similar geometric mean costs and do not create a 2 times rule violation. Therefore, we have only identified those APCs, including those with criteria-based costs, such as device-dependent CPT/ HCPCS codes, with violations of the 2 times rule, where a 2 times rule violation is a relevant concept.

Table 12 of the CY 2027 OPPS/ASC proposed rule (90 FR41790) listed the APCs for which we proposed to make an exception under the 2 times rule for CY 2027 based on the criteria cited previously and claims data submitted between January 1, 2025, and December 31, 2025, and CCRs, if available. The proposed geometric mean costs for covered hospital outpatient services for these and all other APCs that were used in the development of the CY 2027 OPPS/ASC proposed rule can be found via the internet on the CMS website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1850-p.* .

Based on the updated final rule CY 2025 claims data used for this final rule with comment period, we found a total of 28 APCs with violations of the 2 times rule. Of these 28 total APCs, 24 were identified in the proposed rule and four are newly identified in this final rule with comment period. The following APCs appeared in Table 12 of the CY 2027 OPPS/ASC proposed rule (91 FR41790) as violating the 2 times rule. However, after conducting data analysis for this final rule with comment period, we found that the following APCs no longer violate the 2 times rule:

- APC 5613 (Level 3 Therapeutic Radiation Treatment Preparation).
- APC 5674 (Level 4 Pathology).
- APC 5735 (Level 5 Minor Procedures).

In addition, the following four APCs are newly identified with 2 times rule violations using updated data for this final rule with comment period:

- APC 5024 (Level 4 Type A ED Visits).
- APC 5051 (Level1 Skin Procedures).
- APC 5622 (Level 2 Radiation Therapy).
- APC 5672 (Level 2 Pathology).

We received comments on the APCs located in Table 12 of the CY 2027 OPPS/ASC proposed rule (91 FR 41790), along with comments on APC assignments for specific HCPCS codes. These comments and our responses can be found in section III.E. of this final rule with comment period. Based on our analysis of the CY 2025 costs from hospital claims and cost report data available for this final rule with comment period, we are finalizing our proposals with some modifications. Specifically, we are finalizing our proposal to except the 24 proposed APCs that continue to have 2 times violations in this final rule with comment period data from the 2 times rule for CY 2025 claims data and also except four additional APCs that did not violate the 2 times rule in the CY 2027 OPPS/ASC proposed rule data, but do violate the 2 times rule in this final rule with comment period data, for a total of 28 APCs for which we identified 2 times rule violations but that qualify for exceptions.

In summary, Table 16 lists the 28 APCs that we are excepting from the 2 times rule for CY 2027 based on the criteria described earlier and a review of updated claims data for dates of service between January 1, 2025, and December 31, 2025, that were processed on or before June 30, 2026, and updated CCRs, if available. We note that, for cases in which a recommendation by the HOP Panel appears to result in or allow a violation of the 2 times rule, we frequently accept the HOP Panel's recommendation because those recommendations are based on explicit consideration of resource use, clinical homogeneity, site of service, and the quality of the claims data used to determine the APC payment rates. The geometric mean costs for hospital outpatient services for these and all other APCs that were used in the development of this final rule with

comment period can be found via the internet on the CMS website at *https://www.cms.gov/medicare/payment/prospective-paymentsystems/hospitaloutpatient/regulations-notices*.

TABLE 16: FINAL CY 2027 APC EXCEPTIONS TO THE 2 TIMES RULE

APC	APC Group Title
5012	Clinic Visits and Related Services
5024	Level 4 Type A ED Visits
5051	Level 1 Skin Procedure
5054	Level 4 Skin Procedures
5071	Level 1 Excision/ Biopsy/ Incision and Drainage
5301	Level 1 Upper GI Procedures
5521	Level 1 Imaging without Contrast
5522	Level 2 Imaging without Contrast
5523	Level 3 Imaging without Contrast
5524	Level 4 Imaging without Contrast
5572	Level 2 Imaging with Contrast
5573	Level 3 Imaging with Contrast
5611	Level 1 Therapeutic Radiation Treatment Preparation
5612	Level 2 Therapeutic Radiation Treatment Preparation
5622	Level 2 Radiation Therapy
5671	Level 1 Pathology
5672	Level 2 Pathology
5691	Level 1 Drug Administration
5692	Level 2 Drug Administration
5722	Level 2 Diagnostic Tests and Related Services
5731	Level 1 Minor Procedures
5734	Level 4 Minor Procedures
5741	Level 1 Electronic Analysis of Devices
5742	Level 2 Electronic Analysis of Devices
5791	Pulmonary Treatment
5821	Level 1 Health and Behavior Services
5822	Level 2 Health and Behavior Services
5823	Level 3 Health and Behavior Services

C. New Technology APCs

1. Background

In the CY 2002 OPPS final rule (66 FR 59903), we finalized changes to the time period in which a service can be eligible for payment under a New Technology APC. Beginning in CY 2002, we retain services within New Technology APC groups until we gather sufficient claims data to enable us to assign the service to an appropriate clinical APC. This policy allows us to move a service from a New Technology APC in less than 2 years if sufficient data are available. It also allows us to retain a service in a New Technology APC for more than 2 years if sufficient

data upon which to base a decision for reassignment have not been collected.

We also adopted in the CY 2002 OPPS final rule the following criteria for assigning a complete or comprehensive service to a New Technology APC: (1) the service must be truly new, meaning it cannot be appropriately reported by an existing HCPCS code assigned to a clinical APC and does not appropriately fit within an existing clinical APC; (2) the service is not eligible for transitional pass-through payment (however, a truly new, comprehensive service could qualify for assignment to a new technology APC even if it involves a device or drug that could, on its own, qualify for pass-through payment); and (3) the service falls within the scope of Medicare benefits under section 1832(a) of the Act and is reasonable and necessary in accordance with section 1862(a)(1)(A) of the Act (66 FR 59898 through 59903). For additional information about our New Technology APC policy, we refer readers to *https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/pass-through-payment-status-new-technology-ambulatory-payment-classification-apc* on the CMS website and then follow the instructions to access the MEARIS™ system for OPPS New Technology APC applications.[15]

In the CY 2004 OPPS final rule with comment period (68 FR 63416), we restructured the New Technology APCs to make the cost intervals more consistent across payment levels and refined the cost bands for these APCs to retain two parallel sets of New Technology APCs: one set with a status indicator of ‘‘S’’ (Significant Procedures, Not Discounted when Multiple. Paid under OPPS; separate APC payment) and the other set with a status indicator of ‘‘T’’ (Significant Procedure, Multiple Reduction Applies. Paid under OPPS; separate APC payment). These current New Technology APC configurations allow us to price new technology services more appropriately and consistently.

For CY 2026, there were 52 New Technology APC levels, ranging from the lowest cost band assigned to APC 1491 (New Technology—Level 1A ($0– $10)) to the highest cost band

[15] Currently approved under OMB control number 0938-0860; expires October 31, 2027.

assigned to APC 1908 (New Technology—Level 52 ($145,001–$160,000)). We note that the cost bands for the New Technology APCs, specifically, APCs 1491 through 1599 and 1901 through 1908, vary with increments ranging from $10 to $14,999. These cost bands identify the APCs to which new technology procedures and services with estimated service costs that fall within those cost bands are assigned under the OPPS. Payment for each APC is made at the mid-point of the APC's assigned cost band. For example, payment for APC 1507 (New Technology—Level 7 ($501–$600)) is made at $550.50.

Under the OPPS, one of our goals is to make payments that are appropriate for the services that are necessary for the treatment of Medicare beneficiaries. The OPPS, like other Medicare payment systems, is intended to be budget neutral in comparison to what would have been paid under the previous reasonable-cost payment system, and increases are limited to the annual hospital market basket increase reduced by the productivity adjustment. We believe that our payment rates reflect the costs that are associated with providing care to Medicare beneficiaries and continue to be adequate to ensure access to services. For many emerging technologies, there is a transitional period during which utilization may be low, often because providers are first learning about the technologies and their clinical utility. Quite often, parties request that Medicare make higher payments under the New Technology APCs for new procedures in that transitional phase. These requests, and their accompanying estimates for expected total patient utilization, often reflect very low rates of patient use of expensive equipment, resulting in high per-use costs for which requesters believe Medicare should make full payment. Medicare does not, and we believe should not, assume responsibility for more than its share of the costs of procedures based on projected utilization for Medicare beneficiaries and does not set its payment rates based on initial projections of low utilization for services that require expensive capital equipment. For the OPPS, we rely on hospitals to make informed business decisions regarding the acquisition of high-cost capital equipment, taking into consideration their knowledge about their entire patient base (Medicare beneficiaries included)

and an understanding of Medicare's and other payers' payment policies. We refer readers to the CY 2013 OPPS/ASC final rule with comment period (77 FR 68314) for further discussion regarding this payment policy.

Some services assigned to New Technology APCs have low annual volume, which we consider to be fewer than 100 claims in the year of claims data used for ratesetting (86 FR 63528). Where utilization of services assigned to a New Technology APC is low, it can lead to wide variation in payment rates from year to year, resulting in even lower utilization and potential barriers to access of new technologies, which ultimately limits our ability to assign the service to the appropriate clinical APC. To mitigate these issues, we finalized a policy in the CY 2019 OPPS/ ASC final rule with comment period to utilize our equitable adjustment authority at section 1833(t)(2)(E) of the Act to adjust how we determine the costs for low-volume services assigned to New Technology APCs (83 FR 58892 through 58893). Specifically, in the CY 2019 OPPS/ASC final rule with comment period (83 FR 58893), we established that, in each of our annual rulemakings, we would calculate and present the result of each statistical methodology (arithmetic mean, geometric mean, and median) based on up to 4 years of claims data and solicit public comment on which methodology should be used to establish the payment rate for the low-volume new technology service. However, in the CY 2022 OPPS/ASC final rule with comment period (86 FR 63529), we replaced the New Technology APC low volume policy with the universal low volume APC policy. Unlike the discontinued New Technology APC low volume policy, the universal low volume APC policy applies to clinical APCs and brachytherapy APCs, in addition to procedures assigned to New Technology APCs, and uses the highest of the geometric mean, arithmetic mean, or median based on up to 4 years of claims data to set the payment rate for the APC. We refer readers to the CY 2022 OPPS/ASC final rule with comment period (86 FR 63529) for further discussion regarding this policy.

Despite the universal low volume APC policy, we continued to see payment instability for services with very low claims volume of fewer than 10 claims in the 4-year lookback period

used under the universal low volume APC policy. For CY 2025, we finalized a policy to exempt services assigned to New Technology APCs with fewer than 10 claims over the 4-year lookback period used for the universal low volume policy. Instead of assigning these services to a different New Technology APC based on the very few claims available, we maintained the New Technology APC assignment for each service from the prior year, CY 2024. We refer readers to the CY 2025 OPPS/ASC final rule with comment period for a discussion on the policy (89 FR 94016 through 94018). Consistent with our overall policy regarding use of updated claims data in the final rule with comment period, we finalized our proposal to perform a similar analysis for the final rule with comment period using updated claims data, including determining whether specific HCPCS codes continue to meet the criteria for our universal low volume APC policy or would be subject to our proposed policy to continue exempting services with fewer than 10 claims in the 4-year lookback period from the universal low volume APC policy and maintain the New Technology APC assignment from the previous year (91 FR 41791).

In the CY 2026 OPPS/ASC final rule with comment period we finalized a continuation of the policy to exempt services assigned to New Technology APCs with fewer than 10 claims over the 4-year lookback period from the universal low volume policy moving forward. We finalized to continue this policy in future years, until, or unless, an alternative policy was finalized. We refer readers to the CY 2026 OPPS/ASC final rule with comment period for a discussion on the policy (90 FR 53530 through 53531).

In addition to the universal low volume policy and the policy to exempt services with fewer than 10 claims in the 4-year lookback period, it has been our policy to maintain the New Technology APC assignment for services with zero claims in the claims year used for rulemaking. For CY 2027, since we proposed CY 2027 OPPS payment rates based on CY 2025 claims data, if a service has no CY 2025 claims, we proposed to maintain the same New Technology APC assignment for CY 2027 (91 FR 41791). We continue to believe this approach is appropriate because, in the absence of new claims data, there is no additional information upon

which to base a reassignment. This policy ensures consistency and stability in payment until sufficient claims data become available to support a reassignment to a different New Technology APC or appropriate clinical APC.

Finally, we note that, in a budget-neutral system, payments may not fully cover hospitals' costs in a particular circumstance, including those for the purchase and maintenance of capital equipment. We rely on hospitals to make their decisions regarding the acquisition of high-cost equipment with the understanding that the Medicare program must be careful to establish its initial payment rates, including those made through New Technology APCs, for new services that lack hospital claims data based on realistic utilization projections for all such services delivered in cost-efficient hospital outpatient settings. As the OPPS acquires claims data regarding hospital costs associated with new procedures, we regularly examine the claims data and any available new information regarding the clinical aspects of new procedures to confirm that our OPPS payments remain appropriate for procedures as they transition into mainstream medical practice.

For CY 2027, the proposed payment rates for New Technology APCs 1491 to 1599 and 1901 through 1908 are provided in Addendum A to the proposed rule (which is available on the CMS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices*.

2. Services in New Technology APCs with Zero Claims for the Rulemaking Period or Under 10 Claims in the 4-year Lookback Period

For CY 2027, there are several services that have either zero claims for CY 2027 rulemaking (based on CY 2025 claims) or fewer than 10 claims in the previous 4-year lookback period. For CY 2027, we proposed to maintain the New Technology APC assignments for services listed in Table 17.

TABLE 17: SERVICES WITH FEWER THAN 10 CLAIMS IN THE LOOKBACK PERIOD OR ZERO CLAIMS FOR CY 2027 RATESETTING

Name of Service	HCPCS Code	# of Single Frequency Claims Over Previous 4-years	Final CY 2026 OPPS FR APC & SI Assignments	Proposed CY 2027 OPPS NPRM APC & SI Assignments	Final CY 2027 OPPS FR APC & SI Assignments
Blinded Procedure for NYHA Class III/IV Heart Failure	C9758	9 claims	1590, T	1590, T	1590, T
CardiAMP	C9782	3 claims	1590, T	1590, T	1590, T
Corvia Medical Interatrial Shunt	C9760	3 claims	1592, T	1592, T	1592, T
DARI Motion Procedure	0693T	0 claims	1505, S	1505, S	1505, S
Magnetic Resonance Imaging With Inhaled Hyperpolarized Xenon-129 Contrast Agent	C9791	6 claims	1551, T	1551, T	1551, T
Surfacer Inside-Out Access Catheter	C9780	7 claims	1534, S	1534, S	1534, S
Transcatheter Atrial Shunt System (TASS)	C9792	2 claims	1537, S	1537, S	1537, S

We did not receive public comments on these proposals. We are therefore finalizing our proposal without modification to continue to exempt services assigned to New Technology APCs with fewer than 10 claims over the 4-year lookback period from the universal low volume policy.

3. Procedures Assigned to New Technology APC Groups for CY 2027

As we described in the CY 2002 OPPS final rule (66 FR 59902), we generally retain a procedure in the New Technology APC to which it is initially assigned until we have obtained sufficient claims data to justify reassignment of the procedure to a clinically appropriate APC. Additionally, in cases where we find that our initial New Technology APC assignment was based on inaccurate or inadequate information (although it was the best information available at the time), where we obtain new information that was not available at the time of our initial New Technology APC assignment, or where the New Technology APCs are restructured, we may, based on more recent resource utilization information (including claims data) or the availability of refined New Technology APC cost bands, reassign the procedure or service to a different New Technology APC that more appropriately reflects its cost (66 FR 59903).

Consistent with our current policy, for CY 2027, we proposed to retain services within

New Technology APC groups until we obtain sufficient claims data to justify reassignment of the service to an appropriate clinical APC (91 FR 41793). The flexibility associated with this policy allows us to reassign a service from a New Technology APC in less than 2 years if we have obtained sufficient claims data. It also allows us to retain a service in a New Technology APC for more than 2 years if we have not obtained sufficient claims data upon which to base a reassignment decision (66 FR 59902).

a. Administration of Subretinal Therapies Requiring Vitrectomy (APC 1563)

Effective January 1, 2021, CMS established HCPCS code C9770 (Vitrectomy, mechanical, pars plana approach, with subretinal injection of pharmacologic/biologic agent) and assigned it to a New Technology APC based on the geometric mean cost of CPT code 67036 (Vitrectomy, mechanical, pars plana approach) due to similar resource utilization. For CY 2021, HCPCS code C9770 was assigned to APC 1561 (New Technology – Level 24 ($3001-$3500)). This code may be used to describe the administration of HCPCS code J3398 (Injection, voretigene neparvovec-rzyl, 1 billion vector genomes). This procedure was previously discussed in depth in the CY 2021 OPPS/ASC final rule with comment period (85 FR 85939 through 85940). For CY 2022, we maintained the APC assignment of APC 1561 (New Technology – Level 24 ($3001-$3500)) for HCPCS code C9770 (86 FR 63531 through 63532).

HCPCS code J3398 (Injection, voretigene neparvovec-rzyl, 1 billion vector genomes) is for a gene therapy product indicated for a rare mutation-associated retinal dystrophy. Voretigene neparvovec-rzyl (LUXTERNA®) was approved by FDA in December of 2017 and is an adeno-associated virus vector-based gene therapy indicated for the treatment of patients with confirmed biallelic RPE65 mutation-associated retinal dystrophy.[16] This therapy is administered through a subretinal injection, which interested parties describe as an extremely delicate and sensitive surgical procedure. The FDA-approved package insert describes one of the steps for

[16] https://www.fda.gov/media/109906/download.

administering LUXTERNA® as, "after completing a vitrectomy, identify the intended site of administration. The subretinal injection cannula can be introduced via pars plana".

Interested parties, including the manufacturer of LUXTERNA®, recommended CPT code 67036 (Vitrectomy, mechanical, pars plana approach) for the administration of the gene therapy.[17] However, the manufacturer previously contended the administration was not accurately described by any existing codes as CPT code 67036 (Vitrectomy, mechanical, pars plana approach) does not account for the administration itself. CMS recognized the need to accurately describe the unique procedure that is required to administer the therapy described by HCPCS code J3398. Therefore, in the CY 2021 OPPS/ASC final rule with comment period, we established a new HCPCS code, C9770 (Vitrectomy, mechanical, pars plana approach, with subretinal injection of pharmacologic/biologic agent) to describe this process (85 FR 85940). For CY 2021, we assigned HCPCS code C9770 to APC 1561 (New Technology –Level 24 ($3001-$3500)) using the geometric mean cost of CPT code 67036. For CY 2022, we continued to assign HCPCS code C9770 to APC 1561 (New Technology – Level 24 ($3001-$3500)) using the geometric mean cost of CPT code 67036 (86 FR 63532).

CY 2023 was the first year that claims data were available for HCPCS code C9770; therefore, we proposed and finalized a policy to base the payment rate of HCPCS code C9770 on claims data for that code rather than on the geometric mean cost of CPT code 67036. Given the low number of claims for this procedure, we designated HCPCS code C9770 as a low volume procedure under our universal low volume APC policy and used the greater of the geometric mean, arithmetic mean, or median cost calculated based on the available claims data to calculate an appropriate payment rate for purposes of assigning HCPCS code C9770 to a New Technology APC.

[17] https://mysparkgeneration.com/uploads/2022/09/LUXTURNA-Reimbursement-Guide-for-Treatment-Centers-ISI-Update-April-2022-P-RPE65-US-320025.pdf.

Based on the claims data available for the CY 2023 OPPS/ASC final rule with comment period, we found the median was the statistical methodology that estimated the highest cost for the service. The payment rate calculated using this methodology fell within the cost band for APC 1562 (New Technology—Level 25 ($3501–$4000)). Therefore, we finalized our proposal to assign HCPCS code C9770 to APC 1562 for CY 2023 (87 FR 71810).

For CY 2024, we proposed and finalized deletion of HCPCS code C9770 effective December 31, 2023 and recognize CPT code 0810T (Subretinal injection of a pharmacologic agent, including vitrectomy and 1 or more retinotomies) starting January 1, 2024 (88 FR 81617 through 81619). We determined the payment rate for CPT code 0810T using the claims data for HCPCS code C9770 and designated CPT code 0810T as a low volume procedure under our universal low volume APC policy and used the greater of the geometric mean, arithmetic mean, or median cost calculated based on the available claims data for HCPCS code C9770 to calculate an appropriate payment rate for purposes of assigning CPT code 0810T to a New Technology APC. For CY 2024, we finalized assignment of CPT code 0810T to APC 1563 (New Technology - Level 26 ($4001-$4500)) (88 FR 81618). For 2025, claims data for CPT code 0810T was not yet available. Therefore, we continued to use claims data for HCPCS code C9770 to determine the appropriate APC for CPT code 0810T and finalized to continue to assign CPT code 0810T to APC 1563 for CY 2025 (89 FR 94018 and 94019).

CY 2026 was the first year that we had claims data available for CPT code 0810T, and there were 7 claims available. Since the procedure described by CPT code 0810T was billed using HCPCS code C9770 prior to January 1, 2024, we used the available combined 43 claims for both codes during this time period to allow for a more accurate picture of the costs associated with this procedure. For CY 2026, we designated CPT code 0810T as a low volume procedure under our universal low volume APC policy, given that there were only 43 combined claims available. Therefore, we used the greater of the geometric mean, arithmetic mean, or median cost calculated based on the available claims data from a 4-year lookback period to calculate an

appropriate payment rate for purposes of assigning CPT code 0810T to a New Technology APC, which was the arithmetic mean cost of $4,327. This fell within the cost band for APC 1563 (New Technology - Level 26 ($4001-$4500)), and therefore, we continued to assign CPT code 0810T to APC 1563 for CY 2026 (90 FR 53532).

For the CY 2027 proposed rule, there were nine claims available for CPT code 0810T, with a geometric mean cost of $4,183. Since the procedure described by CPT code 0810T was billed using HCPCS code C9770 prior to January 1, 2024, we proposed to use the available combine claims for both codes during this time period to allow for a more accurate picture of the costs associated with this procedure. For CY 2027, we proposed to designate CPT code 0810T as a low volume procedure under our universal low volume APC policy, given that there were only 39 combined claims available. This is below the threshold of 100 claims for a service within a year required to designate a service as a low volume service and apply our universal low volume APC policy. Using all available claims for CPT code 0810T and HCPCS code C9770 from the 4-year lookback period, based on 39 claims, we determined the geometric mean cost to be approximately $4,239, the arithmetic mean cost to be $4,587, and the median cost to be $4,502. Because the arithmetic mean is the statistical methodology that estimated the highest cost for the service, we proposed to use this cost to determine the New Technology APC placement. The arithmetic mean of $4,587 falls within the cost band for APC 1564 (New Technology - Level 27 ($4501-$5000)). Therefore, we proposed to reassign CPT code 0810T to APC 1564 for CY 2027. Additionally, we proposed to perform a similar analysis using updated claims data, including determining if CPT code 0810T continues to meet the criteria for our universal low volume APC policy, in the CY 2027 OPPS/ASC final rule with comment period and update the APC assignment as needed (91 FR 41793 through 41794).

We did not receive any public comments on our proposal to reassign HCPCS code 0810T to APC 1564 for CY 2027. Three additional claims for CY 2025 have been processed since the CY 2027 OPPS/ASC proposed rule. Our analysis of the updated claims data found that the

greater of the geometric mean, arithmetic mean, or median cost calculated for HCPCS codes C9770 and 0810T is approximately $4,473. This falls into the cost band of New Technology APC 1563. Therefore, we are finalizing our proposal with modification to continue to assign CPT code 0810T to APC 1563 (New Technology—Level 26 ($4001–$4500)). Refer to Table 18 for the final OPPS New Technology APC and status indicator assignment for CPT codes 0810T for CY 2027. The final CY 2027 payment rates can be found in Addendum B to this final rule with comment period via the internet on the CMS website. In addition, we refer readers to Addendum D1 to this final rule with comment period for the status indicator meanings for all codes reported under the OPPS. Addendum D1 can also be found via the internet on the CMS website.

TABLE 18: PROPOSED AND FINAL CY 2027 OPPS NEW TECHNOLOGY APC AND STATUS INDICATOR ASSIGNMENT FOR CPT CODE 0810T

CPT Code	Long Descriptor	Proposed CY 2027 OPPS APC, SI	Final CY 2027 OPPS, SI APC
0810T	Subretinal injection of a pharmacologic agent, including vitrectomy and 1 or more retinotomies	1564, T	1563, T

b. BgRT (APC 1518 and 1523)

Biology Guided Radiation Therapy (BgRT) uses positron-emitting radiopharmaceuticals to control delivery of radiation therapy to treat primary and metastatic lung or bone tumors. During radiation treatment delivery, the same system applies these firing filters to the real-time positron emission tomography (PET) data collected by the radiation treatment delivery machine. Effective January 1, 2024, CMS created HCPCS codes C9794 (Therapeutic radiology simulation-aided field setting; complex, including acquisition of PET and CT imaging data required for radiopharmaceutical-directed radiation therapy treatment planning (i.e., modeling) and C9795 (Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance and real-time positron emissions-based delivery adjustments to 1 or more lesions, entire course not to exceed 5 fractions) to describe the modeling and

treatment delivery portions of the BgRT service. We assigned HCPCS code C9794 to APC 1521 (New Technology - Level 21 ($1901-$2000)) and HCPCS code C9795 to APC 1525 (New Technology - Level 25 ($3501-$4000)) for CY 2024.

For CY 2025, we continued to assign HCPCS code C9794 to APC 1521 (New Technology - Level 21 ($1901-$2000)) with a payment rate of $1,950.50 and HCPCS code C9795 to APC 1525 (New Technology - Level 25 ($3501-$4000)) with a payment rate of $3,750.50 because we did not have any claims data for the service.

Effective January 1, 2025, HCPCS codes C9794 and C9795 were replaced by HCPCS codes G0562 and G0563, respectively. For CY 2026, we utilized available claims data for HCPCS codes C9794 and C9795 to propose payment rates for HCPCS codes G0562 and G0563. Due to concerns given the extremely limited number of claims and the substantial decrease that would occur if the proposed rates were finalized, we did not finalize the proposed payment rate changes (90 FR 53533 and 53534). For CY 2026, we finalized the assignment of HCPCS code G0562 to APC 1521 and status indicator "S" and HCPCS code G0563 to APC 1524 (New Technology—Level 24 ($3001-$3500)) and status indicator "S" (90 FR 53534).

Since HCPCS code G0562 and G0563 were made effective January 1, 2025, and the proposed OPPS payment rates for CY 2027 are based on available CY 2025 claims data, this is the first time that we have available claims for HCPCS codes G0562 and G0563, specifically, for ratesetting. For CY 2027, we proposed to designate HCPCS codes G0562 and G0563 as low volume procedures under our universal low volume APC policy, given that there were 24 single frequency claims for G0562 and 47 claims for G0563 during the claims period (91 FR 41794). For HCPCS code G0562, we determined the arithmetic mean cost to be approximately $1,461, the median cost to be approximately $1,601, and the geometric mean cost to be approximately $1,398. Because the median cost is the statistical methodology that estimated the highest cost for the service, we proposed to use this cost to determine the New Technology APC placement. The median cost of $1,601 falls within the cost band for APC 1518 (New Technology—Level 18

($1601-$1700)). Therefore, we proposed to assign HCPCS code G0562 to APC 1518 (New Technology - Level 18 ($1601-$1700) with a payment rate of $1,650.50 for CY 2027 (91 FR 41794). For HCPCS code G0563, we determined the arithmetic mean cost to be approximately $2,644, the median cost to be approximately $2,218, and the geometric mean cost to be approximately $2,467. The arithmetic mean cost is the statistical methodology that estimated the highest cost for the service; therefore, we proposed to use this cost to determine the New Technology APC placement. The arithmetic mean cost of $2,644 falls within the cost band for APC 1523 (New Technology—Level 23 ($2501-$3000)). Therefore, we proposed to assign HCPCS code G0563 to APC 1523 (New Technology—Level 23 ($2501-$3000) with a payment rate of $2750.50 for CY 2027 (91 FR 41795).

Additionally, we proposed to perform a similar analysis using updated claims data, including determining if HCPCS codes G0562 and G0563 continue to meet the criteria for our universal low volume APC policy, in the CY 2027 OPPS/ASC final rule with comment period and update the APC assignments as needed.

We did not receive public comments on our proposals for HCPCS codes G0562 or G0563, and therefore, we are finalizing as proposed.

We note that since the CY 2027 OPPS/ASC proposed rule published, we have additional claims for HCPCS codes G0562 and G0563 to use for ratesetting. For HCPCS code G0562, the revised statistical methodologies based on 29 single frequency claims are: the geometric mean cost is $1,221.60; the arithmetic mean cost is $1,321.64; and the median cost is $1,543.65. The highest of these is the median cost, which falls outside of the proposed APC assignment for HCPCS code G0562 of APC 1518 (New Technology - Level 18 ($1601-$1700). For HCPCS code G0563, the revised statistical methodologies based on 89 single frequency claims are: the geometric mean cost is $ 2,967.16; the arithmetic mean cost is $3,156.16; and the median cost is $3,231.70. The highest of these is the median cost, which falls outside of the proposed APC assignment for HCPCS code G0563 of APC 1523 (New Technology—Level 23 ($2501-$3000)).

Therefore, for CY 2027, we are finalizing the assignment of HCPCS code G0562 to APC 1517 (New Technology – Level 17 ($1501-$1600)) and of HCPCS code G0563 to APC 1524 (New Technology—Level 24 ($3001-3500)). Refer to Table 19 for the proposed CY 2027 and final CY 2027 OPPS New Technology APC and status indicator assignment for HCPCS codes G0562 and G0563. The final CY 2027 payment rates can be found in Addendum B to this final rule via the internet on the CMS website. In addition, we refer readers to Addendum D1 to this final rule for the status indicator meanings for all codes reported under the OPPS. Addendum D1 can also be found via the internet on the CMS website.

TABLE 19: PROPOSED AND FINAL CY 2027 OPPS NEW TECHNOLOGY APC AND STATUS INDICATOR ASSIGNMENTS FOR BIOLOGY GUIDED RADIATION THERAPY

HCPCS Code	Long Descriptor	Proposed CY 2027 OPPS APC, SI	Final CY 2027 OPPS APC, SI
G0562	Therapeutic radiology simulation-aided field setting; complex, including acquisition of PET and CT imaging data required for radiopharmaceutical-directed radiation therapy treatment planning (i.e., modeling)	1518, S	1517, S
G0563	Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance and real-time positron emissions-based delivery adjustments to 1 or more lesions, entire course not to exceed 5 fractions	1523, S	1524, S

c. Cardiac Positron Emission Tomography (PET)/Computed Tomography (CT) Studies (APC 5594).

Effective January 1, 2020, we assigned three CPT codes (78431, 78432, and 78433) that describe the services associated with cardiac PET/CT studies to New Technology APCs. We have explained previously that services that are assigned to New Technology APCs are typically new procedures that do not have sufficient claims history to establish an accurate payment for them. In the CY 2026 OPPS/ASC final rule we noted that, over the past several years, the claims volumes for CPT codes 78431 and 78433 have increased significantly while the geometric mean costs of the codes have remained relatively stable. We explained that, although we had seen stability in the claims data for CPT codes 78431 and 78433, CPT code 78432, which is closely

related to CPT codes 78431 and 78433, continued to have low claims frequency and fluctuating geometric mean costs. We explained that, due to our concerns regarding CPT code 78432 and the lack of an appropriate clinical APC for CPT codes 78431 and 78433 at the time based on resource cost similarity, we finalized maintaining CPT codes 78431 through 78433 in New Technology APCs for CY 2026 (90 FR 53536 and 53537). We stated that while we believe that cardiac PET/CT services, such as those described by CPT codes 78431 through 78433, are clinically similar to services assigned to the Nuclear Medicine and Related Services APC series, such as CPT codes 78429 and 78430, we previously had concerns that the resource costs for the APC series did not align with the resource costs reflected in the claims data for CPT codes 78431 through 78433. As a result, we previously maintained CPT codes 78431 through 78433 in New Technology APCs.

For CY 2027, we proposed changes to APCs 5591 through 5594 (Nuclear Medicine and Related Services) that includes the shifting of the APC assignments for several codes in that APC series. We refer readers to section III.E. Proposed APC-Specific Policies of the CY 2027 OPPS/ASC proposed rule for a discussion of the proposal (91 FR 41808). As a result of these proposed changes, the proposed geometric mean costs of the Nuclear Medicine and Related Services APC series also shifted. For the proposed rule, we believed that the new geometric mean costs of the proposed Nuclear Medicine and Related Services APC series more closely align with the costs reflected in the claims data for CPT codes 78431 through 78433. Therefore, we proposed to assign CPT codes 78431 through 78433 to APC 5594 (Level 4 Nuclear Medicine and Related Services).

Comment: Commenters were supportive of our proposal to reassign CPT codes 78431 through 78433 to APC 5594 for CY 2027. Commenters believed the proposed APC assignments were clinically and resource appropriate.

Response: We appreciate the commenters' support.

In consideration of the comments received and because the geometric mean costs of CPT codes 78431 through 78433 more closely align with the geometric mean costs of the restructured APCs 5591 through 5594, we are finalizing as proposed. Specifically, for CY 2027, we are finalizing assignment of CPT codes 78431 through 78433 from new technology APCs to clinical APC 5594. Refer to Table 20 for the final CY 2026 and final CY 2027 APC and status indicator assignments for CPT codes 78431 through 78433. The final CY 2027 payment rates can be found in Addendum B to this final rule with comment period via the internet on the CMS website. In addition, we refer readers to Addendum D1 to this final rule with comment period for the status indicator meanings for all codes reported under the OPPS. Addendum D1 can also be found via the internet on the CMS website.

TABLE 20: PROPOSED AND FINAL CY 2027 OPPS NEW TECHNOLOGY APC AND STATUS INDICATOR ASSIGNMENTS FOR CARDIAC PET CT STUDIES

HCPCS Code	Long Descriptor	Final CY 2026 OPPS APC, SI	Final CY 2027 OPPS APC, SI
78431	Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); multiple studies at rest and stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan	1522, S	5594, S
78432	Myocardial imaging, positron emission tomography (PET), combined perfusion with metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), dual radiotracer (eg, myocardial viability)	1517, S	5594, S
78433	Myocardial imaging, positron emission tomography (PET), combined perfusion with metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), dual radiotracer (eg, myocardial viability); with concurrently acquired computed tomography transmission scan	1522, S	5594, S

c. Instillation of Anti-Neoplastic Pharmacologic/Biologic Agent into Renal Pelvis (APC 1548)

Effective October 1, 2023, CMS established HCPCS code C9789 (Instillation of anti-neoplastic pharmacologic/biologic agent into renal pelvis, any method, including all imaging guidance, including volumetric measurement if performed) and assigned it to APC 1559 (New

Technology - Level 22 ($2001-$2500)), with a payment rate of $2,250.50 based on our review of the clinical and resource characteristics of this service.

For CY 2025, the OPPS payment rates were based on available CY 2023 claims data. Because we created HCPCS code C9789 effective October 1, 2023, we had limited claims data from CY 2023 available for CY 2025 rulemaking. Specifically, we only had six claims available for ratesetting, so we maintained the New Technology APC assignment of APC 1559 (New Technology – Level 22 ($2001-$2500)) with a payment of $2,250.50 for CY 2025, based on our CY 2025 policy to maintain the New Technology APC assignment for New Technology APC services with fewer than 10 claims in the 4-year lookback period applicable for the universal low-volume APC policy (89 FR 94034).

For CY 2026, the OPPS payment rates were based on available CY 2024 claims data. HCPCS code C9789 had 222 single frequency claims in CY 2024, which exceeded the 100 claims threshold generally used for the universal low volume APC policy. The geometric mean cost for HCPCS code C9789 was approximately $1,211. Therefore, for CY 2026, we assigned HCPCS code C9789 to APC 1551 (New Technology—Level 14 ($1201—$1300)) with a payment rate of $1,250.50 (90 FR 53542 and 53543).

For CY 2027, the OPPS payment rates were proposed based on available CY 2025 claims data. HCPCS code C9789 had 235 single frequency claims for the CY 2025 proposed rule and the geometric mean cost for HCPCS code was $1,173. Therefore, for CY 2027, we proposed to assign HCPCS code C9789 to APC 1550 (New Technology—Level 13 ($1101— $1200)) with a payment rate of $1,150.50 (91 FR 41796).

We received public comments on this proposal. The following is a summary of the comments we received and our responses.

Comment: A commenter supported HCPCS code C7989 remaining in a New Technology APC but expressed concern with the continued reduction in payment for C9789. The commenter requested that CMS issue additional billing guidance to HOPD billing staff regarding the use of

the New Technology APC procedure code with a separately payable drug or biological HCPCS code to ensure accurate and comprehensive reporting of C9789 procedure costs. A commenter also requested that CMS carefully assess claims data associated with HCPCS code C7989 to ensure appropriate assignment. Additionally, a commenter requested that CMS expand the C-APC policy to exclude CGTs from C-APC packaging to include drugs, following expiration of New Technology APC status for the procedure code.

Response: We thank the commenters for their input. In response to the request to carefully assess claims data associated with HCPCS code C7989, we remind interested parties that we thoroughly review, on an annual basis, the APC assignments for all items and services paid under the OPPS, including HCPCS code C9789.

Additionally, as a reminder to our readers, CMS does not provide specific coding guidance, and requests to provide coding guidance are out of scope for the OPPS/ASC final rule with comment period. We refer our readers to section 20.5 in Chapter 4 (Part B Hospital) of the Medicare Claims Processing Manual, "CMS does not instruct hospitals on the assignment of HCPCS codes to revenue codes for services provided under OPPS since hospitals' assignments of cost vary. Where explicit instructions are not provided, HOPDs should report their charges under the revenue code that will result in the charges being assigned to the same cost center to which the cost of those services are assigned in the cost report." We further note that if hospitals have questions about appropriate coding that they cannot resolve on their own, the initial first step would be to review the HCPCS code descriptors or consult the appropriate Medicare Administrative Contractor (MAC) for their jurisdiction. Additionally, while CMS does not provide billing advice to hospitals, we encourage manufacturers and distributors to provide outreach to hospitals regarding billing practices that are most appropriate for their individual technologies.

Regarding the commenter's C-APC expansion request, as we stated in the CY 2026 OPPS/ASC final rule with comment period (90 FR 53542), we again note that HCPCS code

J9281 is assigned to a status indicator of 'K' (Nonpass-Through Drugs and Nonimplantable Biologicals, Including Therapeutic Radiopharmaceuticals; Paid under OPPS; separate APC payment) and procedures and services assigned to a New Technology APC are excluded from the C-APC packaging policy. Therefore, providers may receive separate payment for both the drug and installation procedure when providing this service (90 FR 53542). We refer readers to Addendum J for a list of exclusions to the comprehensive APC packaging policy.

As part of our review and update process, we noted that additional claims for HCPCS code C9789 have been processed since the CY 2027 OPPS/ASC proposed rule. Based on updated claims data available for this final rule with comment period, the geometric mean cost for HCPCS code C9789 is $931 based on 316 single-frequency claims. We believe that 316 single-frequency claims are adequate for ratesetting for this service. Since HCPCS code C9789 has over 100 claims, the New Technology APC assignment is based on the geometric mean cost for that code. The geometric mean cost for the APC of $931falls within APC 1548 (New Technology - Level 11 ($900-$950) with a payment rate of $950.50.

In summary, after consideration of the public comments we received and the additional processed claims, we are finalizing, with modification, a New Technology APC assignment for HCPCS code C9789 to APC 1548 (New Technology - Level 11 ($900-$950) with a payment rate of $950.50.

We refer readers to Table 21 for the final CY 2027 OPPS New Technology APC and status indicator assignment for HCPCS code C9789.

The final CY 2027 payment rates can be found in Addendum B to this final rule with comment period via the internet on the CMS website. In addition, we refer readers to Addendum D1 to this final rule with comment period for the status indicator meanings for all codes reported under the OPPS. Addendum D1 can also be found via the internet on the CMS website.

TABLE 21: PROPOSED AND FINAL CY 2027 OPPS NEW TECHNOLOGY APC AND STATUS INDICATOR ASSIGNMENT FOR HCPCS CODE C9789

HCPCS Code	Long Descriptor	Proposed CY 2027 OPPS APC, SI	Final CY 2027 OPPS APC, SI
C9789	Instillation of anti-neoplastic pharmacologic/biologic agent into renal pelvis, any method, including all imaging guidance, including volumetric measurement if performed	1550, T	1548, T

d. LimFlow TADV procedure, CPT Code 0620T (APC 1580)

The LimFlow TADV procedure which is described by CPT code 0620T (Endovascular venous arterialization, tibial or peroneal vein, with transcatheter placement of intravascular stent graft(s) and closure by any method, including percutaneous or open vascular access, ultrasound guidance for vascular access when performed, all catheterization(s) and intraprocedural roadmapping and imaging guidance necessary to complete the intervention, all associated radiological supervision and interpretation, when performed) is an endovascular procedure that is used to treat patients with chronic limb-threatening ischemia. According to the developer, these patients are no longer eligible for conventional endovascular or open bypass surgery to treat their artery blockage, and without this procedure, they are likely to face limb amputation.

CPT code 0620T was established in January 2021 and was assigned to APC 5194 (Level 4 Endovascular Procedures) with a payment rate of approximately $17,400, which is the highest-paying APC for endovascular procedures. While we proposed to continue to assign CPT code 0620T to APC 5194 for CY 2024, we finalized a reassignment from a clinical APC to a New Technology APC with a higher payment rate based on comments received expressing concern that the low payment rate of the procedure would discourage providers from performing the procedure and deny access to the procedure. For CY 2024, the procedure was assigned to APC 1578 (New Technology - Level 41 ($25,001-$30,000)) (88 FR 81694). For CY 2025 ratesetting, there were 11 single frequency claims for CPT code 0620T in the CY 2023 claims data. As this is below the threshold of 100 claims for a service within a year, we applied our universal low volume APC policy and used the highest of the geometric mean cost, arithmetic mean cost, or

median cost based on up to 4 years of claims data to assign the service to the appropriate New Technology APC. Based on our review of the available claims and the application of the universal low volume APC policy, we assigned HCPCS code 0620T to APC 1579 (New Technology – Level 42 ($30,001-$40,000)) with a payment rate of $35,000.50 based on the median cost of approximately $36,400 (89 FR 94034 through 94036).

For CY 2026, the OPPS payment rates were proposed to be based on available CY 2024 claims data. There were 19 single frequency claims for 0620T in the CY 2024 claims data. As this is below the threshold of 100 claims for a service within a year, we proposed to again apply our universal low volume APC policy and use the highest of the geometric mean cost, arithmetic mean cost, or median cost based on up to 4 years of claims data to assign the service to the appropriate New Technology APC. Based on our review of the available claims and the application of the universal low volume APC policy, for CY 2026 we assigned HCPCS code 0620T to APC 1580 (New Technology – Level 43 ($40,001-$50,000)) with a payment rate of $45,000.50 based on the arithmetic mean cost of approximately $43,748 (90 FR 53543 and 53544).

For CY 2027, the OPPS payment rates were proposed based on available CY 2025 claims data. There were 28 single frequency claims for 0620T in the CY 2025 proposed rule claims data. As this is below the threshold of 100 claims for a service within a year, we proposed to again apply our universal low volume APC policy and use the highest of the geometric mean cost, arithmetic mean cost, or median cost based on up to 4 years of claims data to assign the service to the appropriate New Technology APC. Based on our review of the available claims, we determined that the arithmetic mean is approximately $51,748; the median is approximately $46,455; and the geometric mean cost is approximately $47,513. Of these, the arithmetic mean was the statistical methodology that estimated the highest cost for the service. The payment rate calculated using this methodology falls within the cost band for APC 1581 (New Technology – Level 44 ($50,001-$60,000)). Therefore, for CY 2027, we proposed to designate this service as

a low volume service under our universal low volume APC policy and to assign HCPCS code 0620T to APC 1581 (New Technology—Level 44 ($50,001-$60,000)) with a payment rate of $55,000.50 (91 FR 41797).

Comment: Two commenters supported the proposal to assign CPT code 0620T to APC 1581 (New Technology—Level 44 ($50,001-$60,000)) with a payment rate of $55,000.50 for CY 2027 based on the application of the universal low volume APC policy.

Response: We thank the commenters for their input.

Three additional claims for CY 2025 have been processed since the CY 2027 OPPS/ASC proposed rule. Our analysis of the updated claims data found that the greater of the geometric mean, arithmetic mean, or median cost calculated for CPT code 0620T is approximately $45,838 based on the arithmetic mean. This value falls within APC 1580 (New Technology—Level 43 ($40,001–$50,000)) with a payment rate of $45,000.50. Therefore, for CY 2027, we are finalizing our proposal with modification to continue to assign CPT code 0620T to APC 1580 based on the application of the universal low volume APC policy. Refer to Table 22 for the final OPPS New Technology APC and status indicator assignments for CPT code 0620T for CY 2027. The final CY 2027 payment rates can be found in Addendum B to this final rule with comment period via the internet on the CMS website.

TABLE 22: PROPOSED AND FINAL CY 2027 OPPS NEW TECHNOLOGY APC AND STATUS INDICATOR ASSIGNMENT FOR CPT CODE 0620T

CPT Code	Long Descriptor	Proposed CY 2027 OPPS APC, SI	Final CY 2027 OPPS, SI APC
0620T	Endovascular venous arterialization, tibial or peroneal vein, with transcatheter placement of intravascular stent graft(s) and closure by any method, including percutaneous or open vascular access, ultrasound guidance for vascular access when performed, all catheterization(s) and intraprocedural roadmapping and imaging guidance necessary to complete the intervention, all associated radiological supervision and interpretation, when performed	1581, S	1580, S

e. Liver Histotripsy Service (APC 1575)

CPT code 0686T (Histotripsy (ie, non-thermal ablation via acoustic energy delivery) of malignant hepatocellular tissue, including image guidance) was first effective July 1, 2021, and describes the histotripsy service associated with the use of the HistoSonics system. Histotripsy is a non-invasive, non-thermal, mechanical process that uses a focused beam of sonic energy to destroy cancerous liver tumors and is currently in a non-randomized, prospective clinical trial to evaluate the efficacy and safety of the device for the treatment of primary or metastatic tumors located in the liver.[18] When HCPCS code 0686T was first effective, the histotripsy procedure was designated as a Category A IDE clinical study (NCT04573881). Since devices in Category A IDE studies are excluded from Medicare payment, payment for CPT code 0686T only reflected the cost of the service that is performed (absent the cost of the device) each time it is reported on a claim. On March 2, 2023, the histotripsy IDE clinical study was re-designated as a Category B (Non-experimental/Investigational) IDE study. Due to this new designation, payment for CPT code 0686T in CY 2024 reflected payment for both the service that was performed and the device used each time it was reported on a claim. For CY 2024, we assigned CPT code 0686T to APC 1576 (New Technology – Level 39 ($15,001 - $20,000)) with a payment rate of $17,500.50. For CY 2025, we continued to assign CPT code 0686T to APC 1576 (New Technology – Level 39 ($15,001-$20,000) due to our CY 2025 policy to maintain current New Technology APC assignments for CY 2025 for New Technology APC services with fewer than 10 claims in the 4-year lookback period applicable for the universal low volume APC policy, and based on the fact that there were only 3 claims for CPT code 0686T in the prior 4-year period. For CY 2026, we again finalized the assignment of CPT code 0686T to APC 1576 (New Technology – Level 39 ($15,001-$20,000) using our standard ratesetting methodology.

[18] ClinicalTrials.gov. "The HistoSonics System for Treatment of Primary and Metastatic Liver Tumors Using Histotripsy (#HOPE4LIVER) (#HOPE4LIVER)." Accessed October 24, 2026. *https://clinicaltrials.gov/ct2/show/study/NCT04573881*.

For CY 2027, the OPPS payment rates were proposed based on available CY 2025 claims data. CPT code 0686T had 166 single frequency claims in the proposed CY 2025 claims data, which exceeds the 100 claims threshold generally used for the universal low volume APC policy. Since the total number of CY 2025 single frequency claims for CY code 0686T surpassed the 100claims threshold generally used for the universal low volume APC policy, we would use the geometric mean cost of the CY 2025 claims data to set the payment rate for CY 2027 under our standard ratesetting methodology, rather than the highest of the three statistical methodologies over a 4-year lookback period. In the proposed rule, the geometric mean cost for CPT code 0686T was $14,311. Therefore, for CY 2027, we proposed to assign CPT code 0686T to APC 1575 (New Technology—Level 38 ($10,001-$15,000)) with a payment of $12,500.50 based on the GMC ($14,311) (91 FR 41798).

We received public comments on this proposal. The following is a summary of the comments we received and our responses.

Comment: Commenters noted that for Histotripsy of the Liver (CPT 0686T), it is standard of care to do a post-procedure diagnostic imaging procedure, and therefore they believe that CMS should utilize a J1, comprehensive status indicator, and ratesetting for this procedure should include all available claims, as opposed to the single claim. Commenters believe that utilizing the J1 status indicator would increase the GMC for CPT 0686T. Commenters also believe CMS would need to create a new APC, as they believe no clinically similar APC exists. The commenters then requested that CMS utilize our Equitable Adjustment Authority to maintain the assignment of CPT code 0686T to New Technology APC assignment APC 1576 (New Technology – Level 39 ($15,001-$20,000)), with a payment of $17,500. Commenters also requested that CPT code 0686T receive a device intensive designation.

Response: We thank the commenters for their input. We note that procedures and services assigned to a New Technology APC are excluded from the C-APC packaging policy. Providers may receive separate payment for both the procedure described by CPT code 0686T

and other services or procedures integral, ancillary, or supportive to CPT code 0686T. Additionally, under the OPPS, currently only clinical procedure APCs can be assigned comprehensive status indicator "J1". We refer readers to section IV.B and XIII.C.4 of this final rule with comment period for our responses to comments on our device-intensive procedure policies, section II.A.2 for additional information on the C-APC packaging policy, and Addendum J for a list of exclusions to the comprehensive APC packaging policy.

Regarding commenters' reference to a newly created APC dedicated solely to Histotripsy, we do not believe it is necessary at this time; however, we will continue to consider this option in the future.

Eighteen additional single-frequency claims for CY 2025 have been processed since the CY 2027 OPPS/ASC proposed rule, bringing the total number of single-frequency claims to 184, which we believe are adequate for ratesetting for this service. Based on the updated claims data available for this final rule with comment period, the geometric mean cost for HCPCS code 0686T is approximately $14,12. After discussion with our medical officers and continued review of data available for this final rule with comment period, we are finalizing, as proposed, the assignment of HCPCS code 0686T to New Technology APC 1575 (New Technology- Level 38 ($10,001-$15,000)) with a payment rate of around $12,500.50.

We refer readers to Addendum B to this final rule with comment period for the final CY 2027 OPPS payment rate for this code. Addendum B is available via the internet on the CMS website.

f. Supervised Visits for Esketamine Self- Administration (APCs 1513 and 1517)

On March 5, 2019, FDA approved SPRAVATO® (esketamine) nasal spray, used in conjunction with an oral antidepressant for treatment of depression in adults who have tried other antidepressant medicines but have not benefited from them (treatment-resistant depression (TRD)). This is the first FDA approval of esketamine for any use.

Esketamine is a noncompetitive N- methyl D-aspartate (NMDA) receptor antagonist. It is a nasal spray supplied as an aqueous solution of esketamine hydrochloride in a vial with a nasal spray device. Each device delivers two sprays containing a total of 28 mg of esketamine. Patients would require either two (2) devices (for a 56 mg dose) or three (3) devices (for an 84 mg dose) per treatment.

Because of the risk of serious adverse outcomes resulting from sedation and dissociation and respiratory depression caused by esketamine nasal spray administration, and the potential for abuse and misuse of the product, it is only available through a restricted distribution system under a Risk Evaluation and Mitigation Strategy (REMS). A REMS is a drug safety program that the FDA can require for certain medications with serious safety concerns to help ensure the benefits of the medication outweigh its risks. The SPRAVATO® REMS program requires, among other requirements, that the esketamine nasal spray be dispensed and administered to enrolled patients in health care settings that are certified in the REMS. See *www.fda.gov* for more information regarding the SPRAVATO® REMS program requirements.

A treatment session of esketamine consists of instructed nasal self- administration by the patient followed by a period of at least 2 hours post-administration observation of the patient under direct supervision of a health care professional in the certified health care setting. Refer to the CY 2020 PFS final rule and interim final rule for more information about supervised visits for esketamine nasal spray self- administration (84 FR 63102 through 63105); see also the SPRAVATO® REMS document and SPRAVATO® labeling available on the FDA website. [19, 20]

To facilitate prompt beneficiary access to the new, potentially life-saving treatment for TRD using esketamine, we created two new HCPCS G codes, G2082 (*Office or other outpatient visit for the evaluation and management of an established patient that requires the supervision of a physician or other qualified health care professional and provision of up to 56 mg of*

[19] *https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/211243s016lbl.pdf.*
[20] *https://www.accessdata.fda.gov/drugsatfda_docs/appletter/2025/211243Orig1s021ltr.pdf.*

esketamine nasal self-administration, includes 2 hours post-administration observation) and G2083 (*Office or other outpatient visit for the evaluation and management of an established patient that requires the supervision of a physician or other qualified health care professional and provision of greater than 56 mg esketamine nasal self-administration, includes 2 hours post-administration observation*), effective January 1, 2020. HCPCS code G2082 is for an outpatient visit for the evaluation and management of an established patient who requires the supervision of a physician or other qualified health care professional and provision of up to 56 mg of esketamine through nasal self-administration and includes two hours of post- administration observation. HCPCS code G2083 describes a similar service to HCPCS code G2082 but involves the administration of more than 56 mg of esketamine.

For CY 2026, HCPCS code G2082 was assigned to APC 1512 (New Technology - Level 12 ($1001 - $1100)) with a payment rate of $1,050.50 and HCPCS code G2083 was assigned to APC 1518 (New Technology - Level 18 ($1601-$1700)) with a payment rate of $1,650.50.

For CY 2027, the OPPS payment rates were proposed based on available CY 2025 claims data as the available single frequency claims exceed the 100 claims threshold generally used for our universal low volume policy. Therefore, for CY 2027, we proposed to assign HCPCS codes G2082 and G2083 to New Technology APCs based on each of the codes' geometric mean costs. Specifically, we proposed to assign HCPCS code G2082 to APC 1513 New Technology - Level 13 ($1101 - $1200) with a payment rate of $1,150.50 based on its geometric mean cost of $1,181 which was calculated using the available 742 single frequency claims from CY 2025 claims data. We also proposed to maintain the APC assignment for HCPCS code G2083 to APC 1518 New Technology - Level 18 ($1601-$1700)) with a payment rate of $1,650.50 based on its geometric mean cost of $1,648, which was calculated using the available 5,741 single frequency claims from CY 2025 claims data (91 FR 41799).

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: Commenters supported the proposed APC assignments, noting that the increased reimbursement promotes patient access for behavioral health services. Commenters continue to request a clinical APC assignment for the esketamine treatment citing the uniqueness of this service justifies the establishment of a new clinical APC for these two codes and also recognizing that there does not appear to be an existing clinical APC series that are both clinically comparable and similar in resource use to these two unique codes. Clinical APCs, according to the commenters, would provide payment stability for these codes long term.

Commenters also asked us to clarify a discrepancy noted in the CY 2027 OPPS/ASC proposed rule table where we listed G2083 as having a CY 2026 APC final assignment of APC 1517, even though it should have been APC 1518.

Response: We thank the commenters for their input. As we have stated in previous rules, we have been contemplating potential clinical APC assignments for the past number of rulemaking cycles but are not convinced as to what clinical APC would be appropriate in terms of clinical and resource homogeneity, nor are we convinced that a new clinical APC with just these two codes is appropriate at this time. We appreciate the public's continued interest and support of this service and their requests for a stable long-term payment pathway. We will continue to consider potential clinical APC options for these codes through future rulemaking.

We appreciate the commenters noting the discrepancy in the CY 2027 OPPS/ASC proposed rule. In Table 19 of the CY 2027 OPPS/ASC proposed rule, we inadvertently listed the final APC assignment for G2083 as APC 1517 (New Technology - Level 17 ($1501-$1600)) for CY 2026 (91 FR 41799). G2083 was finalized to APC 1518 New Technology - Level 18 ($1601-$1700).

We note the geometric mean costs for both HCPCS codes G2082 and G2083 have changed since the CY 2027 OPPS/ASC proposed rule. Based on the updated claims data available for this final rule, the geometric mean cost for HCPCS code G2082 is around $1,146, which was calculated using the available 809 single frequency claims, and the geometric mean

cost for HCPCS code G2083 is around $1,544 which was calculated using the available 6,342 single frequency claims from CY 2025 claims data. Based on this updated claims data available for this final rule with comment period, we are finalizing a New Technology APC assignment for HCPCS code G2082 to APC 1513 (New Technology - Level 13 ($1101 - $1200)) with a payment rate of $1,150.50 and a New Technology APC assignment for HCPCS code G2083 to APC 1517 (New Technology - Level 17 ($1501-$1600)) with a payment of $1,550.50.

Refer to Table 23 for the CY 2027 proposed and final APC and status indicator assignments for HCPCS codes G2082 and G2083. The CY 2027 payment rates for these codes can be found in Addendum B to this final rule with comment period. In addition, we refer readers to Addendum D1 to this final rule with comment period for the SI definitions for all codes reported under the OPPS. Addenda B and D1 are available via the internet on the CMS website.

TABLE 23: PROPOSED AND FINAL CY 2027 NEW TECHNOLOGY APC AND STATUS INDICATOR ASSIGNMENTS FOR HCPCS CODES G2082 AND G2083

HCPCS Code	Long Descriptor	Proposed CY 2027 OPPS APC, SI	Final CY 2027 OPPS APC, SI
G2082	Office or other outpatient visit for the evaluation and management of an established patient that requires the supervision of a physician or other qualified health care professional and provision of up to 56 mg of esketamine nasal self-administration, includes 2 hours post-administration observation	1513, S	1513, S
G2083	Office or other outpatient visit for the evaluation and management of an established patient that requires the supervision of a physician or other qualified health care professional and provision of greater than 56 mg esketamine nasal self-administration, includes 2 hours post-administration observation	1518, S	1517, S

g. SAINT Neuromodulation System (APCs 1511 and 1525)

The SAINT Neuromodulation System is a non-invasive repetitive transcranial magnetic stimulation (rTMS) system that identifies an individualized target and delivers navigationally directed repetitive magnetic pulses to that individualized target located within the left

dorsolateral prefrontal cortex to treat major depressive disorder (MDD). The patient first receives structural MRI and functional MRI scans that are analyzed by the provider to identify and localize the personalized stimulation target in the patient's dorsolateral prefrontal cortex. Once the areas targeted for treatment are identified, the patient receives non-invasive magnetic stimulation in the targeted area. The patient has 10 treatment sessions per day with each treatment session lasting 10 minutes followed by 50 minutes of rest before another treatment session occurs. The treatment is administered over five days for a total of 50 sessions of non-invasive magnetic stimulation therapy. There are four CPT codes listed below that describe the MRI scans that are used to target the treatment and describe the administration of the non-invasive magnetic stimulation therapy.

- 0889T - *Personalized target development for accelerated, repetitive high-dose functional connectivity MRI-guided theta-burst stimulation derived from a structural and resting-state functional MRI, including data preparation and transmission, generation of the target, motor threshold-starting location, neuronavigation files and target report, review and interpretation*.
- 0890T - *Accelerated, repetitive high-dose functional connectivity MRI-guided theta-burst stimulation, including target assessment, initial motor threshold determination, neuronavigation, delivery and management, initial treatment day*.
- 0891T - *Accelerated, repetitive high-dose functional connectivity MRI-guided theta-burst stimulation, including neuronavigation, delivery and management, subsequent treatment day*.
- 0892T - *Accelerated, repetitive high-dose functional connectivity MRI-guided theta-burst stimulation, including neuronavigation, delivery and management, subsequent motor threshold redetermination with delivery and management, per treatment day*.

For CY 2025, the OPPS payment rates were proposed based on available CY 2023 claims data. However, CPT codes 0889T, 0890T, 0891T, and 0892T did not become effective until July

1, 2024, which means there were no claims data for the procedures described these CPT codes. We assigned our proposed rates for these services based on our evaluation of the resources needed to perform these services.

Because we only had a partial year of data for CY 2026 rulemaking, we used our equitable adjustment authority under section 1833(t)(2)(E) of the Act to maintain the APC assignments for CPT codes 0889T, 0890T, 0891T, and 0892T.

For CY 2027, the OPPS payment rates were proposed based on available CY 2025 claims data (91 FR 41800). We proposed to assign CPT code 0889T to APC 1511 (New Technology - Level 11 ($901 - $1000)) with a payment rate of $950.50 based on the median cost using 74 single frequency claims. We proposed to assign CPT code 0890T to APC 1521 (New Technology—Level 21 ($1901–$2000)) with a payment rate of $1950.50 based on the arithmetic mean using 73 single frequency claims. We proposed to assign CPT code 0891T to APC 1520 (New Technology—Level 20 ($1801–$1900)) with a payment rate of $1,850.50 based on the geometric mean cost calculated from 241 single frequency claims. We proposed to assign CPT code 0892T to APC 1523 (New Technology—Level 23 ($2501–$3000)) with a payment rate of $2,750.50 based on the arithmetic mean calculated from 19 single frequency claims.

The HOP Panel met on August 24, 2026, and in response to the presentation on SAINT Neuromodulation system, the Panel recommended maintaining CPT codes 0890T, 0891T, and 0892T in their current APC assignments for CY 2027.

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: Commenters overwhelmingly requested that CMS maintain the current New Technology APC assignments, as the proposed rates would reduce the Medicare payment for these services by approximately 25 to 50 percent and, in their opinion, put beneficiary access to this service at risk. One of the commenters noted that providers have acknowledged incorrect reporting of the resources needed to provide these services, and have since updated their cost

reporting processes for SAINT. The updated claims data were not available for the 2025 dates of service, however, and were not reflected in the proposed rule. Many commenters shared the clinical benefits of this treatment and how it is a highly effective option for patients with Treatment Resistant Depression.

Response: We thank the commenters for their input. We agree that the proposed rates may not accurately reflect the costs for implementing, providing, and maintaining this service in the hospital outpatient setting. We acknowledge the challenges of capturing costs with a new service and appreciate the interested parties dialogue with CMS about these challenges and their effect on the claims data.

Since the CY 2027 OPPS/ASC proposed rule was published, we note that there were changes in the claims data for CPT code 0889T and 0890T. Based on this updated claims data, the median cost for CPT 0889T is $818 using 89 single frequency claims and the median cost for CPT code 0890T is $1,759 using 88 single frequency claims.

After consideration of the public comments we received, and taking into consideration the HOP Panel's recommendation, we are not finalizing our proposal for CY 2027. For CY 2027, we are using our equitable adjustment authority under section 1833(t)(2)(E) of the Act to maintain the current APC assignments for CPT codes 0889T, 0890T, 0891T, and 0892T. Refer to Table 24 for the proposed and final OPPS New Technology APC and status indicator assignments for CPT codes 0889T, 0890T, 0891T, and 0892T. The final CY 2027 payment rates for these codes can be found in Addendum B to this final rule with comment period. In addition, we refer readers to Addendum D1 to this final rule with comment period for the SI definitions for all codes reported under the OPPS. Addenda B and D1 are available via the internet on the CMS website.

TABLE 24: PROPOSED AND FINAL CY 2027 OPPS NEW TECHNOLOGY APC AND STATUS INDICATOR ASSIGNMENTS FOR CPT CODES 0889T, 0890T, 0891T, AND 0892T

CPT Code	Long Descriptor	Proposed CY 2027 OPPS APC, SI	Final CY 2027 OPPS APC, SI

0889T	Personalized target development for accelerated, repetitive high-dose functional connectivity MRI-guided theta-burst stimulation derived from a structural and resting-state functional MRI, including data preparation and transmission, generation of the target, motor threshold-starting location, neuronavigation files and target report, review and interpretation	1511, S	1511, S
0890T	Accelerated, repetitive high-dose functional connectivity MRI-guided theta-burst stimulation, including target assessment, initial motor threshold determination, neuronavigation, delivery and management, initial treatment day	1521, S	1525, S
0891T	Accelerated, repetitive high-dose functional connectivity MRI-guided theta-burst stimulation, including neuronavigation, delivery and management, subsequent treatment day	1520, S	1525, S
0892T	Accelerated, repetitive high-dose functional connectivity MRI-guided theta-burst stimulation, including neuronavigation, delivery and management, subsequent motor threshold redetermination with delivery and management, per treatment day	1523, S	1525, S

h. Skin Cell Suspension Autograft (SCSA) Procedures (CPT Codes 15006 through 15009) (APC 1575)

Effective January 1, 2025, both CPT code 15013 (Preparation of skin cell suspension autograft, requiring enzymatic processing, manual mechanical disaggregation of skin cells, and filtration; first 25 sq cm or less of harvested skin) and HCPCS code C8002 (Preparation of skin cell suspension autograft, automated, including all enzymatic processing and device components (do not report with manual suspension preparation)) describe the preparation step of a skin cell suspension autograft (SCSA) procedure to treat acute thermal burn injuries. Both codes describe the preparation step of a three-step SCSA procedure: harvesting, preparation, and application. The difference between the codes is that CPT code 15013 describes the manual preparation of the SCSA, and HCPCS code C8002 describes the automated preparation of the SCSA. Due to the similarities between the procedures, in the CY 2025 OPPS/ASC final rule with comment period, we assigned both CPT code 15013 and HCPCS code C8002 to APC 1567 (New Technology—Level 30 ($6,001-$6,500)) with a payment rate of $6,250.50 and status indicator "T". In the CY 2025 OPPS/ASC final rule with comment period, we noted that we believed the

sum of the payment rates for the three-step process should approximate $10,000. However, because of the effect of the multiple procedure reduction, the total payment for the skin cell suspension autograft furnished using the RECELL System would have been approximately $8,000, contrary to the intended target of $10,000 as stated in the CY 2025 OPPS/ASC final rule with comment period. To correct this error, in the CY 2025 OPPS/ASC Correction Notice, we assigned both CPT code 15013 and HCPCS code C8002 to APC 1532 (New Technology—Level 32 ($7,001-$7,500)) with a payment rate of $7,250.50 and status indicator "S" (Procedure or service, not discounted when multiple, paid under OPPS; separate APC payment).

For CY 2026, the OPPS payment rates were based on available CY 2024 claims data. Since CPT code 15013 and HCPCS code C8002 were not effective until January 1, 2025, we did not have any claims for either code for CY 2024. Therefore, for CY 2026, we finalized to continue to assign CPT code 15013 and HCPCS code C8002 to APC 1532 (New Technology—Level 32 ($7,001-$7,500)) with a payment rate of $7,250.50 (91 FR 41801).

Effective January 1, 2027, CPT codes 15011 through 15018 will be deleted and replaced with a bundled four code structure: CPT codes 15006-15009 (placeholder codes 15X19 through 15X22):

- CPT 15006 (placeholder CPT code 15X19): Skin cell suspension autograft (SCSA), trunk, arms, and/or legs; first 100 sq cm or less, or 1 percent of body area of infants and children
- CPT 15007 (placeholder CPT code 15X20): each additional 100 sq cm, or each additional 1 percent of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)
- CPT 15008 (placeholder CPT code 15X21): Skin cell suspension autograft (SCSA), face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1 percent of body area of infants and children
- CPT 15009 (placeholder CPT code 15X22): Skin cell suspension autograft (SCSA), face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each

additional 100 sq cm, or each additional 1 percent of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)

Unlike CPT codes 15011 through 15018, which provide a three step-based coding structure with each procedural step billed separately, CPT codes 15006 through 15009 provide a simplified bundled coding structure based on anatomic size (91 FR 41801 through 41802).

In light of these coding changes, we proposed for CY 2027 to maintain overall payment rates for the SCSA procedure, as we did not believe that changes in coding structure alone warranted changes in payment for a procedure that remains clinically unchanged. Specifically, we proposed to assign CPT codes 15006 and 15008 to APC 1575 (New Technology - Level 38 ($10,001-$15,000)) with a proposed payment rate of $12,500.50 and status indicator "S." We also proposed to assign add-on CPT codes 15007 and 15009 to status indicator "N". Due to the new bundled coding structure, for CY 2027 we also proposed to delete HCPCS code C8002 (Preparation of skin cell suspension autograft, automated, including all enzymatic processing and device components (do not report with manual suspension preparation)), which describes the automated preparation step of the SCSA procedure (91 FR 41802).

We received public comments on our proposals. The following is a summary of the comments we received and our responses.

Comment: Commenters supported our proposals and urged CMS to finalize the proposed APC and status indicator assignments for CPT codes 15006 through 15009 to maintain overall payment for the procedure. A commenter supported our proposal to delete HCPCS code C8002, noting that the automated preparation step is now included into the new bundled SCSA code structure. Commenters emphasized that stable and accurate payment is essential to preserving patient access to SCSA treatment, particularly for those with acute thermal burn injuries requiring treatment of large surface areas or anatomically complex sites.

Response: We thank the commenters for their support. We are finalizing the new technology APC and status indicator assignments for CPT codes 15006 through 15009 as

proposed. Refer to Table 25 for the final OPPS New Technology APC and status indicator assignments for CPT codes 15006 through 15009 and HCPCS code C8002 for CY 2027. The final CY 2027 payment rates can be found in Addendum B to this final rule via the internet on the CMS website.

TABLE 25: FINAL CY 2027 NEW TECHNOLOGY APC AND STATUS INDICATOR ASSIGNMENTS FOR NEW CPT CODES 15006 THROUGH 15009 AND HCPCS CODE C8002 EFFECTIVE JANUARY 1, 2027

HCPCS Code	Long Descriptor	Final CY 2027 OPPS APC, SI
15006	Skin cell suspension autograft (SCSA), trunk, arms, and/or legs; first 100 sq cm or less, or 1% of body area of infants and children	1575, S
15007	each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	N/A, N
15008	Skin cell suspension autograft (SCSA), face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children	1575, S
15009	Skin cell suspension autograft (SCSA), face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	N/A, N
C8002	Preparation of skin cell suspension autograft, automated, including all enzymatic processing and device components (do not report with manual suspension preparation)	N/A, D

i. Renal Histotripsy Service (APC 1575)

HCPCS code C9790 *(Histotripsy (ie, non-thermal ablation via acoustic energy delivery) of malignant renal tissue, including image guidance)*) was created October 1, 2023, and was used to describe the Medicare approved Category B IDE (investigational device exemption) clinical study involving the renal histotripsy procedure associated with the use of the HistoSonics Edison System. CPT code 0888T (Histotripsy (ie, non-thermal ablation via acoustic energy delivery) of malignant renal tissue, including image guidance) replaced HCPCS code C9790 effective July 1, 2024.

Renal histotripsy is a non-invasive, non-thermal, mechanical process that uses a focused beam of sonic energy to destroy solid renal tumors and is currently in a prospective, multi-center, single-arm pivotal trial designed to evaluate the effectiveness and safety of the device for the destruction of kidney tissue by treating primary solid renal tumors. Because the renal histotripsy

clinical study is designated as a Category B (non-experimental/investigational) IDE study, the Medicare payment for CPT code 0888T reflects payment for both the service that is performed, and the device used each time it is reported on a claim. For CY 2025 we assigned CPT code 0888T to APC 1576 (New Technology—Level 39 ($15,001– $20,000)) with a payment rate of $17,500.50 based on the previous APC and status indicator assignments for HCPCS code C9790.

For CY 2026, the proposed OPPS payment rates were based on available CY 2024 claims data. We had identified one single frequency claim for HCPCS code C9790 and eight single frequency claims for CPT code 0888T. Given our proposal to maintain current New Technology APC assignments for CY 2026 for New Technology services with fewer than 10 claims in the 4-year lookback period applicable for the universal low-volume APC policy, we finalized maintaining the APC assignment for CPT code 0888T to APC 1576 (New Technology—Level 39 ($15,001– $20,000)) with a payment rate of $17,500.50 (90 FR 53558).

For CY 2027, the proposed rates are based on available CY 2025 claims data. For the proposed rule, we identified 14 single frequency claims for CPT code 0888T, which encompassed a four year lookback. Using this claims data from the CY 2025 proposed rule, our analysis found the geometric mean cost of CPT 0888T is approximately $5,940, the median cost is approximately $6,740 and the arithmetic mean cost is approximately $8,145. The arithmetic mean is the statistical methodology that estimates the highest cost for the service. Therefore, we proposed, for CY 2027, to assign CPT code 0888T to APC 1534 (New Technology—Level 34 ($8001-$8500)) with a payment rate of $8,250.50 (91 FR 41802).

We received public comments on our proposal. The following is a summary of the comments we received and our responses.

Comment: Commenters requested we maintain the OPPS payment and increased ASC payments.

Response: We thank the commenters for their feedback.

Since the proposed rule was published there are four additional single frequency claims

available in the CY 2025 claims data. With this change in volume for CPT code 0888T, we note, the revised statistical methodologies are: geometric mean cost is approximately $6,942, the median cost is approximately $7,160, and the arithmetic mean cost is approximately $10,159. The arithmetic mean is the statistical methodology that yields the highest estimated cost of the service. This updated cost data falls outside the proposed APC assignment of APC1534 (New Technology- Level 34 ($8001-$8500); therefore, we are not finalizing as proposed. Instead, for CY 2027, we are finalizing the assignment of CPT code 0888T to APC 1575 (New Technology- Level 38 ($10,001- 15,000)) with a payment rate of approximately $12,500.

The final CY 2027 payment rates for this code can be found in Addendum B to this final rule with comment period. In addition, we refer readers to Addendum D1 to this final rule with comment period for the SI definitions for all codes reported under the OPPS. Addenda B and D1 are available via the internet on the CMS website.

Refer to Table 26 for the proposed CY 2027 and final CY 2027 OPPS New Technology APC and status indicator assignment for CPT code 0888T.

TABLE 26: PROPOSED AND FINAL CY 2027 OPPS NEW TECHNOLOGY APC AND STATUS INDICATOR ASSIGNMENTS FOR THE RENAL HISTOTRIPSY SERVICE

CPT Code	Long Descriptor	Proposed CY 2027 OPPS APC, SI	Final CY 2027 OPPS ASC, SI
0888T	Histotripsy (ie, non-thermal ablation via acoustic energy delivery) of malignant renal tissue, including image guidance	1534, S	1575, S

j. Implantable Glucose Monitoring System (APC 1563)

Effective January 1, 2017, the AMA CPT Editorial Panel established CPT codes 0446T (*Creation of subcutaneous pocket with insertion of implantable interstitial glucose sensor, including system activation and patient training*) and 0448T (*Removal of implantable interstitial glucose sensor with creation of subcutaneous pocket at different anatomic site and insertion of new implantable sensor, including system activation*) to describe an implantable glucose sensor for patients with diabetes. These codes were used to describe sensors with a 90-day or 180-day

battery life. Although these CPT codes were effective January 1, 2017, the implantable interstitial glucose sensor did not receive FDA authorization for marketing until June 6, 2019.

For CY 2021, we assigned CPT codes 0446T and 0448T to APC 5054 (Level 4 Skin Procedures) and a status indicator of ‘‘T’’ (Procedure or Service, Multiple Procedure Reduction Applies; Paid under OPPS; separate APC payment.) and maintained those APC assignments until April 1, 2025.

In the CY 2025 OPPS/ASC final rule with comment period, we created the following two HCPCS G-codes effective January 1, 2025, to describe the implantable interstitial glucose sensor with a 365-day battery life.

- G0546 (*Creation of subcutaneous pocket with insertion of 365 day implantable interstitial glucose sensor, including system activation and patient training*); and
- G0565 (*Removal of implantable interstitial glucose sensor with creation of subcutaneous pocket at different anatomic site and insertion of new 365 day implantable sensor, including system activation*).

We assigned HCPCS codes G0564 and G0565 to APC 1561 (New Technology— Level 24 ($3001–$3500)) with a payment rate of $3,250.50.

For the April 1, 2025, quarterly update, we deleted HCPCS codes G0564 and G0565 and assigned 0446T and 0448T to APC 1561 (New Technology— Level 24 ($3001–$3500)) with a payment rate of $3,250.50 to describe the new implantable interstitial glucose sensor with a 365-day battery life. The 365-day glucose sensor replaced previous versions of the implantable interstitial glucose sensor with shorter battery lives. Therefore, the 365-day sensor is the only sensor on the market and can only be described by CPT codes 0446T and 0448T.

For CY 2026, we finalized maintaining the APC assignments for CPT codes 0446T and 0448T to APC 1561 (New Technology—Level 24 ($3001– $3500)) with a payment rate of $3,250.50. Because CPT codes 0446T and 0448T were assigned to New Technology APCs to describe this new sensor for the April 2025 quarterly update and the G-codes that described this

service were only effective for one quarter, we did not have any claims data for the service (90 FR 53556).

For CY 2027, the OPPS payment rates were proposed based on available CY 2025 claims data. Both CPT codes 0446T and 0448T had less than 10 claims, so we proposed to maintain their current APC assignment to APC 1563 (New Technology - Level 26 ($4001-$4500)), status indicator of 'T' and a payment rate of $4,250.50.

We received public comments on this proposal. The following is a summary of the comments we received and our responses.

Comment: Several commenters requested that we maintain the APC assignment for CPT codes 0446T and 0448T in a New Technology APC, stating continuous glucose monitoring is an important tool for diabetic patients, especially patients with transportation barriers, limited access to specialty care, and patients who may not be as compliant with follow-up visits. Maintaining the APC assignments, the commenters contended, would protect beneficiary access to this service while allowing CMS to gather claims data and get a better idea of the true costs of this service.

A commenter requested that CMS reassign CPT codes 0446T and 0448T to APC 1530 (New Technology— Level 30 ($6001–$6500)) with a payment of $6,250.50. The commenter cited the increased cost of the implanted 365-day glucose sensor as the reason for their request and the value of the longer sensor duration, including fewer insertion and removal procedures and better adherence to therapy. They explained that extensive research and development, along with high manufacturing costs, have contributed to the cost of the implantable continuous glucose monitoring system (iCGM system) which they state is $6,800. The commenter also requested that the OPPS payment align with the PFS payment which they state is approximately $5,800, to provide consistent payment regardless of the setting. The commenter notes that the utilization in other care settings has increased while usage in the hospital outpatient setting has been limited.

It was also noted that the continuous glucose monitoring system is under consideration for a Category I CPT code, which would allow the service to be valued through the CPT and RUC processes and support appropriate future reimbursement.

Response: We appreciate the public comment and understand the implicated value that a longer life sensor brings to Medicare beneficiaries. We agree that there would be inherently increased costs to hospitals for the new technology of a 365-day system, but as we stated last year, we do not agree that the costs to hospitals would be almost double the costs of the 180-day system. (90 FR 53556) We also remind the commenter that the OPPS pays for operational costs for hospital facilities, while the PFS pays for the professional services. As such, we do not believe that the costs will always be aligned between the two fee schedules.

Since the CY 2027 OPPS/ASC proposed rule was published, we note that there were no changes in claims data for CPT code 0446T, but CPT 0448T now has 10 single frequency claims in the 4-year lookback period and therefore is subject to our low volume policy. Using this claims data from CY 2025, our analysis found the arithmetic mean cost is $1,779, the median cost is $1,394, and the geometric mean cost is $1,278. Because the arithmetic mean cost is the statistical methodology that estimates the highest cost for the service, we would usually assign CPT 0448T to APC 1551 (New Technology - Level 14 ($1201- $1300)), status indicator of 'T' and a payment of $1,250.50. However, we believe it is important to maintain both of these codes in their current APC assignments.

In summary, after consideration of the public comment we received, we are finalizing our proposal based on our statutory authority set out at section 1833(t)(2)(E) of the Act, to assign both CPT codes 0446T and 0448T to APC 1563 (New Technology—Level 26 ($4001–$4500)) with a payment of $4,250.50 and a status indicator of 'T'.

We remind hospitals that we review, on an annual basis, the APC assignments for all items and services paid under the OPPS. The final CY 2027 payment rates for these codes can be found in Addendum B to this final rule with comment period. In addition, we refer readers to

Addendum D1 to this final rule with comment period for the SI definitions for all codes reported under the OPPS. Addenda B and D1 are available via the internet on the CMS website.

k. Scalp Cooling Fitting CPT Code 97007 (APC 1516)

Scalp cooling is a service furnished during chemotherapy to prevent or minimize hair loss, a common side effect of chemotherapy treatment for cancer. Effective July 1, 2021, scalp cooling was described by CPT codes 0662T (Scalp cooling, mechanical; initial measurement and calibration of cap) and 0633T (Scalp cooling, mechanical; placement of device, monitoring, and removal of device (list separately in addition to code for primary procedure)).

However, effective January 1, 2026, CPT codes 0662T and 0663T were deleted and replaced by three Category I CPT codes:

- 97007—*Mechanical scalp cooling, including individual cap supply with head measurement, fitting, and patient education.*
- 97008—*Mechanical scalp cooling; including hair preparation, individual cap placement, therapy initiation, and precooling period).*
- 97009 —*Mechanical scalp cooling; provided after discontinuation of chemotherapy, each 30 minutes (List separately in addition to code for primary procedure).*

CPT code 97007 describes the fitting and supply of the cap, which happens on a different date of service than a chemotherapy session, while CPT codes 97008 and 97009 describe the scalp cooling therapy on the same date of service as the chemotherapy session. For CY 2026, we assigned status indicator "N" to CPT codes 97008 and 97009 to align with our packaging policies generally, and specifically with regard to packaging of CPT code 0663T, which we believed served as a predecessor code for CPT codes 97008 and 97009 (90 FR 53597).

For CY 2027, we proposed to assign CPT code 97007 to APC 1516 (New Technology - Level 16 ($1401 - $1500)) with a payment rate of $1,450.50 using the geometric mean cost of $1,425.11 based on 109 single frequency claims for the predecessor code, CPT code 0662T, that were available for the proposed rule. We refer readers to the Addendum B to the CY 2027

OPPS/ASC proposed rule for our proposals regarding CPT codes 97008 and 97009. Additionally, we refer readers to section III.E. to this final rule for preamble on our final policy for CPT code 97008.

We received a public comment on our proposal for CPT code 97007. The following is a summary of the comment we received and our response.

Comment: A commenter representing a scalp cooling device requested that we reassign CPT code 97007 to APC 1519 (New Technology - Level 19 ($1701-$1800)) with a payment rate of $1,750.50 for CY 2027. The commenter explained that because claims data for the predecessor CPT code may not have included hospital costs associated with the cap supply since the supply was not specified in the code descriptor, the claims data for CPT code 0662T should not be used to set a payment rate for CPT code 97007. Instead, the commenter asked that we use invoice data to assign CPT code 97007 to APC 1519 until there is reliable claims data upon which to base payment.

Response: We thank the commenter for their input. According to Medicare's National Coverage Determination (NCD) policy, specifically NCD 110.6 (Scalp Hypothermia During Chemotherapy to Prevent Hair Loss), the scalp cooling cap itself is classified as an incident to supply to a physician service and would not be paid under the OPPS. However, interested parties have indicated that there are substantial resource costs associated with calibrating and fitting the cap, which has informed payment policy for scalp cooling.

Since Medicare began paying for scalp cooling in CY 2022, we have collected OPPS claims data on which to base payment rates for the service. For CY 2027, more than 100 single frequency claims are available to inform the payment rate for CPT code 97007. Because claims data is available here, we do not believe invoice pricing is the appropriate basis for setting the final payment rate for CPT code 97007, and we decline to adopt the commenter’s suggested approach. Therefore, for CY 2027, we are finalizing our proposal to use CPT code 0662T claims data to set the APC assignment for CPT code 97007.

We note that additional claims for CPT code 97007 have been processed since the CY 2027 OPPS/ASC proposed rule. Based on updated claims data, CPT code 97007 has an updated geometric mean cost of approximately $1,401.75 based on 166 single frequency claims. Because the geometric mean cost of CPT code 97007 is within the range for APC 1516, the proposed APC assignment for CPT code 97007 for CY 2027, we are finalizing the APC assignment of CPT code 97007 as proposed. Based on the available claims data, for CY 2027, we are finalizing to assign CPT code 97007 to APC 1516 (New Technology - Level 16 ($1401 - $1500)) with a payment rate of $1450.50.

Refer to Table 27 for the proposed and final CY 2027 and New Technology APC and status indicator assignment for CPT code 97007. The final CY 2027 payment rates can be found in Addendum B to this the final rule via the internet on the CMS website. In addition, we refer readers to Addendum D1 to this the final rule for the status indicator definitions for all codes reported under the OPPS. Addendum D1 can also be found via the internet on the CMS website.

TABLE 27: PROPOSED CY 2027 AND FINAL CY 2027 OPPS NEW TECHNOLOGY APC AND STATUS INDICATOR ASSIGNMENT FOR CPT CODE 97007

CPT Code	Long Descriptor	Proposed CY 2027 OPPS APC, SI	Final CY 2027 OPPS, SI APC
97007	Mechanical scalp cooling, including individual cap supply with head measurement, fitting, and patient education	1516, S	1516, S

4. Final CY 2027 Policy for SaMS Procedures Currently Assigned to New Technology APCs

We refer readers to Section X.B. for the final CY 2027 policy and payment rates for SaMS procedures assigned to New Technology APCs for CY 2026.

D. Universal Low Volume APC Policy for Clinical and Brachytherapy APCs

In the CY 2022 OPPS/ASC final rule with comment period (86 FR 63743 through 63747), we adopted a policy to designate clinical and brachytherapy APCs as low volume APCs if they have fewer than 100 single claims that can be used for ratesetting purposes in the claims

year used for ratesetting for the prospective year. For the CY 2026 OPPS/ASC proposed rule, CY 2024 claims were generally the claims used for ratesetting; and clinical and brachytherapy APCs with fewer than 100 single claims from CY 2024 that can be used for ratesetting would be low volume APCs subject to our universal low volume APC policy. As we stated in the CY 2022 OPPS/ASC final rule with comment period, we adopted this policy to reduce the volatility in the payment rate for those APCs with fewer than 100 single claims. Where a clinical or brachytherapy APC has fewer than 100 single claims that can be used for ratesetting, under our low volume APC payment adjustment policy, we determine the APC cost as the greatest of the geometric mean cost, arithmetic mean cost, or median cost based on up to 4 years of claims data. We excluded APC 5853 (Partial Hospitalization for CMHCs) and APC 5863 (Partial Hospitalization for Hospital-based PHPs) from our universal low volume APC policy given the different nature of policies that affect the partial hospitalization program. We also excluded APC 2698 (Brachytx, stranded, nos) and APC 2699 (Brachytx, non-stranded, nos) as our current methodology for determining payment rates for non-specified brachytherapy sources is appropriate.

Based on claims data available for the CY 2027 OPPS/ASC proposed rule, we proposed to designate five brachytherapy APCs and four clinical APCs as low volume APCs under the OPPS. The five brachytherapy APCs and four clinical APCs meet our criteria of having fewer than 100 single claims in the claims' year used for ratesetting (CY 2025 for the CY 2027 OPPS/ASC proposed rule). Nine of the 10 APCs were designated as low volume APCs in CY 2025. Based on data for the CY 2027 OPPS/ASC proposed rule, APC 2645 (Brachytx, non-stranded, gold-198) had 87 single claims and met our criteria to be designated as a low volume APC (91 FR 41807).

Comment: Commenters supported our proposal to continue our low volume APC policy for CY 2027.

Response: We thank commenters for their support.

After consideration of the public comments received, based on CY 2025 claims data available for this final rule with comment period, we are finalizing our proposal to designate five brachytherapy APCs and four clinical APCs as low volume APCs under the OPPS. Table 28 includes the CY 2025 claims available for ratesetting for each of the APCs we are designating as low volume APCs for CY 2027. The final cost statistics for our CY 2027 low volume APCs, such as the median, arithmetic mean, and geometric mean cost are available for download with this final rule with comment period on the CMS website. We refer readers to our website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices*; click on the relevant regulation to download the low volume APC cost statistics under the comprehensive (OPPS) ratesetting methodology in the downloads section of the web page.

TABLE 28: FINAL LOW VOLUME APCS USING COMPREHENSIVE (OPPS) RATESETTING METHODOLOGY FOR CY 2027

APC	APC Description	CY 2025 Claims Available for Ratesetting
2635	Brachytx, non-str, HA, p-103	29
2642	Brachytx, stranded, c-131	43
2643	Brachytx, non-stranded, c-131	80
2645	Brachytx, non-stranded, gold-198	92
2647	Brachytx, NS, Non-HDRIr-192	14
5244	Level 4 Blood Product Exchanges and Related Services	56
5495	Level 5 Intraocular Procedures	99
5496	Level 6 Intraocular Procedures	38
5881	Ancillary Outpatient Services When Patient Dies	49

E. APC-Specific Policies

1. Creation and/or Revisions of Clinical APCs

Neurostimulator and Related Procedures (APCs 5461 Through 5465)

In prior rulemaking, some interested parties have requested that we create a Level 6 Neurostimulator and Related Procedures APC, due to their concerns around clinical and resource cost similarity in the Level 5 Neurostimulator and Related Procedures APC. We most recently responded to this request in the CY 2026 OPPS/ASC final rule with comment period (90 FR

53584). We noted that we believed that the current 5 level APC structure for the Neurostimulator and Related Procedures series provided for an appropriate distribution of clinical and cost similarity at the different APC levels.

As discussed in the CY 2021 OPPS/ASC final rule with comment period, we reiterate that the OPPS is a prospective payment system. We group procedures with similar clinical characteristics and resource costs into APCs and establish a payment rate that reflects the geometric mean of all services in the group even though the cost of any individual service within the APC may be higher or lower than the APC's geometric mean. As a result, in the OPPS, any individual procedure may potentially be paid more or less than the cost of the services because the payment rate is based on the geometric mean of the entire group of services in the APC. However, the impact of these payment differences should be mitigated when distributed across a large number of APCs (85 FR 85968).

We continued to believe that a five-level structure for the Neurostimulator and Related Procedures APC series remained appropriate, and therefore in the CY 2027 OPPS/ASC proposed rule our proposed assignments for the structure and for many codes in the APC series remained the same as they were in the CY 2026 OPPS/ASC final rule.

Comment: A commenter supported the assignment of CPT code 61885 (Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array) to APC 5465. Commenters supported maintaining the assignment of CPT code 33276 (Insertion of phrenic nerve stimulator system (pulse generator and stimulating lead[s]), including vessel catheterization, all imaging guidance, and pulse generator initial analysis with diagnostic mode activation, when performed) to New Technology APC 1580. Other commenters supported our proposal to maintain the assignment of CPT code 64568 (Open implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator) to New Technology APC 1580.

Some commenters noted that the claims used in modeling the estimated costs for CPT

code 64568 appeared to be restricting procedure pairings to HCPCS codes C1767 (Generator, neurostimulator (implantable), non-rechargeable) and C1778 (Lead, neurostimulator (implantable)) and requested that the customary methodology be applied when evaluating CPT code 64568. Commenters also requested that CMS remove hypoglossal nerve stimulation claims for the treatment of obstructive sleep apnea from the determination of the geometric mean cost of CPT code 64568.

Response: We appreciate the commenters' support for the proposed assignments of CPT codes 33276 and 64568 to New Technology APC 1580, and of CPT code 61885 to APC 5465. We agree that it is appropriate to maintain the current temporary New Technology APC assignments for CPT codes 33276 and 64568. We will continue to monitor the claims data for the code as additional claims become available.

In reviewing the claims data for CPT code 64568, we agree that the claims were restricted to only allow specific procedure-device combinations under the device dependent APC methodology for the specific code. Based on the proposed and finalized assignment of the code to New Technology APC 1580, we note that there will not be a specific impact on the CY 2027 OPPS status indicator and APC assignment for CPT code 64568. We no longer restrict those procedure-device combinations.

We recognize the concerns commenters raised with regards to the claims data for CPT code 64568 and how they may describe varying degrees of resource complexity as a result of describing different types of nerve stimulation procedures and the associated clinical indications. However, we believe that with the assignment of CPT code 64568 to New Tech APC 1580, and the future availability of CY 2026 claims that would separate those hypoglossal nerve stimulation services based on distinct C codes, we do not believe it is necessary to update the final rule claims data and associated cost files to assume which claims describe each type of service.

Comment: Some commenters requested the creation of a Level 6 Neurostimulator and

Related Procedures APC, with some requesting that specific codes or codes with similar costs be included in that Level 6 APC. Those commenters believed that establishing the Level 6 APC would be a permanent way of addressing disparities between payment and resource costs for high-cost, low-volume neurostimulator procedures. They also noted that creating a Level 6 APC would be a way to use more claims for ratesetting based on the estimated costs of the procedures, under a comprehensive APC methodology. Commenters also noted that restructuring and creation of new clinical APCs would allow for efficient payment for services being phased out of the IPO list.

Response: We appreciate the thoughtful responses commenters have provided with regard to the Neurostimulator and Related Procedures APC series. At this time, we continue to believe the 5-level APC structure for the APC series remains appropriate and that the individual New Technology APC assignments with respect to the high-cost procedures in this evolving area resolve the concerns around procedure payment relative to cost. Finally, we note that for the CY 2027 OPPS/ASC final rule we are not removing any codes from the IPO list to the Neurostimulator and Related Procedures APC series. We will continue to monitor the claims data for these procedures as more information around their volume and estimated costs become available.

After consideration of public comments, we are finalizing the proposed assignments of CPT codes 33276 and 64568 to New Technology APC 1580, finalizing the proposed assignment of 61885 to APC 5465, and maintaining the 5-level APC structure for the Neurostimulator and Related Procedures APC series for CY 2027.

Laparoscopy and Related Services (APCs 5361 Through 5362)

As part of the CY 2016 OPPS APC restructuring process, the four level APC series for Laparoscopy and Related Services was consolidated into a 2-level APC series (80 FR 70379). Since that time, we have maintained that 2- level APC structure based on the clinical and resource homogeneity of the services assigned to those APCs.

Comment: A commenter noted that several of the codes newly proposed to be removed from the inpatient only list and assigned to the Level 2 Laparaoscopy and Related Services APC have higher geometric mean costs relative to the APC geometric mean cost for this APC, including for CPT codes 32663 (Thoracoscopy, surgical; with lobectomy (single lobe)), 32666 (Thoracoscopy, surgical; with therapeutic wedge resection (eg, mass, nodule), initial unilateral), and 32669 (Thoracoscopy, surgical; with removal of a single lung segment (segmentectomy)). The commenter requested that CMS consider whether a higher level Laparoscopy and Related Services APC is needed to establish appropriate payment for these services in the outpatient setting.

Response: While we monitor the structure of the OPPS and the various APCs, we note that some of the principles guiding the CY 2016 OPPS APC restructuring and consolidation included improved resource and clinical homogeneity, as well as reduced resource overlap in APCs within a clinical family (80 FR 70379). APC 5362 (Level 2 Laparoscopy and Related Services) has an estimated geometric mean cost of $11,401, with a range of geometric mean costs for two times rule purposes ranging from $9,347 for CPT code 58552 (Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)) to $13,534 for CPT code 55866 (Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed). While we recognize the commenter's concern around estimated costs for services removed from the IPO list being assigned to the Laparaoscopy and Related Services APC series, we note that geometric mean costs for CPT codes 32666 and 32669 fall well within that range of significant costs for the APC, and that all three codes have limited outpatient claims volume. We do not believe that there is a current need for an additional APC level for the Laparoscopy and Related Services APC series. However, we will continue to monitor the claims data as more claims become available and consider the need for additional APC levels in the future.

After consideration of the public comments, we are finalizing the 2-level APC structure

for the Laparoscopy and Related Services APC series in this final rule with comment period as proposed.

Nuclear Medicine and Related Services APC Series (APC 5591 Through 5594)

The Nuclear Medicine and Related Services APC series was created as part of the broader APC restructuring and consolidation in the CY 2016 OPPS/ ASC final rule with comment period (80 FR 70392 through 70397). The APC series was developed from what were previously separate APC groupings primarily organized by anatomy and imaging modality. Since the initial establishment of the Nuclear Medicine and Related Services series in the CY 2016 OPPS/ASC final rule with comment period, we have maintained the four-level APC structure for the series.

In the CY 2025 OPPS/ASC final rule with comment period, we finalized a policy of paying separately for diagnostic radiopharmaceuticals with estimated per day costs higher than a packaging threshold specific to diagnostic radiopharmaceuticals (89 FR 93948 through 93963). Because certain diagnostic radiopharmaceuticals are paid separately under the policy, the nuclear medicine and other services these diagnostic radiopharmaceuticals would otherwise be packaged into would no longer include those costs. As a result, based on the associated changes to the ratesetting process, we observed impacts on the estimated cost of services assigned to the Nuclear Medicine and Related Services APC series such that the range of cost significant codes across the various APC levels became less distinct, in particular between Levels 3 and 4.

As part of our standard process of reviewing updated claims and cost report data, we continued to observe in the CY 2027 OPPS data that the differences between the four levels of APC geometric means were less distinct than they were previously, in part due to the policy of paying separately for diagnostic radiopharmaceuticals. Specifically, under a four-level APC structure using the 2027 NPRM claims data and maintaining the same APC assignments as in the CY 2026 OPPS/ASC final rule with comment period, the geometric mean cost of the Level 3 APC would have been $1,367.99 while the geometric mean cost of the Level 4 APC would have

been $1,497.06. The range of cost significant codes in the Level 3 APC would have been from $812 to $1,404, while the range for the Level 4 APC would have been from $1,024 to $1,676; indicating a high degree of overlap in the estimated costs of the services assigned to those APC levels. Given the relative proximity of the APC geometric mean costs and the clinical and cost similarities of the services between the APCs in the Nuclear Medicine and Related Services series, we believed that it was appropriate to reorganize the Nuclear Medicine and Related Services APC series for the CY 2027 OPPS (91 FR 41808).

Additionally, we noted that CPT codes 78431 (Myocardial imaging, positron emission tomography (pet), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); multiple studies at rest and stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan), 78432 (Myocardial imaging, positron emission tomography (pet), combined perfusion with metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), dual radiotracer (eg, myocardial viability);), and 78433 (Myocardial imaging, positron emission tomography (pet), combined perfusion with metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), dual radiotracer (eg, myocardial viability); with concurrently acquired computed tomography transmission scan) had sufficient CY 2025 claims data available to be appropriately assigned to clinical APCs for CY 2027 OPPS ratesetting. We believed the restructuring of the series now made it appropriate to propose to assign these codes to APC 5594 (Level 4 Nuclear Medicine and Related Services) and we proposed to assign these three CPT codes to APC 5594 for CY 2027 (91 FR 41808).

Based on our review of the updated claims data, we proposed to reassign a number of services to revised levels in the Nuclear Medicine and Related Services APC series for CY 2027 and to assign CPT codes 78431, 78432, and 78433 to APC 5594 (Level 4 Nuclear Medicine and Related Services) in the CY 2027 OPPS. Please see the APC- sorted Two Times Listing for the proposed rule on the CMS website or Addendum B to the proposed rule to see the Nuclear

Medicine APC we proposed to assign each HCPCS code in the series.

Comment: Commenters supported the proposed reorganization of the Nuclear Medicine and Related Services APC series and the proposed assignment of PET/CT procedures to APC 5594 (Level 4 Nuclear Medicine and Related Services)

Response: We appreciate the commenters' support.

Comment: Two commenters expressed concern regarding the proposed reassignment of CPT code 78830 (Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (spect) with concurrently acquired computed tomography (ct) transmission scan for anatomical review, localization and determination/detection of pathology, single area (eg, head, neck, chest, pelvis) or acquisition, single day imaging) to APC 5592 (Level 2 Nuclear Medicine and Related Services). One of the commenters was concerned that the change would cause a move to more expensive, more invasive tests and that a phased in approach while more claims data continue to be collected.

A commenter expressed concern about the proposed assignment of CPT codes 78075 (Adrenal imaging, cortex and/or medulla), 78454 (Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection), 78811 (Positron emission tomography (pet) imaging; limited area (eg, chest, head/neck)), and 78831 (Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (spect), minimum 2 areas (eg, pelvis and knees, chest and abdomen) or separate acquisitions (eg, lung ventilation and perfusion), single day imaging, or single area or acquisition over 2 or more days) to APC 5592 (Level 2 Nuclear Medicine and Related Services) and recommended assignment to APC 5593 (Level 3 Nuclear Medicine and Related Services)

instead.

Response: We understand the commenter's concern. Based on the data in this final rule, the geometric mean costs for these codes range from $746.48 for CPT code 78811 to $899.39 for CPT code 78831. We believe that these codes are more appropriately placed based on their estimated costs in APC 5592, with a geometric mean cost of $591.45 rather than the Level 3 APC 5593, which has an estimated geometric mean cost $1,433.70. Additionally, in reviewing the prior year's claims data, the geometric mean cost for these codes were similarly situated. While we will continue to monitor the claims data for these codes in the future, we do not believe a phased approach is necessary, as they are appropriately assigned to APC 5592 based on the geometric mean cost of these services.

After consideration of the public comments we received, we are finalizing the HCPCS assignments for CPT codes 78075, 78454, 78811, 78830, and 78831 to APC 5592, as proposed.

Audiology and Otolaryngology

2. Cochlear Infusion of a Pharmacologic Agent, CPT Code 1056T (APC 5165)

For CY 2027, the AMA CPT Editorial Board created a new Category I CPT code 1056T (Placeholder code X565T) to describe a cochlear infusion procedure required for the administration of OTARMENI™ which is the first FDA-approved gene therapy for genetic hearing loss.

Later, the AMA CPT Editorial Board changed the effective date of the CPT code 1056T, *Cochlear infusion of pharmacologic agent (ie, gene therapy vector), including mastoidectomy, labyrinthotomy, and repair of fenestrations,* from January 1, 2027, to October 1, 2026. OTARMENI™ is an adeno-associated virus vector-based gene therapy indicated for the treatment of pediatric and adult patients with severe-to-profound and profound sensorineural hearing loss (any frequency >90 dB HL) associated with molecularly confirmed biallelic variants in the *OTOF* gene, preserved outer hair cell function, and no prior cochlear implant in the same ear.

OTARMENI™ is administered as a single dose intracochlear infusion. The recommended dose for each ear is 7.2×10^{12} vector genomes in a total volume of 0.24 ml.

In the CY 2027 OPPS/ASC proposed rule, we proposed to assign CPT code 1056T to SI "J1", APC 5163 (Level 3 ENT Procedures) with a proposed payment rate of $1,755.96.

We received public comments on this proposal. The following is a summary of the comments we received.

Comment: The commenters requested that CMS reassign CPT code 1056T from APC 5163 (Level 3 ENT Procedures) to APC 5165 (Level 5 ENT Procedures).

They stated that CPT code 1056T describes a highly specialized surgical procedure that requires significant operative expertise, dedicated training, substantial facility resources, and multidisciplinary coordination. The procedure includes complex otologic surgical components such as mastoidectomy and labyrinthotomy, which are more comparable to higher-acuity ENT procedures than to those typically associated with a Level 3 APC assignment. Because CPT code 1056T includes mastoidectomy as well as additional work associated with intracochlear infusion of a gene therapy vector, the commenters believe that APC 5165 better reflects the resources required to perform the cochlear infusion procedure and represents the most appropriate APC assignment for 1056T.

Commenters also noted that cochlear infusion reported with CPT code 1056T, differs substantially from the procedure described by CPT code 69801 (*Labyrinthotomy, with perfusion of vestibuloactive drug(s), transcanal),* which per our proposed rule review was determined to be similar to CPT code 1056T and is assigned to APC 5163. CPT code 1056T describes an open surgical approach that includes mastoidectomy, labyrinthotomy, repair of fenestrations, and intracochlear infusion of a gene therapy vector, whereas CPT code 69801 describes a minimally invasive transcanal drug perfusion procedure that does not include mastoidectomy.

Response: We appreciate the commenters' feedback on this new CPT code, and we agree with the commenters' recommendation to change the APC assignment for this code. Because

CPT code 1056T describes an open surgical approach that includes mastoidectomy, which differs from a minimally invasive transcanal drug perfusion procedure described by CPT code 69801, we now believe that CPT code 1056T is more appropriately assigned to APC 5165 (Level 5 ENT Procedures).

In summary, after consideration of the public comments we received, we are not adopting our proposal as final. Instead, we are assigning CPT code 1056T to APC 5165 (Level 5 ENT Procedures) for CY 2027.

Table 29 shows the finalized status indicator and APC assignment for this procedure code. We refer readers to Addendum B of this final rule with comment period for the payment rates for all codes reportable under the OPPS. Addendum B is available via the internet on the CMS website.

TABLE 29: FINAL CY 2027 APC AND STATUS INDICATOR ASSIGNMENT FOR CPT CODE 1056T

HCPCS Code	Long Descriptor	Final CY2027 OPPS SI	Final CY2027 OPPS APC
1056T	Cochlear infusion of pharmacologic agent (ie, gene therapy vector), including mastoidectomy, labyrinthotomy, and repair of fenestrations	J1	5165

2. Vestibular Testing Codes, CPT codes 92513, 92514, and 92527 (APC 5721)

For CY 2027, the AMA CPT Editorial Board created 4 New Category I CPT codes 92513, 92514, 92527 and 92528 (placeholder CPT codes 92X10, 92X11, 92XX5, and 92XX6). These new codes reflect advances in vestibular testing and provide greater specificity for reporting services used by audiologists to evaluate vestibular function.

- 92513-*Video head impulse testing (vHIT), with recording, interpretation, and report; of lateral semicircular canal function;*
- 92514-*Video head impulse testing (vHIT), with recording, interpretation, and report; of lateral and vertical semicircular canal function;*

- 92527-*Rotational vestibular assessment by sinusoidal harmonic acceleration (SHA) testing with calibrated, computer-controlled chair, with interpretation and report; and*
- 92528-*Rotational vestibular assessment by sinusoidal harmonic acceleration (SHA) testing with calibrated, computer-controlled chair, with interpretation and report; with velocity step testing (VST)*

In the CY 2027 OPPS/ASC proposed rule, we proposed to assign CPT codes 92513, 92514, and 92527 to APC 5721 (Level 1 Diagnostic Tests and Related Services) with status indicator "S" and proposed payment rate of $146.93. We proposed to assign CPT code 92528 to status indicator "N".

Comment: We received one public comment on this proposal. The commenter supported our assignment of CPT codes 92513, 92514, and 92527 to APC 5721 for CY 2027; however, they were concerned with our proposed assignment of status indicator "N" to CPT code 92528 which would package payment for VST into payment for the base rotational vestibular assessment service (CPT code 92527). The commenter stated that the additional velocity step testing represented by CPT code 92528 requires clinical work and resources beyond those necessary to perform the base SHA testing service represented by CPT code 92527. This, according to the commenter, includes additional provider time and greater work intensity associated with CPT code 92528. The new CPT code family distinguishes the base SHA assessment from the additional VST service. The commenter also recognized our longstanding policy of packaging most procedures described by add-on codes. However, they believed that the distinct resource requirements associated with CPT code 92528 warranted reconsideration.

Response: We thank the commenter for their feedback. Our medical advisors reviewed the service described by CPT code 92528, and we do not believe that it takes significant additional time or hospital resources to perform this service. Therefore, we concluded that VST service described by an add-on CPT code 92528 is appropriately packaged into the base SHA testing service described by CPT code 92527. This is consistent with our packaging policy outlined at

42 CFR 419.2(b), which lists the types of items and services for which payment is packaged under the OPPS. Specifically, certain services described by add-on codes.

Therefore, we believe our proposed assignment of status indicator "N" to CPT code 92528 remains appropriate. As a result, we are finalizing our proposal without modification to assign CPT code 92528 to status indicator "N" for CY 2027.

We refer readers to Addendum D1 to this final rule with comment period for the SI meanings for all codes reported under the OPPS. Addenda D1 is available via the internet on the CMS website.

Cardiac Related Procedures and Services

4. Cardiac Magnetic Resonance (CMR) Imaging, CPT Codes 75557, 75559, 75561, 75563 (APCs 5523, 5524, 5572, and 5573)

For CY 2027, we proposed to continue to assign the following cardiac magnetic resonance imaging (MRI) CPT codes to APC 5523 (Level 3 Imaging without Contrast), APC 5524 (Level 4 Imaging without Contrast), APC 5572 (Level 2 Imaging with Contrast), and APC 5573 (Level 3 Imaging with Contrast). The codes, long descriptors and payment assignments are listed below.

- CPT code 75557 – *Cardiac magnetic resonance imaging for morphology and function without contrast material*. CPT code 75557 is currently assigned to APC 5523 (Level 3 Imaging without Contrast) and has a geometric mean cost of $305 based on 1,453 single frequency claims used for ratesetting;

- CPT code 75559 – *Cardiac magnetic resonance imaging for morphology and function without contrast material; with stress imaging*. CPT code 7559 is currently assigned to APC 5524 (Level 4 Imaging without Contrast) and has a geometric mean cost of $378, based on 19 single frequency claims used for ratesetting;

- CPT code 75561 – *Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences*. CPT code

75561 is assigned to APC 5572 (Level 2 Imaging with Contrast) and has a geometric mean cost of $460, based on 33,824 single frequency claims used for ratesetting; and

- CPT code 75563 - *Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with stress imaging*. CPT code 75563 is assigned to APC 5573 (Level 3 Imaging with Contrast) and has a geometric mean cost of $783 based on 3,401 single frequency claims used for ratesetting.

We received one public comment on these codes.

Comment: The commenter states that our "current modality-based APC structure creates a substantial and increasingly difficult-to-justify payment disparity between clinically comparable advanced cardiac imaging services." The commenter suggests that contrast-enhanced cardiac MRI (CMR) requires more hospital resources than single-photon emission computed tomography (SPECT) and positron emission tomography (PET) myocardial perfusion imaging and should not be placed in general imaging APCs with/without contrast APCs that also include non-cardiac related imaging examinations requiring very different resources. According to the commenter, the payment for SPECT and PET is influenced by advanced cardiac imaging while the payment for CMR is influenced by a much broader range of imaging procedures. The commenter refers to the historical placement of CPT 75563 in APC 5593 (Level 3 Nuclear Medicine and Related Services)—before the CY 2017 APC restructuring—and how there is resource and clinical homogeneity between CMR and nuclear cardiac imaging. This is especially important, the commenter continues, because these codes include contrast-enhanced imaging and pharmacologic stress. The commenter notes that these services are paid approximately 40-60 percent less despite the commenter's belief that there is comparable or greater clinical resource intensity.

The commenter requested that we reassign CPT code 75561 to APC 5593 and reassign CPT code 75563 to APC 5594. The commenter also requested that we evaluate the appropriate

placement of CPT code 75557 which is currently assigned to APC 5523 and CPT code 75559 which is currently assigned to APC 5524.

Response: We thank the commenter for their thoughtful input. The OPPS payment rates were proposed based on available CY 2025 claims data. Our claims data shows that APC 5593 (Level 3 Nuclear Medicine and Related Services) has a geometric mean cost of approximately $1,433 which is significantly higher than the geometric mean costs of the cardiac MRI codes ($305 to $783).

As stated in last year's final rule (90 FR 53567), we do not believe that cardiac MRI with stress imaging is very similar to myocardial perfusion imaging just because both tests are performed under a stress protocol, and therefore should be assigned to a nuclear medicine APC. APC 5593 contains procedures that describe nuclear medicine tests, not MRI services. We continue to believe (and have stated in previous rulemaking), that MRI services should not be assigned to the nuclear medicine APCs (81 FR 79630 and 90 FR 53567).

In summary, after consideration of the public comment, we are finalizing our proposal without modification to maintain the APC assignments for the cardiac MRI codes for CY 2027. The final CY 2027 payment rates for these codes can be found in Addendum B to this final rule with comment period. In addition, we refer readers to Addendum D1 to this final rule with comment period for the status indicator definitions for all codes reported under the OPPS. Addenda B and D1 are available via the internet on the CMS website.

5. Cardiac CT Services, CPT Codes 75572, 75573, and 75574 (APC 5572)

Cardiac computed tomography services are described by the following Category I CPT codes and have been effective since January 1, 2010:

- 75572 - *Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology (including 3D image postprocessing, assessment of cardiac function, and evaluation of venous structures, if performed);*

- 75573 - *Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology in the setting of congenital heart disease (including 3D image postprocessing, assessment of left ventricular [LV] cardiac function, right ventricular [RV] structure and function and evaluation of vascular structures, if performed); and*
- 75574 - *Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed).*

For CY 2027, the OPPS payment rates were proposed based on available CY 2025 claims data for ratesetting. We note that CPT code 75572 has a geometric mean cost of $183 calculated using 41,211 single frequency claims; CPT code 75573 has a geometric mean cost of $234 calculated using 559 claims; and CPT code 75574 has a geometric mean cost of $227 calculated using 116,963 claims. For CY 2027, we proposed to maintain these codes to APC 5572 (Level 2 Imaging with Contrast) with a payment rate of around $400.

As a reminder to readers, we reassigned these codes to APC 5572 in CY 2025 because of the assumption that facilities would have chosen the cardiology revenue code if they had been able to versus the CT scan (035X) and Radiology Diagnostic (032X) revenue codes. We became aware of an edit (that we removed in December 2024) that was prohibiting hospitals from reporting these codes with a cardiology revenue code (048X) which maps to the cardiology cost center (03140). The cardiology cost center has a higher cost-to-charge ratio (CCR) than the imaging cost centers. Utilizing cost centers with lower CCRs results in a lower OPPS payment compared to utilizing cost centers with higher CCRs. With the edit no longer in place, hospitals are able to bill for cardiac CT services with whichever revenue code they believe is appropriate for these services, including cardiology revenue code 048X. For a full discussion of this issue, we refer readers to 89 FR 94057 through 94062. We received public comments on these codes.

Comment: We received numerous comments in support of maintaining the current APC assignment. Commenters requested that we continue to maintain the APC assignment while they continue their efforts to educate their providers and hospitals to change their billing practices. They note that there is continued hesitancy surrounding the selection of appropriate revenue codes because of 'CT' in the coding descriptors. The revenue codes hospitals use to report cardiac CT services materially affects whether OPPS payment accurately reflects the resources involved in furnishing them. Reporting cardiac CT services under cardiology revenue codes (048x) more accurately reflects the resources associated with furnishing the service. Additionally, a commenter requested that CMS issue sub-regulatory guidance and provider education confirming that cardiology revenue codes are appropriate to report for cardiac CT services, so that facility cost data and OPPS rate-setting better reflect the clinical resources used to provide the services.

Response: We appreciate the commenters' support. Once again, we agree with commenters that effectuating change in any health system can be challenging. As we stated in the CY 2025 OPPS/ASC final rule, we will continue to monitor the claims data for these services, knowing that it may take a number of years before we see changes in the claims data.

As noted previously, commenters continue to request guidance that explicitly states that it is appropriate to use the cardiology revenue codes when billing for cardiac CT services. As a reminder to our readers and as we have previously stated, we do not provide specific coding guidance. We refer our readers to section 20.5 in Chapter 4 (Part B Hospital) of the Medicare Claims Processing Manual, "CMS does not instruct hospitals on the assignment of HCPCS codes to revenue codes for services provided under OPPS since hospitals' assignments of cost vary. Where explicit instructions are not provided, HOPDs should report their charges under the revenue code that will result in the charges being assigned to the same cost center to which the cost of those services are assigned in the cost report.'' We have consistently stated that hospital

outpatient facilities must determine the most appropriate cost center and revenue code for the cardiac CT codes (87 FR 71849, 88 FR 81664, and 90 FR 53566).

In summary for CY 2027, we are finalizing our proposal without modification and assigning CT codes 75572, 75573, and 75574 to APC 5572 (Level 2 Imaging with Contrast). The final CY 2027 payment rates for these codes can be found in Addendum B to this final rule with comment period. In addition, we refer readers to Addendum D1 to this final rule with comment period for the status indicator definitions for all codes reported under the OPPs. Addenda B and D1 are available via the internet on the CMS website.

6. Cardiac Leadless Pacemaker Procedures, CPT Codes 0823T, 0796T, 0795T, 0801T, 0802T, and 0825T (APCs 5231 and 5232)

CPT codes 0823T and 0796T describe the insertion of a permanent single-chamber leadless pacemaker and the insertion of a permanent dual-chamber leadless pacemaker when a right ventricular single leadless pacemaker already exists. Their long descriptors and current APC and status indicators are listed below.

- CPT code 0823T – *(Transcatheter insertion of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography) and device evaluation (eg, interrogation or programming), when performed)*; assigned to APC 5224 (Level 4 Pacemaker and Similar Procedures) and status indicator 'J1'.

- CPT code 0796T – *Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; right atrial pacemaker component (when an existing right ventricular single leadless pacemaker exists to create a dual-chamber leadless pacemaker system)*; assigned to APC (Level 4 Pacemaker and Similar Procedures) and status indicator 'J1'.

CPT codes 0795T and 0801T describe the insertion of a permanent dual-chamber leadless pacemaker and the removal and replacement of a permanent dual-chamber leadless pacemaker Their long descriptors and current APC and status indicators are listed below.

- 0795T - *Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; complete system (ie, right atrial and right ventricular pacemaker components)*; assigned to APC 5224 (Level 4 Pacemaker and Similar Procedures) and status indicator 'J1'.

- 0801T - *Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; dual-chamber system (ie, right atrial and right ventricular pacemaker components)*; assigned to APC 5224 (Level 4 Pacemaker and Similar Procedures) and status indicator 'J1'.

We note that CPT codes 0795T and 0801T are currently receiving device pass-through payments (approximately $15,000 in addition to the APC payment) when coded with C1605 *(Pacemaker, leadless, dual chamber (right atrial and right ventricular implantable components), rate-responsive, including all necessary components for implantation)*. When pass-through payment expires at the end of CY 2026, the device costs are packaged into the current APC payment.

For the CY 2027 OPPS/ASC proposed rule, we proposed to make the following reassignments:

- CPT code 0823T – Reassign to APC 5231 (Level 1 ICD and Similar Procedures) with a payment rate of approximately $25,000;

- CPT code 0796T - Reassign to APC 5231 (Level 1 ICD and Similar Procedures) with a payment rate of approximately $25,000;
- CPT code 0795T – Reassign to APC 5232 (Level 2 ICD and Similar Procedures) with a proposed payment rate of approximately $35,200; and
- CPT code 0801T – Reassign to 5232 (Level 2 ICD and Similar Procedures) with a proposed payment of approximately $35,200.

We received public comments on these proposals. A summary of the comments and our responses are listed below.

Comment: We received numerous comments supporting our proposal. Several commenters noted how clinically valuable these procedures are and that the increased payment for these services will preserve beneficiary access to these procedures. A couple of commenters requested that we also reassign CPT codes 0802T and 0825T from APC 5224 to APC 5231 to establish cost-reflective payment across the full set of leadless pacemaker procedures.

Response: We thank the commenters for their support. We reviewed CPT codes 0802T *(Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; right atrial pacemaker component)* and CPT code 0825T *(Transcatheter removal and replacement of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography) and device evaluation (eg, interrogation or programming), when performed)* and note that the geometric mean cost for CPT code 0802T is $31,531 based on five single claims and the geometric mean cost for CPT code 0825T is $25,393 based on 12 single frequency claims. Even though these codes are new and there are only a few claims, we agree with the commenters that we should reassign CPT codes

0802T and 0825T to APC 5231 based on clinical and resource coherence with the other leadless pacemaker codes.

As we do every year, we will monitor the claims data and reevaluate the APC assignments for these codes in the next rulemaking cycle to determine if a more appropriate APC assignment is warranted. In summary, after consideration of the public comments we received, we are finalizing our proposal without modification, to assign CPT codes 0823T and 0796T to APC 5231 (Level 1 ICD and Similar Procedures) and to assign CPT codes 0795T and 0801T to APC 5232 (Level 2 ICD and Similar Procedures). We are also finalizing our proposal with modification to assign CPT codes 0802T and 0825T to APC 5231 (Level 1 ICD and Similar Procedures). The final CY 2027 payment rates for these codes can be found in Addendum B to this final rule with comment period. In addition, we refer readers to Addendum D1 to this final rule with comment period for the status indicator definitions for all codes reported under the OPPS. Addenda B and D1 are available via the internet on the CMS website. Refer to Table 30 for the code descriptors and APC and status indicator assignments for CPT codes 0802T and 0825T for CY 2027.

TABLE 30: CY 2027 PROPOSED AND FINAL APC, SI ASSIGNMENTS FOR CPT CODES 0802T AND 0825T

CPT Code	Long Descriptor	Proposed CY 2027 APC, SI	Final CY 2027 APC, SI
0802T	Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; right atrial pacemaker component	5224, J1	5231, J1
0825T	Transcatheter removal and replacement of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography) and device evaluation (eg, interrogation or programming), when performed	5224, J1	5231, J1

7. C-Codes Describing Percutaneous Coronary Intervention With Drug-Eluting Stents

Effective January 1, 2013, CMS created several HCPCS C-codes to describe certain percutaneous coronary intervention procedures utilizing drug eluting stents to mirror those PCI CPT codes that do not utilize drug eluting stents. The AMA CPT Editorial Board deleted several of those CPT codes effective January 1, 2026. For CY 2027, we proposed to delete the following C-codes that mirrored the deleted CPT codes, specifically revising the status indicators to "D" (Discontinued Codes) indicating that they are no longer active codes (91 FR 41811). The C-codes and their long descriptors are listed below.

- C9601- *Percutaneous transcatheter placement of drug-eluting intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)*
- C9603 - *Percutaneous transluminal coronary atherectomy, with drug-eluting intracoronary stent, with coronary angioplasty when performed; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)*
- C9605 - *Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of drug-eluting intracoronary stent, atherectomy and angioplasty, including distal protection when performed; each additional branch subtended by the bypass graft (list separately in addition to code for primary procedure)*
- C9608 - *Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of drug-eluting intracoronary stent, atherectomy and angioplasty; each additional coronary artery, coronary artery branch, or bypass graft (list separately in addition to code for primary procedure)*.

We received several comments related to this proposal.

Comments: Commenters supported the deletion of these C-codes but a couple of commenters requested that we create a new C-code to mirror CPT code 92930 (*Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed, single major coronary artery and/or its branch(es); 2 or more distinct coronary lesions with 2 or more coronary stents deployed in 2 or more coronary segments, or a bifurcation lesion requiring angioplasty and/or stenting in both the main artery and the side branch*) when two drug eluting stents are used in two or more distinct lesions. The commenters stated that without an equivalent C-code for this scenario, there would be a CPT/HCPCS mismatch.

Response: We thank the commenters for their support to delete the previous C-codes. We disagree with commenters that a new C-code should be created to mirror CPT code 92930. The deleted C-codes were created when drug-eluting stents were novel and had significantly higher costs associated with them and we needed a mechanism to capture those costs. We believe that the gap between the costs of drug-eluting stents and bare metal stents are not as significant as they were over ten years ago when these C-codes were created.

In summary, after consideration of the public comments we received, we are finalizing our proposal without modification to delete the previous HCPCS C-codes and decline to create a C-code at this time to mirror CPT code 92930.

Cell and Gene Therapy Related Services

8. Chimeric Antigen Receptor (CAR-T) Administration, CPT Code 38228 (APC 5694)

Chimeric Antigen Receptor T-Cell (CAR T-cell) therapy is a cell-based gene therapy in which T-cells are collected and genetically engineered to express a chimeric antigen receptor that will bind to a certain protein on a patient's cancerous cells. The CAR T-cells are then administered to the patient to attack certain cancerous cells, and the individual is observed for potential serious side effects that would require medical intervention. We refer readers to previous discussions in the OPPS/ASC final rules with comment period for background regarding the specific CAR T-cell products, including the CY 2020 OPPS/ASC final rule with

comment period (84 FR 61231 through 61234) and the CY 2019 OPPS/ASC final rule with comment period (83 FR 58904 through 58908). The AMA created four Category III CPT codes that are related to CAR T-cell therapy, effective January 1, 2019. We also finalized that the procedures described by CPT code 0540T would be assigned status indicator "S" (Procedure or Service, Not Discounted when Multiple) and APC 5694 (Level 4 Drug Administration) from CY 2019 through CY 2024 and did not propose to change the APC assignment for CY 2025 when CPT code 0540T was replaced by CPT code 38228 (Chimeric antigen receptor T-cell (CAR-T) therapy; CAR-T cell administration, autologous). For CY 2027, we proposed to maintain CPT code 38228 to APC 5694 and status indicator 'S'. We received one comment.

Comment: A commenter requested that CMS reassign CPT code 38228 (CAR T-cell administration) from APC 5694 (Level 4 Drug Administration) to APC 5242, citing closer clinical alignment with CPT 38241 (Hematopoietic progenitor cell (HPC); autologous transplantation) than with the other services currently assigned to APC 5694.

Response: We appreciate the commenter's feedback and reviewed the claims data and the clinical considerations raised. We note that in the CY 2019 OPPS/ASC final rule, CMS compared payment for CAR T-cell administration to CPT code 96413 (Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug) in the absence of available claims data. We still believe this is a clinically similar HCPCS code and the claims data for CPT code 38228 are reasonably in range with its current APC placement relative to the suggested APC 5242. We will consider this public comment in future rulemaking. After review of the service and with input from our medical advisors, we are finalizing as proposed.

The final CY 2027 payment rate for this code can be found in Addendum B to this final rule with comment period. In addition, we refer readers to Addendum D1 to this final rule with comment period for the SI definitions for all codes reported under the OPPS. Addenda B and D1 are available via the internet on the CMS website.

Diagnostic Tests

9. Syn-One Test®

The Syn-One Test® detects phosphorylated synuclein to aid clinicians in the diagnosis of a synucleinopathy, which includes Parkinson's disease, dementia with Lewy bodies, multiple system atrophy, and related neurodegenerative disorders. Three small skin biopsies are taken from the patient at different sites and sent to the CND lab for analytical processing, staining, imaging, and pathology interpretation under CND's validated laboratory procedures. CND then reports the results to the patient's provider. The hospital does not perform any of the testing.

Syn-One bills with established pathology CPT codes from the Physician Fee Schedule (PFS), including CPT codes 88305 *(Tissue exam by pathologist)*, 88314 *(Special stain including interpretation and report; histochemical stain on frozen tissue block (List separately in addition to code for primary procedure))*, 88346 *(Immunofluorescence, per specimen; initial single antibody stain procedure),* 88350 *(Immunofluorescence, per specimen; each additional single antibody stain procedure (List separately in addition to code for primary procedure))*, and 88356 *(Morphometric analysis; nerve)*. We received one public comment on this service.

Comment: A commenter requested a limited exception to the laboratory date of service (DOS) policy and our packaging rules for specialized pathology services performed after the patient's hospital outpatient encounter. The commenter also requested a G-code and an appropriate status indicator to identify the specialized pathology services that are not subject to the date of service policy. The commenter also noted that we are proposing to pay for certain algorithmic analyses performed on laboratory tests under the OPPS instead of the Clinical Laboratory Fee Schedule.

Response: We thank the commenter for their input. We are not making any changes to the DOS policy in this final rule, but we may consider this issue in future rulemaking.

The commenter is welcome to apply for a HCPCS code to describe the Syn-One Test® through the Medicare Electronic Application Request Information System (MEARIS) on the CMS website.

10. Transdermal Glomerular Filtration Rate (TGFR) System CPT Codes 0602T and 0603T (APC 5721)

The CPT Editorial Panel created CPT code 0602T (*Glomerular filtration rate (GFR) measurement(s), transdermal, including sensor placement and administration of a single dose of fluorescent pyrazine agent)* and 0603T (*Glomerular filtration rate (GFR) monitoring, transdermal, including sensor placement and administration of more than one dose of fluorescent pyrazine agent, each 24 hours),* which became effective July 1, 2020, and describes a transdermal glomerular filtration rate measurement device called the TGFR system. The device is used to monitor and assess kidney function in real time by measuring fluorescence intensity transdermal as a function of time via a reuseable sensor placed on the skin.

For CY 2027, we proposed to maintain the status indicator assignments for CPT codes 0602T and 0603T of 'Q4' (Conditionally Packaged Laboratory Tests; Paid under OPPS or CLFS). We note that we have no claims data for ratesetting purposes.

The following is a summary of the comments we received and our response.

Comment: We heard from several commenters, including the manufacturer who requested that CMS provide clarification on its treatment of CPT 0602T and 0603T and its assignment to a "Q4" status indicator. Commenters also requested that we assign CPT 0602T and 0603T to an appropriate APC and status indicator so that they may receive payment under OPPS.

One commenter stated that the TGFR system was approved by the FDA in December of 2025 and placed in medical centers in 2026. The commenter notes that the devices were assigned a status indicator of "Q4", suggesting that CPT codes 0602T and 0603T are associated

with a clinical laboratory test. The commenter opines that MediBeacon® Transdermal GFR system is not regulated under 42 CFR 493 Laboratory Requirements (CLIA).

The commenter notes that the TGFR System does not require any blood, plasma, urine or other specimens outside the body to assess kidney function and as such it is an *in vivio* test and not an *in vitro* diagnostic. The commenter states the TGFR System is used on the patient themselves and no lab is required.

Response: We thank the commenters for their input. After further evaluation and discussion with our medical officers, we believe that it is appropriate for the procedure described by CPT codes 0602T and 0603T to be paid separately. Therefore, we are reassigning CPT codes 0602T and 0603T to APC 5721 (Level 1 Diagnostic Tests and Services) and status indicator 'S' (Procedure or Service, Not Discounted When Multiple; Paid under OPPS; separate APC payment).

In summary, after consideration of the public comments, we are finalizing with modification the APC and status indicator assignment for CPT codes 0602T and 0603T. Specifically, we are finalizing the assignment of CPT codes 0602T and 0603T to APC 5721 (Level 1 Diagnostic Tests and Services) and we are revising the status indicator for CPT codes 0602T and 0603T to 'S' indicating that these services are separately payable. Refer to Table 31 for the long descriptors, APC assignments, and status indicator assignments for CPT codes 0602T and 0603T for CY 2027.

The final CY 2027 payment rates for this code can be found in Addendum B to this final rule with comment period. In addition, we refer readers to Addendum D1 to this final rule with comment period for the SI definitions for all codes reported under the OPPS. Addenda B and D1 are available via the internet on the CMS website.

TABLE 31: PROPOSED AND FINAL CY 2027 APC AND STATUS INDICATOR ASSIGNMENTS FOR CPT CODES 0602T AND 0603T

CPT Code	Long Descriptor	Proposed CY 2027 APC, SI	Final CY 2027 APC, SI
0602T	Glomerular filtration rate (GFR) measurement(s), transdermal, including sensor placement and administration of a single dose of fluorescent pyrazine agent	Q4	5721, S
0603T	Glomerular filtration rate (GFR) monitoring, transdermal, including sensor placement and administration of more than one dose of fluorescent pyrazine agent, each 24 hours	Q4	5721, S

Dialysis Related Services and Technologies

11. Dialysis-Related Amyloidosis (DRA) Treatment with LIXELLE® Apheresis Columns and Dialysis Technologies

LIXELLE® b2-microglobulinApheresis Column is indicated for use in the treatment of dialysis-related amyloidosis (DRA), a disease that affects people with end-stage renal disease (ESRD). DRA is a metabolic disorder from the failure of the kidney to filter and remove b2 microglobulin, typically from chronic hemodialysis (typically 5 years or longer). The LIXELLE® device is used in an apheresis procedure that selectively removes b2-microglobulin from circulating blood and is used in accordance with a physician prescription in conjunction with hemodialysis. It is intended to be used at each hemodialysis session (that is, frequency of treatment is expected to be 3 times per week). In March 2015, FDA approved a Humanitarian Device Exemption (HDE) application for LIXELLE® a Class III Humanitarian Use Device (HUD).

For CY 2027, there are currently no specific HCPCS or CPT codes that represent the service performed with the LIXELLE® apheresis device. We received public comments on this topic. The following is a summary of the comments we received and our responses.

Comment: A commenter notes that access to LIXELLE® has been limited by the lack of a clear reimbursement pathway, and they urge CMS to clarify coverage in the OPPS Final Rule for the benefit of the small number of patients with DRA. The commenter states that the FDA

recognizes that there continues to be no feasible alternative treatments for DRA in the United States, and that extensive clinical evidence supports LIXELLE® as reasonable and necessary for the treatment of DRA.

The commenter understands that CMS continues to evaluate how to facilitate Medicare reimbursement for treatments of medical devices that are administered during dialysis procedures but that are not "renal dialysis services" and supports a CMS policy clarification that such treatments and dialysis procedures that accompany them are appropriately reimbursed through OPPS benefit. The commenter reminded CMS that the FDA further clarified that "qualified health care professionals such as physician assistants, nurse practitioner or registered nurses are qualified to supervise hemodialysis procedures" to alleviate previous clinical supervision concerns.

Another commenter supported the payment of dialysis technologies not included in the End Stage Renal Disease (ESRD) bundle through the OPPS and urged CMS to assign an appropriate APC to facilitate payment for the apheresis procedure with LIXELLE® in the OPPS.

Response: We appreciate the comments and continued interest regarding coverage and payment for medical device technologies used in conjunction with dialysis services, such as LIXELLE® for the treatment of DRA. We understand that DRA represents a serious complication for long-term dialysis patients and the need for effective treatment options. We continue to contemplate coverage pathways for innovative treatments that address unmet medical needs in the ESRD population and note this complex, ongoing issue is still under consideration.

We remind commenters that routine outpatient maintenance dialysis for End-Stage Renal Disease (ESRD) is not paid under the OPPS and because the treatment with Lixelle is used at each hemodialysis session (e.g., routine maintenance dialysis), we do not believe that the OPPS is a viable option for payment for the DRA treatment with LIXELLE® at this time. We also recognize the challenges of ensuring appropriate payment pathways for innovative treatments

that may be administered during dialysis but fall outside the definition of a renal dialysis service under § 413.171 and thus are not paid for under the ESRD PPS.

We will continue to evaluate the appropriate payment mechanisms for such technologies for future rulemaking.

Endoscopy Procedures

12. Esophagogastroduodenoscopy, Flexible, Transoral; with Optical Endomicroscopy, CPT Code 43252 (APC 5302)

CPT code 43252 describes an upper gastrointestinal endoscopy that includes real-time, microscopic tissue analysis using optical endomicroscopy.

In the CY 2027 OPPS/ASC proposed rule, we proposed to continue assigning CPT code 43252 to APC 5302 (Level 2 Upper GI Procedures) with status indicator "J1", and a proposed payment rate of $2,185.75 for CY 2027.

Comments: We received one public comment related to this code.

The manufacturer requested that we use CMS's equitable adjustment authority under section 1833(t)(2)(E) of the Social Security Act to reassign CPT 43252 to APC 5303 (Level 3 Upper GI Procedures) for CY 2027 or assign CPT 43252 to an appropriate New Technology APC to stabilize payment while representative cost data accumulate. They further asked that CMS issue guidance on how hospitals should report per-use costs for reposable devices.

They described an ongoing underreporting issue that some hospitals reported starting in 2024 and noted that even though the number of hospitals that reported CPT code 43252 had declined from sixteen to fifteen, the geometric mean cost of CPT code had risen from $1,727.65 to $2,343.31 (an increase of $615.66, or approximately 36 percent) between the CY 2026 final rule and this proposed rule. According to the manufacturer, this is underreporting correcting itself because a shrinking group of hospitals started to slowly correct chargemaster practices for reposable device costs, and measured costs climbed toward the true cost of the procedure.

Response: As we have stated regularly over the history of the OPPS, it is the responsibility of providers and other interested parties, not CMS, to resolve potential claims and cost reporting issues for individual CPT codes and medical services payable by Medicare. In the claims available for OPPS ratesetting for this final rule, CPT code 43252 has an estimated geometric mean cost of $2,323.30 based on 176 single claims. The geometric mean cost of APC 5302 (Level 2 Upper GI Procedures) is $2,034.07. We believe that the proposed placement of CPT code 43252 in APC 5302 remains appropriate based on its geometric mean cost relative to that of the APC.

Therefore, we are finalizing our proposal, without modification, to continue to assign CPT code 43252 to APC 5302 for CY 2027. We refer readers to Addendum B to this final rule with comment period for the payment rates for all codes reportable under the OPPS. Addendum B is available via the internet on the CMS website. We will continue to monitor the claims data and adjust the APC placement for CPT code 43252 based on the claims data in future rulemaking.

13. Endoscopic Submucosal Dissection, CPT 43498 and 45991 (APC 5303 and 5313)

Effective January 1, 2027, the AMA CPT Editorial Panel created CPT codes 43498 (Endoscopic submucosal dissection (ESD) of upper gastrointestinal tract, including mucosal closure, when performed) and 45991 (Endoscopic submucosal dissection (ESD) of lower gastrointestinal tract, including mucosal closure, when performed), previously described by placeholder CPT codes 4XX01 and 4XX02 respectively. For CY 2027, we proposed to assign CPT codes 43498 to APC 5303 (Level 3 Upper GI Procedures) with a proposed payment rate of around $4,306. We also proposed to assign CPT code 45991 to APC 5313 (Level 4 Lower GI Procedures). Additionally, we proposed to delete HCPCS code C9779 (Endoscopic submucosal dissection (esd), including endoscopy or colonoscopy, mucosal closure, when performed), which served as the predecessor code for CPT codes 43498 and 45991. For CY 2026, HCPCS code C9779 was assigned to APC 5303.

We received public comments on this proposal. The following is a summary of the comments we received and our response.

Comment: Six commenters requested that we reassign CPT codes 43498 and 45991 to APC 5331 (Complex GI Procedures), which had a proposed payment rate of around $7,141. Commenters stated that the procedures described by CPT codes 43498 and 45991 are clinically similar to the CPT code 43497 (Lower esophageal myotomy, transoral (ie, peroral endoscopic myotomy [POEM])).

Response: We thank the commenters for their input. After further review, we agree with the commenters that CPT codes 43498 and 45991 are clinically similar to the POEM procedure described by CPT code 43497. Additionally, our updated claims data shows that the predecessor code C9779 had a geometric mean cost of around $5,278, showing that the cost of the procedure may be higher than the payment for its previously assigned APC. Therefore, we are finalizing our proposal with modification to assign CPT codes 43498 and 45991 to APC 5331 (Complex GI Procedures), as reflected in Table 32. The final CY 2027 payment rate for the code can be found in Addendum B to this final rule with comment period. We also refer readers to Addendum D1 to this final rule with comment period for the SI meanings for all codes reported under the OPPS. Addenda B and D1 are available via the internet on the CMS website.

TABLE 32: PROPOSED AND FINAL CY 2027 OPPS APC AND SI ASSIGNMENTS FOR CPT CODES 43498 AND 45991

CPT Code	Long Descriptor	Proposed CY 2027 SI	Proposed CY 2027 APC	Final CY 2027 SI	Final CY 2027 APC
43498	Endoscopic submucosal dissection (ESD) of upper gastrointestinal tract, including mucosal closure, when performed	J1	5303	J1	5331
45991	Endoscopic submucosal dissection (ESD) of lower gastrointestinal tract, including mucosal closure, when performed	J1	5313	J1	5331

Endovascular and Vascular Procedures

14. Permanent Placement of Common Carotid Artery Filters, CPT Code 1091T (APC 1576)

Effective April 1, 2026, we created HCPCS code C8010 *(Percutaneous placement of permanent common carotid embolic protection device, including all system components and imaging guidance; bilateral)* as a result of a New Technology APC application. This code is associated with Javelin Medical's clinical study that was approved by CMS for Medicare coverage on July 30, 2024, as a Category B IDE study.[21] Because the clinical study is conducted in the hospital outpatient setting, we created HCPCS code C8010 and initially assigned it to APC 1575 (New Technology - Level 38 ($10,001-$15,000)) with a payment rate of $12,500.50. The study information is listed below in Table 33.

TABLE 33: Permanent Placement of Common Carotid Artery Filters Category B Investigational Device Exemption (IDE) Study

Study Title	Sponsor Name	NCT Number	IDE Number	CMS Approval Date	Category
Carotid Implants for PreveNtion of STrokE ReCurrEnce From Large Vessel Occlusion in Atrial Fibrillation Patients Treated With Oral Anticoagulation	Javelin Medical	NCT05723926	G220272	07/30/2024	B

We then heard from the interested parties informing us that the APC assignment does not cover all of the costs associated with the procedure and care when the implants alone each cost $5,000. After review of the additional information provided and input from our medical advisors, we reassigned HCPCS code 8010 to APC 1576 (New Technology - Level 39 ($15,001-$20,000)) with a payment of $17,500.50 effective July 1, 2026.

At the beginning of August, the AMA announced that the Category III codes that were released in July with an effective date of January 1, 2027, have a new effective date of October 1, 2027. We note that the AMA Editorial Panel created CPT placeholder code X626T

[21] *https://www.cms.gov/medicare/coverage/investigational-device-exemption-ide-studies/approved/g220272-nct05723926.*

(permanent code 1091T) to describe the placement of bilateral carotid artery filters. The long descriptor is as follows:

- CPT 1091T - *Placement of permanent common carotid artery filter, percutaneous, bilateral, including ultrasound guidance, when performed*.

For the October quarterly update, we deleted the predecessor HCPCS code C8010 and assigned CPT code 1091T to APC 1576 (New Technology - Level 39 ($15,001-$20,000)) with a status indicator (SI) of 'S' effective October 1, 2026, because CPT code 1091T describes the same procedure that HCPCS code C8010 did.

For CY 2027, we proposed to assign CPT code 1091T to APC 1576 (New Technology - Level 39 ($15,001-$20,000)) and delete HCPCS code C8010.

Comment: We received a comment requesting that we finalize the APC assignment for the placement of the permanent carotid filters under the auspices of the new Category III CPT code.

Response: We appreciate the comment and agree with the commenter.

In summary, after consideration of the public comment we received, we are finalizing our proposal to delete HCPCS C8010 and assign CPT code 1091T to APC 1576 (New Technology - Level 39 ($15,001-$20,000)). The final CY 2027 payment rates for this code can be found in Addendum B to this final rule with comment period. In addition, we refer readers to Addendum D1 to this final rule with comment period for the SI definitions for all codes reported under the OPPS. Addenda B and D1 are available via the internet on the CMS website.

15. Venous Mechanical Thrombectomy, CPT code 37187 (APC 5193)

CPT code 37187 (Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance) was made effective January 1, 2006 and discussed in the CY 2007 OPPS final rule. Since the CY 2018 OPPS, this code has been assigned to the Endovascular Procedures APC series and has been assigned to APC 5193 since the CY 2021 OPPS (85 FR 85987).

Comment: A commenter requested that CMS reconsider the current methodology used to determine claims for ratesetting for CPT code 37187 and the proposed assignment of the code to APC 5193. The commenter opined that the current rate does not adequately reflect the reported geometric mean cost for the procedure and variation in the costs at the claim level. The commenter, using the growth in Medicare usage of venous thrombectomy and increased utilization of the hospital outpatient setting, asked CMS to consider whether the rate-setting claims adequately reflect current practice patterns and the adoption of technology, variation in coding, complexity of patients, and site-of-service trends, and to consider whether additional data or a different methodology would better determine accurate payments.

Response: We appreciate the commenter's concerns regarding payment for CPT code 37187. CMS previously reassigned CPT 37187 from APC 5192 to APC 5193 for CY 2021 after finding that its geometric mean cost was comparable to other clinically related thrombectomy and endovascular services in APC 5193 (85 FR 85987). We reviewed the most updated claims data available for CY 2027 rate setting and continue to believe that APC 5193 appropriately reflects the clinical characteristics and relative resource costs of CPT code 37187. Under the OPPS, payment rates are established at the APC level based on the geometric mean cost of all applicable services assigned to the APC based on clinical and cost similarity. The number of claims used to calculate the geometric mean cost for CPT code 37187 represents claims remaining after application of the comprehensive APC rate-setting methodology and should not be interpreted as total Medicare utilization. Under that methodology, qualifying higher-cost combinations involving CPT code 37187 receive a complexity adjustment and are reassigned to the next higher-level endovascular APC. Consequently, those complexity-adjusted claims are removed from the cost calculation for CPT code 37187 in APC 5193 and included separately in APC 5194. We further note that most claims containing CPT code 37187 that were available were used for OPPS ratesetting purposes, whether for the code itself or as part of a code combination qualifying for complexity adjustment.

Although the commenter identified variation among CPT code 37187 claims, this variation does not, by itself, demonstrate that the claims are inaccurate or that the service is inappropriately assigned. Moreover, we believe that some of that variation is a reflection of the varying practice patterns in the claims containing codes, most of which we are using in our OPPS ratesetting process. Therefore, we are finalizing the assignment of CPT code 37187 to APC 5193.

16. Simulation Angiogram for Radioembolization of Tumors, HCPCS Code C8004 (APC 5194)

CMS created HCPCS code C9797 (*Vascular embolization or occlusion procedure with use of a pressure-generating catheter (e.g., one-way valve or occlusion balloon, intermittently or temporarily occluding), inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction*) to describe a vascular embolization or occlusion procedure with use of a pressure-generating catheter effective April 1, 2024. We assigned C9797 to APC 5194 (Level 4 Endovascular Procedures) and a status indicator of 'J1'.

CMS then created HCPCS C8004 *(Simulation angiogram with use of a pressure-generating catheter (e.g., one-way valve or occlusion balloon, intermittently or temporarily occluding), inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the angiogram, for subsequent therapeutic radioembolization of tumors)* to describe the simulation angiogram service using a pressure-generating catheter effective April 1, 2025. We assigned HCPCS code C8004 to APC 5193 (Level 3 Endovascular Procedures) and status indicator 'J1'. The simulation procedure has a nearly identical workflow to the embolization procedure, including the use of the same pressure-generating catheter, and allows delivery of the diagnostic radioactive tracer to maximize the radiation dose to the tumor and avoid the normal liver tissue. The simulation procedure is followed by the embolization procedure usually 3 to 14 days later.

HCPCS code C1982 *(Catheter, pressure-generating, (e.g., one-way valve or occlusion balloon, intermittently or temporarily occluding)* describes the type of catheter used with these procedures. The device code is currently assigned to status indicator 'N' which means it is packaged with the procedure code.

For CY 2027, we proposed to maintain the payment assignments for all three HCPCS codes. We did, however, update the long descriptors for all three HCPCS codes for the October 2026 OPPS update to broaden the definition of pressure-generating catheter. We are also aware of the new HCPCS G-code G0577 *(Vascular embolization or occlusion procedure with use of a pressure-generating catheter (e.g., one-way valve, intermittently occluding), inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction performed in the non-facility setting)* that was created for the non-facility setting and is retroactive to July 1, 2026. HCPCS G-code G0577 is assigned to status indicator B and is not payable in the OPPS.

We received one public comment on HCPCS code C8004.

Comment: We received one comment requesting that we reassign HCPCS code C8004 to APC 5194 (Level 4 Endovascular Procedures) because of the clinical and resource similarities between C8004 and C9797. The commenter states that these two procedures are the same except that C8004 uses a diagnostic radiopharmaceutical for the simulation angiogram and C9797 uses a brachytherapy source for the embolization treatment. The commenter also pointed to the geometric mean cost (GMC) of C8004 and how it is within the range of significant procedures assigned to APC 5194.

Response: We appreciate the commenter's input. First, we note that the GMC for APC 5193 (Level 3 Endovascular Procedures) is $12,304 and the GMC for APC 5194 (Level 4 Endovascular Procedures) is $19,661. Second, the GMC for C8004 is $22,076, and the GMC for

C9797 is $21,910. We agree with the commenter and believe that APC 5194 is a more appropriate assignment for C8004 based on clinical and resource homogeneity.

In summary, after consideration of the public comment we received, we are modifying our proposal and finalizing assignment of HCPCS code C8004 to APC 5194 (Level 4 Endovascular Procedures). While we did not receive public comment on the OPPS proposed rule on the coding descriptors for these codes, we will review the coding descriptors for these codes, including the new G-code, for the January 2027 quarterly update to determine if further coding/descriptor refinements are necessary. Refer to Table 34 for the code descriptor, APC assignment, and status indicator assignment for HCPCS code C8004 for CY 2027.

The final CY 2027 payment rates for this code can be found in Addendum B to this final rule with comment period. In addition, we refer readers to Addendum D1 to this final rule with comment period for the status indicator (SI) definitions for all codes reported under the OPPS. Addenda B and D1 are available via the internet on the CMS website.

TABLE 34: PROPOSED AND FINAL CY 2027 APC AND STATUS INDICATOR ASSIGNMENT FOR HCPCS CODE C8004

HCPCS Code	Long Descriptor	Proposed CY 2027 APC, SI	Final CY 2027 APC, SI
C8004	Simulation angiogram with use of a pressure-generating catheter (e.g., one-way valve, intermittently occluding), inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the angiogram, for subsequent therapeutic radioembolization of tumors	5193, J1	5194, J1

Gastrointestinal Related Procedures

17. Colorectal Anastomosis (Colovac), CPT Code 0967T

The CPT Editorial Panel created CPT code 0967T (Transanal insertion of endoluminal temporary colorectal anastomosis protection device, including vacuum anchoring component and flexible sheath connected to external vacuum source and monitoring system) which became

effective July 1, 2025, and describes the insertion of a device called the Colovac. The device is used following colorectal surgery to protect the anastomotic site from contact with fecal matter.

For CY 2027, we proposed to maintain the APC assignment to 5312 (Level 2 Lower GI Procedures) and status indicator 'T'. We note that we have zero claims for ratesetting purposes. The following is a summary of the comments we received and our response.

Comment: We heard from several commenters, including the manufacturer who requested that we reassign CPT code 0967T to a status indicator of 'E1' while the Colovac device is still investigational. Commenters also requested that we remove CPT code 0967T from the ASC Covered Procedures List.

Response: We thank the commenters for their input. We are unable to determine if the Colovac device has received marketing authorization by the FDA. Services with devices that lack FDA marketing authorization are assigned to status indicator 'E1' (Not covered by any Medicare outpatient benefit category; Statutorily excluded by Medicare, Not reasonable and necessary; Not paid by Medicare when submitted on outpatient claims) and are not payable in HOPDs or in ASCs. We look forward to hearing from the manufacturer when FDA marketing authorization has been obtained.

In summary, after consideration of the public comments that we received, we are finalizing our proposal with modification. We are assigning CPT code 0967T to status indicator 'E1' and removing this code from the ASC Covered Procedures List. We refer readers to Addendum D1 to this final rule with comment period for the SI definitions for all codes reported under the OPPS. Addendum D1 is available via the internet on the CMS website.

18. Gastrointestinal Myoelectrical Activity Study (Stomach Through Colon), CPT Code 0779T (APC 5723)

Effective January 1, 2023, CPT code 0779T (Gastrointestinal myoelectrical activity study, stomach through colon, with interpretation and report) is often associated with abdominal patches, that records myoelectric signals of the gastrointestinal tract from the stomach, small and

large intestines, over multiple days, such as the G-Tech Medical's GutTracker Wireless Patch System. Since CPT code 0779T became effective January 1, 2023, we have had no claims and therefore have maintained its initial APC assignment to APC 5723 (Level 3 Diagnostic Tests and Related Services).

For CY 2027, the OPPS payment rates were based on available CY 2025 claims data. CPT code 0779T does not currently have any single claims. Because we did not have any available claims data, we proposed to continue to assign CPT code 0779T to APC 5723 for CY 2027.

We received public comments on this proposal. The following is a summary of the comments we received and our responses.

Comment: A commenter, the manufacturer, requested reassignment of 0779T from APC 5723 (Level 3 Diagnostic Tests and Related Services) to APC 5724 (Level 4 Diagnostic Tests and Related Services). The commenter stated that APC 5723 is inadequate to cover the costs of the hospital's supplies, equipment, and staff needed to provide this service. The commenter cited the acquisition of continuous physiologic data across three gastrointestinal organ regions for up to six days and the required post-acquisition processing for CPT 0779T as justification for the higher-level APC assignment. The commenter claimed clinical and resource coherence to CPT code 91035 (Esophagus, gastroesophageal reflux test; with mucosal attached telemetry pH electrode placement, recording, analysis and interpretation) as a multi-day, multi-organ ambulatory diagnostic.

Response: We thank the commenter for their comment. After further review and additional discussion with our medical officers, we are finalizing our proposal without modification to continue to assign CPT code 0779T to APC 5723 for CY 2027. CMS continues to believe that assigning CPT code 0779T to APC 5723 is supported. More specifically, CMS believes CPT code 0779T shares more clinical and resource similarities with the services assigned to APC 5723 than those assigned to APC 5724, which are generally more complicated

and invasive services. In regard to the commenter's reference to similarities to CPT code 91035, we note that while CPT code 0779T and CPT code 91035 are both diagnostic gastroenterology tests used to track physiological activity inside the digestive tract, we believe the invasiveness of the upper endoscopy included in CPT code 91035 requires more resources than an external wearable patch system described by CPT code 0779T. We will continue to monitor the claims data and update the payment rate in future rulemaking based on the available claims.

The final CY 2027 payment rates can be found in Addendum B to this final rule with comment period via the internet on the CMS website. In addition, we refer readers to Addendum D1 to this final rule with comment period for the status indicator meanings for all codes reported under the OPPS. Addendum D1 can also be found via the internet on the CMS website.

19. Gastric Electrophysiology Mapping With Simultaneously Validated Patient System Profiling (GEMS) Service, CPT Code 0868T (APC 5724)

Effective July 1, 2023, based on a New Technology application received by CMS for the GEMS service, CMS established HCPCS code C9787 (Gastric electrophysiology mapping with simultaneous patient symptom profiling) and assigned it to APC 5723 (Level 3 Diagnostic Tests and Related Services) based on a crosswalk to CPT code 0779T. Effective July 1, 2024, HCPCS code C9787 was deleted and replaced by CPT code 0868T (High-resolution gastric electrophysiology mapping with simultaneous patient symptom profiling, with interpretation and report). CMS assigned CPT code 0868T to APC 5723, the same APC to which its predecessor code, HCPCS code C9787, was assigned. For CY 2026, CMS maintained the APC assignment for CPT code 0868T.

For CY 2027, CMS proposed to continue to assign CPT code 0868T to APC 5723 with a proposed payment rate of $435.61. For CY 2027 ratesetting, there are 37 single frequency claims available for CPT code 0868T, with a geometric mean cost of $2,497.78.

The manufacturer of the GEMS service presented at the August 2026 meeting of the Advisory Panel on Outpatient Payment (HOP Panel). The HOP Panel recommended to reassign CPT code 0868T to APC 5724 (Level 4 Diagnostic Tests and Related Services) for CY 2027.

We received public comments on this proposal. The following is a summary of the comments we received and our responses.

Comment: We received several comments requesting that we reassign CPT code 0868T from APC 5723 to APC 5724 consistent with the HOP Panel's August 2026 recommendation. Commenters pointed to the cost disparity between CPT code 0868T's geometric mean cost and APC 5723's proposed payment rate. Commenters explained that the current payment provided for the service is inadequate to cover the costs and requested that CMS set payment at a level that allows hospitals to continue to furnish the service.

Response: We thank the commenters for their input. We agree with commenters and the HOP Panel's August 2026 recommendation that the proposed APC assignment for CPT code 0868T is inappropriate at this time based on a review of the available claims data. Additionally, we believe that CPT code 0868T shares similarities with CPT code 91035 (Esophagus, gastroesophageal reflux test; with mucosal attached telemetry pH electrode placement, recording, analysis and interpretation) and is proposed to be assigned to APC 5724 with status indicator "S".

Therefore, based on the comments received, we are not finalizing the APC assignment for CPT code 0868T as proposed. For CY 2027, we are finalizing assigning CPT code 0868T to APC 5724 (Level 4 Diagnostic Tests and Related Services). Refer to Table 35 for the code descriptor, APC assignment, and status indicator assignment for CPT code 0868T.

The final CY 2027 payment rates for this code can be found in Addendum B to this final rule with comment period. In addition, we refer readers to Addendum D1 to this final rule with comment period for the status indicator (SI) definitions for all codes reported under the OPPS. Addenda B and D1 are available via the internet on the CMS website.

TABLE 35: PROPOSED AND FINAL CY 2027 OPPS APC AND SI ASSIGNMENT FOR CPT CODE 0868T

HCPCS Code	Long Descriptor	Proposed CY 2027 OPPS APC, SI	Final CY 2027 OPPS APC, SI
0868T	High-resolution gastric electrophysiology mapping with simultaneous patient symptom profiling, with interpretation and report	5723, S	5724, S

Imaging Services

20. Duplex Scan of Hemodialysis Fistula, CPT Code 0876T

The AMA CPT Editorial Panel established CPT code 0876T *(Duplex scan of hemodialysis fistula, computer-aided, limited (volume flow, diameter, and depth, including only body of fistula))* effective July 1, 2024. We assigned CPT code 0876T to status indicator 'E1' for July 1, 2024, based on our belief that the implantable marker used with this procedure did not have FDA marketing authorization.

For CY 2026, we proposed to continue to assign CPT code 0876T to E1 (Not covered by any Medicare outpatient benefit category; Statutorily excluded by Medicare, Not reasonable and necessary; Not paid by Medicare when submitted on outpatient claims) because we had not been notified by interested parties regarding an updated FDA status. We received public comments on this proposal (90 FR 53577). The following is a summary of the comment we received and our response.

Comment: We received one comment requesting that we assign CPT code 0876T to an APC and a payable status indicator (SI). The commenter noted that a significant number of end-stage renal disease admissions are for access complications, but repeated interventions to salvage an existing fistula are more cost-effective than replacing access.

Response: We thank the commenter for their input. We are unable to determine if FDA-regulated devices used in this service have all received marketing authorization from the FDA and therefore are maintaining the status indicator assignment of "E1". We look forward to hearing from the manufacturer when FDA marketing authorization has been obtained.

In summary, after consideration of the public comment that we received, we are finalizing the status indicator assignment for CPT code 0876T without modification. We refer readers to Addendum D1 to this final rule with comment period for the SI definitions for all codes reported under the OPPS. Addendum D1 is available via the internet on the CMS website.

21. Computed Tomographic Colonography, CPT Code 74263 (APC 5523)

For CY 2025, we finalized assigning CPT code 74263 to APC 5523 (Level 3 Imaging without Contrast) using CPT code 74176 (Computed tomography, abdomen and pelvis; without contrast material) as a crosswalk code because of the coverage changes for colorectal cancer screening services. (See 89 FR 94287 through 94290 for a full discussion of the coverage changes for colorectal cancer screening services.)

For the CY 2026 OPPS/ASC proposed rule, we proposed to maintain the APC assignment for CPT code 74263 in APC 5523 (Level 3 Imaging without Contrast) with a proposed payment of around $245 and a status indicator of 'S' (Procedure or Service, Not Discounted When Multiple; Paid under OPPS) (90 FR 53575).

For CY 2027, we proposed to continue to assign CPT code 74263 to APC 5523 (Level 3 Imaging without Contrast) and a status indicator of 'S' (Procedure or Service, Not Discounted When Multiple; Paid under OPPS).

We received one comment on this proposal. The following is a summary of the comment we received and our response.

Comment: A commenter requested that CMS reassign CPT code 74263 from APC 5523 (Level 3 Imaging without contrast) to APC 5524 (Level 4 Imaging without Contrast). The commenter notes that reimbursement for Computed Tomographic Colonography (CTC) remains substantially lower than payment for comparable CT imaging services. They state that unlike other imaging services assigned to non-contrast imaging APC's, CTC requires significant radiologist and technologist involvement, as well as increased resource costs, and an APC assignment to 5524 (Level 4 Imaging without Contrast) would better align payment with

complexity and recourse costs. They state that the current payment rate may discourage hospitals and imaging practices from offering billing of CTC, which in turn limits beneficiary access and suppresses utilization. The commenter urges CMS to account for service-specific resource differences and avoid treating all non-contrast imaging services as comparable in complexity or cost. They encourage CMS to consider exceptions, safeguards, or transition policies for preventive screenings, which will ensure that payment changes do not reduce beneficiary access or discourage adherence to recommended screening guidelines.

Response: We thank the commenter for the information regarding the clinical and operational resources associated with the CT colonography (CTC). We recognize that CTC involves bowel preparation, oral contrast administration, insufflation, multiple image acquisitions, image postprocessing and technologist involvement. However, we do not agree that these considerations support reassignment of CPT code 74263 to APC 5524. The OPPS payment rates were proposed based on available 2025 claims data. Our claims data shows that APC 5523 (Level 3 Imaging without contrast) has a geometric mean cost (GMC) of $250, and APC 5524 (Level 4 Imaging without contrast) has a GMC of $577. We reviewed CPT code 74263 and noted that the GMC is $88 based on 692 single frequency claims.

While we understand the commenter's rationale, we believe that reassigning CPT code 74263 to APC 5524 would result in overpayments based on the GMC for the code of $88, compared to the GMC of APC 5524 which is $577.

In summary, after consideration of the public comment we received, we are finalizing our proposal without modification to assign CPT code 74263 to APC 5523 (Level 3 Imaging without Contrast).

The final CY 2027 payment rates for this code can be found in Addendum B to this final rule with comment period. In addition, we refer readers to Addendum D1 to this final rule with comment period for the SI definitions for all codes reported under the OPPS. Addenda B and D1 are available via the internet on the CMS website.

22. Breast Imaging Service Performed with QT Scanner, CPT Code 1079T (APC 5522)

Effective October 1, 2026, CPT code 1079T (placeholder code X579T) *(3D quantitative transmission water bath volumetric ultrasound tomography, breast, with augmentative algorithmic derivation of breast tissue composition (ie, fibroglandular volume), bilateral, with physician or other qualified health care professional interpretation and report)* describes the breast imaging service performed with QT Scanner. The device uses a 360-degree moving transducer to generate quantitative 3D breast images. The QT Scanner 2000 Model A is indicated to provide reflection-mode and transmission-mode breast images and calculates fibroglandular tissue volume (breast density), and is "not intended to be used as a replacement for screening mammography."

For CY 2027, we proposed to assign CPT code 1079T to status indicator “E1” because we did not believe the QT Scanner service would fall under an existing benefit category.

We received a public comment on this proposal. The following is a summary of the comment we received and our response.

Comment: A commenter, the manufacturer of QT Scanner, requested that we revise the proposed “E1” status indicator to status indicator “S” for CPT code 1079T and assign the code to a new technology APC. Per the commenter, physician-ordered diagnostic use of the QT Scanner falls within an existing Medicare benefit category under section 1861(s)(3) and section 1861(s)(2)(B) of the Social Security Act, and NCD 220.5 (Ultrasound Diagnostic Procedures (Effective May 22, 2007)) provides coverage either as breast sonography under Category I or as an unenumerated diagnostic ultrasound procedure subject to local MAC discretion under Section D. The commenter also cited FDA clearance of the QT Scanner 2000 Model A (K253898) and CPT's creation of the Category III CPT code as support for the existence of a diagnostic use distinct from screening.

Response: After reviewing the comment, we agree, on a narrow basis, that assignment of status indicator E1 is not appropriate for CPT code 1079T. We agree that physician-ordered use

of a QT Scanner to evaluate a specific clinical finding could be capable of falling within the existing diagnostic ultrasound benefit category described in NCD 220.5 Ultrasound Diagnostic Procedures, consistent with CMS's treatment of other forms of breast sonography. In the event this code is covered, and determined to be reasonable and necessary, we believe an appropriate APC assignment for CPT code 1079T is APC 5522 (Level 2 Imaging without Contrast), based on similar codes in that APC series, for example CPT code 76641 *(Ultrasound, breast, unilateral or bilateral, real-time with image documentation, complete)*. Therefore, for CY 2027, in response to the commenter, we are revising our proposal in this final rule and assigning CPT code 1079T to APC 5522 with status indicator "S."

As we have consistently stated in past OPPS/ASC final rules with comment period (see, for example, 87 FR 71879 and 88 FR 81660 through 81661), the fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under the OPPS does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. Coverage of a claim where the QT Scanner is used would require an independent showing, made at the time the claim is adjudicated, that the service was reasonable and necessary for the individual beneficiary under section 1862(a)(1)(A) of the Act, ordered by a physician to address a specific diagnostic question.

While our decision to finalize payment rests on the plausible diagnostic use of this technology within the existing framework of NCD 220.5, under current rules, use of the QT Scanner would not be covered by Medicare as a screening service. Coverage of breast ultrasonography as a screening service would require either a statutory change or a qualifying recommendation from the United States Preventive Services Task Force under section 1861(ddd) of the Act. Neither condition currently exists. Therefore, claims for QT Scanner where the service is furnished for routine screening of asymptomatic beneficiaries would not currently be covered. Additionally, we clarify that the indication for the FDA-cleared device, itself, does not support the use of the QT Scanner device for breast cancer screening.

In summary, we are not finalizing our proposal to assign CPT code 1079T to status indicator "E1" as proposed. In response to the commenter, for CY 2027, we are assigning CPT code 1079T to APC 5522 and status indicator "S." Refer to Table 36 for the final CY 2027 OPPS APC and status indicator assignments for CPT code 1079T. The final CY 2027 payment rates for this code can be found in Addendum B to this final rule with comment period. In addition, we refer readers to Addendum D1 to this final rule with comment period for the status indicator definitions for all codes reported under the OPPS. Addenda B and D1 are available via the internet on the CMS website.

TABLE 36: PROPOSED AND FINAL CY 2027 OPPS APC AND SI ASSIGNMENT FOR CPT CODE 1079T

HCPCS Code	Long Descriptor	Proposed OPPS CY 2027 APC, SI	Final OPPS CY 2027 APC, SI
1079T	3D quantitative transmission water bath volumetric ultrasound tomography, breast, with augmentative algorithmic derivation of breast tissue composition (ie, fibroglandular volume), bilateral, with physician or other qualified health care professional interpretation and report	E1	5522, S

Maternity Care Services

23. Maternity Care Services, CPT Codes 59081 – 59083, 59431, 59432, 59502 - 59504 (APCs 5414 through 5416)

Effective January 1, 2027, the AMA created several new codes describing maternity care provided during the antepartum, labor management, and postpartum periods.

Listed below are the CPT codes (and placeholder codes), long descriptors, and their proposed APC assignments.

- 59081 (59XX2) - Initial day labor management; complex, per day; proposed APC assignment 5414.
- 59082 (59XX3) - Subsequent day labor management; straightforward, per day; proposed APC assignment 5414.

- 59083 (59XX4) - Subsequent day labor management; complex, per day; proposed APC assignment 5414.
- 59431 (59XX5) - Vaginal delivery only (with or without episiotomy and/or forceps); proposed APC assignment 5414.
- 59432 (59XX6) - Vaginal delivery, with or without episiotomy; after previous cesarean delivery; proposed APC assignment 5414.
- 59502 (59XX7) - Cesarean delivery; primary; proposed APC assignment 5416.
- 59503 (59XX8) - Cesarean delivery; repeat; proposed APC assignment 5416.
- 59504 (59XX9) - Subtotal or total hysterectomy after cesarean delivery; proposed APC assignment 5416.

We received comments regarding the CY 2027 proposed assignments. The following is a summary of the comments we received and our responses.

Comment: Commenters offered appreciation for the OPPS inclusion of APC assignments for the new code and expressed concern that the proposed APC assignments do not adequately distinguish between certain maternity services in terms of clinical and resource requirements. Commenters encouraged CMS to ensure that the upper levels of the Gynecologic Procedures APC family maintain appropriate clinical and resource homogeneity and sufficient payment differentiation for exceptionally resource-intensive gynecologic and obstetric procedures. Commenters noted that complex labor management can involve greater monitoring, staffing, clinical intervention, and other hospital resources than straightforward labor management. Commenters stated that assigning both services to the same APC effectively eliminates resource distinctions for hospital outpatient payment purposes. Commenters stated that it would be more appropriate to assign complex labor management codes to APC 5415, Level 5 Gynecologic Procedures.

Additionally, commenters claimed that the vaginal delivery codes better align with APC 5416, Level 6 Gynecologic Procedures, based on the instrumentation, complexity, and time of a

vaginal delivery and the similarities of the codes existing in APC 5416. They also stated that the abdominal surgical procedure of cesarean deliveries requires an operating room, a surgical, sterile environment, and the necessary equipment for an abdominal incision and closure, not dissimilar to the requirements in APC 5342, Level 2 Abdominal/Peritoneal/Biliary and Related Procedures, or APC 5361, Level 1 Laparoscopy and Related Services. Commenters further stated that payment for cesarean hysterectomy at the same APC level as primary and repeat cesarean delivery does not adequately recognize these significant differences in hospital resource requirements.

Response: We thank the commenters for their comments and support in ensuring appropriate assignment of the newly established codes related to maternity care services. After consideration of the public comments we received, and discussion and input from our Medical Officers, and where applicable, a review of claims data for related predecessor codes, we believe that CPT code 59432 (59XX6) shares greater resource cohesion with several services and procedures included in APC 5415. However, we continue to believe that CPT codes 59081, 59082, 59083, 59431, 59502, 59503, and 59504 are appropriately assigned. We note that we will continue to monitor the APC series as more claims data are available for the procedures assigned to this series and remain interested in suggestions and supporting materials regarding changes to those assignments for future years.

In summary, for CY 2027, CMS will finalize the maternity care service codes as proposed, with the modification of assigning CPT code 59432 to APC 5415. The final CY 2027 payment rates can be found in Addendum B to this final rule with comment period via the internet on the CMS website. In addition, we refer readers to Addendum D1 to this final rule with comment period for the status indicator meanings for all codes reported under the OPPS. Addendum D1 can also be found via the internet on the CMS website.

TABLE 37: PROPOSED AND FINAL CY 2027 OPPS APC AND STATUS INDICATOR ASSIGNMENT FOR CPT CODE 59432

HCPCS Code	Long Descriptor	CY 2027 Proposed APC Assignment	CY 2027 Final APC Assignment
59432	Vaginal delivery, with or without episiotomy; after previous cesarean delivery	5414	5415

Neuro and Nerve Related Procedures

24. Transcutaneous Magnetic Peripheral Nerve Stimulation CPT Codes 0766T and 0767T (APC 5722)

Transcutaneous Magnetic Peripheral Nerve Stimulation is intended to stimulate peripheral nerves for relief of chronic intractable pain, post-traumatic pain, post-surgical pain and/or for relief of chronic painful diabetic peripheral neuropathy in the lower extremities for patients 18 and older. CPT code 0766T (Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse, peripheral nerve, with identification and marking of the treatment location, including noninvasive electroneurographic localization (nerve conduction localization), when performed; first nerve) became effective January 1, 2023. For CY 2025, CPT code 0766T was reassigned to APC 5722 (Level 2 Diagnostic Tests and Related Services) with the status indicator "S" (Significant Procedures, Not Discounted when Multiple. Paid under OPPS; separate APC payment). There are no claims available for CPT code 0766T in CY 2025. For CY 2027, we proposed to continue assigning CPT code 0766T to APC 5722.

CPT code 0767T (Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse, peripheral nerve, with identification and marking of the treatment location, including noninvasive electroneurographic localization (nerve conduction localization), when performed; each additional nerve (list separately in addition to code for primary procedure)) became effective January 1, 2023 and assigned status indicator "N" (packaged). CPT code 0767T is an add-on code and we proposed to continue assignment of status indicator "N" for this code for CY 2026 (90 FR 53583).

We note that at the August 24, 2026, HOP Panel Meeting, a presentation was made requesting (1) the reassignment of 0766T from APC 5722 to APC 5724 (Level 4 Diagnostic Tests and Related Services) and (2) reassignment of the status indicator for 0767T from "N" to "S" (Significant Procedures, Not Discounted when Multiple. Paid under OPPS; separate APC payment). The Panel made no recommendations on these requests.

We received 4 comments on this proposal. The following is a summary of the comments we received and our responses.

Comment: All commenters requested CPT code 0766T be reassigned to APC 5724 (Level 4 Diagnostic Tests and Related Services), claiming that CPT code 0766T is not clinically similar and does not use comparable resources to other services in APC 5722. All commenters also stated that it is necessary to change the status indicator from "N" to "S" for CPT code 0767T because the additional nerve stimulations require the physician to reposition the device, identify and map a separate nerve target, establish appropriate stimulation parameters, and deliver treatment to that additional anatomical target. All commenters requested that CMS follow the 2025 HOP Panel recommendations to reassign 0766T to APC 5724 and reassign the 0767T status indicator to "S" (Significant Procedures, Not Discounted when Multiple. Paid under OPPS; separate APC payment).

Response: We disagree that CPT code 0766T is comparable, clinically and in resource costs, to the services assigned to APC 5724. We continue to believe CPT code 0766T is more comparable, clinically and from a resource cost perspective, to CPT code 90867 (Therapeutic repetitive transcranial magnetic stimulation (tms) treatment; initial, including cortical mapping, motor threshold determination, delivery and management), and CPT code 90868 (Therapeutic repetitive transcranial magnetic stimulation (tms) treatment; subsequent delivery and management, per session), which are assigned to APC 5722 (Level 2 Diagnostic Tests and Related Services), because these services share similar magnetic stimulation and nerve localization processes.

We note that CPT code 0767T is an add-on code. Add-on codes are always performed in addition to the primary service or procedure and not reported as a stand-alone code. As specified under regulation 42 CFR 419.2(b)(18), add-on codes are generally packaged under the OPPS, and payment for the codes are bundled with the primary codes. Consequently, CPT code 0767T is not paid separately under the OPPS and its payment is packaged into payment for the primary code.

After consideration of the public comments we received, we are finalizing our proposed APC assignment and status indicators for CPT codes 0766T and 0767T without modification. We refer readers to Addendum B to this final rule with comment period for the payment rates for all codes reportable under the OPPS. Addendum B is available via the internet on the CMS website.

25. BioWavePENS, CPT 1088T (APC 5721)

Effective October 1, 2026, the AMA CPT Editorial Panel created CPT code 1088T (*Percutaneous application of high-frequency neuromodulation signals using microneedle electrode array for the treatment of nociceptive or neuropathic pain, including electrode placement and patient training, per day)* to describe the procedure for percutaneous electrical nerve stimulation using microneedle electrode arrays for the treatment of pain. Beginning on October 1, 2026, we assigned CPT code 1088T to APC 5721 (Level 1 Diagnostic Tests and Related Services) with a proposed payment rate of around $147.

We received one public comment on this proposal. The following is a summary of the comment we received and our response.

Comment: A commenter requested that CMS assign CPT code 1088T to APC 5443 (Level 3 Nerve Injections), which had a proposed payment rate of around $1,019, due to clinical similarity to other percutaneous nerve interventions in APC 5443.

Response: We thank the commenter for their input. We note that since is a new code and became effective on October 1, 2026, we do not currently have any claims data for this

procedure. After further review, we continue to believe that CPT code 1088T is appropriately assigned to APC 5721. Therefore, we are finalizing our proposal to assign CPT code 1088T to APC 5721 (Level 1 Diagnostic Tests and Related Services). We note that we will continue to monitor the claims data and update the payment rate in future rulemaking based on the available claims. The final CY 2027 payment rate for the code can be found in Addendum B to this final rule with comment period. We also refer readers to Addendum D1 to this final rule with comment period for the SI meanings for all codes reported under the OPPS. Addenda B and D1 are available via the internet on the CMS website.

26. Hypoglossal Nerve Neurostimulator (HGNS) Procedures, C8007-C8009 and C8011-C8013, (APCs 5465, 5463, and 5432)

Effective January 1, 2022, the AMA's CPT Editorial Panel created three new codes to describe the open implantation of hypoglossal nerve neurostimulator (HGNS) array with an implanted pulse generator and a separate distal respiratory sensor, the revision or replacement of the HGNS, and the removal of the HGNS for the treatment of obstructive sleep apnea (OSA). The codes, their long descriptors, and APC and status indicators are listed below.

- 64582 - *Open implantation of hypoglossal nerve neurostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array*. CPT code 64582 is assigned to APC 5465 (Level 5 Neurostimulator and Related Procedures) and status indicator ''J1'' (Hospital Part B Services Paid Through a Comprehensive APC).

- 64583 - *Revision or replacement of hypoglossal nerve neurostimulator array and distal respiratory sensor electrode or electrode array, including connection to existing pulse generator.* CPT code 64583 is assigned to APC 5463 (Level 3 Neurostimulator and Related Procedures) and status indicator ''J1" (Hospital Part B Services Paid Through a Comprehensive APC).

● 64584 - *Removal of hypoglossal nerve neurostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array*. CPT code 64584 is assigned to APC 5432 (Level 2 Nerve Procedures) and status indicator ‘‘Q2’’ (T-Packaged Codes).

As the technology has evolved, we realized that the current HGNS CPT codes did not accurately describe the newer hypoglossal nerve neurostimulators that are on the market. As a result, some providers utilized CPT code 64568 (*Open implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator*) to describe the implantation of hypoglossal nerve neurostimulators that are not described by the current hypoglossal nerve neurostimulator implantation code.

As a result of the questions and concerns regarding coding and billing for the implantation, revision or replacement, or removal of hypoglossal nerve neurostimulators that are not described by existing coding, we created six new C-codes (91 FR 41809). These new C-codes describe the implantation, revision or replacement, and removal of hypoglossal nerve neurostimulators that do not contain a separate implantable respiratory sensor electrode or electrode array, and systems that do not contain an implanted battery or pulse generator. The C-codes and their long descriptors and payment assignments are listed below.

● C8007 – *Open implantation of hypoglossal nerve neurostimulator array and pulse generator, not requiring insertion of a separate distal respiratory sensor electrode or electrode array*. C8007 is assigned to APC 5465 (Level 5 Neurostimulators and Related Procedures) and status indicator “J1” (Hospital Part B Services Paid Through a Comprehensive APC).

● C8008 – *Revision or replacement of hypoglossal nerve neurostimulator array including connection to existing pulse generator*. C8008 is assigned to APC 5463 (Level 3 Neurostimulators and Related Procedures) and status indicator “J1” (Hospital Part B Services Paid Through a Comprehensive APC) .

- C8009 – *Removal of hypoglossal nerve neurostimulator array and pulse generator*. C8009 is assigned to APC 5432 (Level 2 Nerve Procedures) and status indicator "Q2" (T-Packaged Codes; Paid under OPPS).

- C8011 – *Open implantation of hypoglossal nerve(s) neurostimulator electrode array(s) and receiver, including external power source and all system components*. C8011 is assigned to APC 5465 (Level 5 Neurostimulators and Related Procedures) and status indicator "J1" (Hospital Part B Services Paid Through a Comprehensive APC).

- C8012 – *Revision or replacement of hypoglossal nerve(s) neurostimulator electrode array(s) and receiver*. C8012 is assigned to APC 5463 (Level 3 Neurostimulators and Related Procedures) and status indicator "J1" (Hospital Part B Services Paid Through a Comprehensive APC).

- C8013 - *Removal of hypoglossal nerve(s) neurostimulator electrode array(s) and receiver*. C8013 is assigned to APC 5432 (Level 2 Nerve Procedures) and status indicator "Q2" (T-Packaged Codes; Paid under OPPS).

We used the current HGNS CPT codes as the crosswalk codes for making payment assignments for these new C-codes. These new C-codes and their APC and status indicator assignments were published in the April 2026 quarterly update CR (Transmittal 13686, Change Request 14380, dated March 13, 2026), and are retroactive to January 1, 2026.

Comment: We received two comments supporting the creation of these codes, their APC assignments, and the fact that we made them effective retroactive to January 1, 2026. A commenter suggested that CMS delay finalizing these codes, as they believe that the AMA CPT Editorial Panel is creating new HGNS codes. Another commenter requested that we reassign C-code C8011 to a New Technology APC suggesting that APC 5465 (Level 5 Neurostimulator and Related Procedures) does not adequately account for the device costs and hospital resources required to perform this procedure.

Response: We thank the commenters for their input and support for the creation of these codes. We appreciate the fact that a commenter has suggested that we wait to finalize the HCPCS C-codes we created that describe the HGNS procedures; however, we want to address the coding and billing issues that surround these newer technologies that are not described by existing codes. If and when new CPT codes are created that describe these newer HGNS procedures, we will review the new codes and determine if maintaining the HCPCS C-codes are necessary. Regarding the APC assignments for these C-codes, we believe that the proposed APC assignments are appropriate, as we crosswalked the new C-codes to the existing coding for the HGNS procedures. We do not believe that it is appropriate to assign C8011 to a New Technology APC at this time without having adequate claims data to support the reassignment. We review, on an annual basis, the APC assignments for all services and items paid under the OPPS based on our analysis of the latest claims data and review of the clinical characteristics of the procedure.

In summary, after consideration of the public comments we received, we are finalizing the proposed APC assignments for the C-codes noted previously without modification. The final CY 2027 payment rates for these codes can be found in Addendum B to this final rule with comment period. In addition, we refer readers to Addendum D1 to this final rule with comment period for the SI definitions for all codes reported under the OPPS. Addenda B and D1 are available via the internet on the CMS website.

27. IB-Stim, CPT Code 64567 (APC 5301)

Effective January 1, 2026, the AMA CPT Editorial Panel created CPT code 64567 (*Percutaneous electrical nerve field stimulation, cranial nerves, without implantation*). This code describes a neuromodulation therapy for the treatment of functional gastrointestinal disorders. CPT code 64567 replaced the predecessor CPT code 0720T (Percutaneous electrical nerve field stimulation, cranial nerves, without implantation). For CY 2027, we proposed to continue to assign CPT code 64567 to APC 5301 (Level 1 Upper GI Procedures).

We received one public comment on this proposal. The following is a summary of the comment we received and our response.

Comment: A commenter requested that CMS reassign CPT code 64567 to APC 5312 (Level 2 Lower GI Procedures). The commenter stated that APC 5312 would better align payment with the clinical and resource cost of CPT code 64567.

Response: We thank the commenter for their input. Since CPT code 64567 was new for CY 2026, we note that we will not have any claims data for this code until CY 2028 rulemaking. Additionally, there were no claims data for the predecessor CPT code 0720T.

After further review of the commenter's request, we are reassigning CPT code 64567 to APC 5311 (Level 1 Lower GI Procedures) to better align the procedure clinically, as reflected in Table 38. We note that we will continue to monitor the claims data and update the payment rate in future rulemaking based on the available claims. The final CY 2027 payment rate for the code can be found in Addendum B to this final rule with comment period. We also refer readers to Addendum D1 to this final rule with comment period for the SI meanings for all codes reported under the OPPS. Addenda B and D1 are available via the internet on the CMS website.

TABLE 38: PROPOSED AND FINAL CY 2027 OPPS APC AND SI ASSIGNMENTS FOR CPT CODE 64567

CPT Code	Long Descriptor	Proposed CY 2027 APC, SI	Final CY 2027 APC, SI
64567	Percutaneous electrical nerve field stimulation, cranial nerves, without implantation	5301, T	5311, T

28. ReneuRX™ System, CPT Code 1096T (APC 5442)

Effective October 1, 2026, the AMA CPT Editorial Panel created CPT code 1096T (Injection(s) of thermoregulated multiphase suspension to demyelinate nerves innervating the knee joint, including imaging guidance, when performed). Because the technology associated with the procedure had not received FDA marketing authorization at the time of its assignment, we assigned CPT code 1096T to status indicator "E1" (Not covered by any Medicare outpatient benefit category; Statutorily excluded by Medicare; Not reasonable and necessary; Not paid by

Medicare when submitted on outpatient claims (any outpatient bill type)) for the October 2026 quarterly update.

We received one public comment on this proposal. The following is a summary of the comment we received and our response.

Comment: A commenter stated that this device received FDA approval on August 21, 2026. Therefore, they requested that CMS reassign CPT code 1096T to APC 5431 (Level 1 Nerve Procedures) with a proposed payment rate of around $2,270. The commenter stated that this assignment was appropriate due to the clinical similarity to other procedures in this APC.

Response: We thank the commenter for their input. We agree with the commenter that CPT code 1096T should be reassigned to a clinical APC since the technology associated with the procedure has received FDA authorization. However, we disagree with the commenter's recommendation to assign the procedure to APC 5431. After careful review, we believe that this procedure has similar clinical and resource utilization to procedures in APC 5442 (Level 2 Nerve Injections). Therefore, we are finalizing our proposal with modification to assign CPT code 1096T to APC 5442 (Level 2 Nerve Injections) retroactive to October 1, 2026. We note that we will monitor the claims data and update the payment rate in future rulemaking based on the available claims. The final CY 2027 payment rate for the code can be found in Addendum B to this final rule with comment period. We also refer readers to Addendum D1 to this final rule with comment period for the SI meanings for all codes reported under the OPPS. Addenda B and D1 are available via the internet on the CMS website.

TABLE 39: PROPOSED AND FINAL CY 2027 APC AND SI ASSIGNMENT FOR CPT CODE 1096T

CPT Code	Long Descriptor	Proposed CY 2027 APC, SI	Final CY 2027 APC, SI
1096T	Injection(s) of thermoregulated multiphase suspension to demyelinate nerves innervating the knee joint, including imaging guidance, when performed	E1	5442, T

Oncology Related Services

29. Radiation Oncology Treatment Delivery, CPT Codes 77402, 77407, 77412 (APCs 5621 and 5623)

At the September 2024 CPT Editorial Panel meeting, the Panel approved the revision of radiation therapy CPT codes 77402, 77407 and 77412 to establish a technique-agnostic family of codes and bundle imaging into the three CPT codes. In addition, Intensity Modulated Radiation Therapy (IMRT) treatment delivery codes 77385 and 77386 and CT guidance code 77014 were deleted and consolidated into this new code structure:

Revised CPT code 77402 *(Radiation treatment delivery; Level 1 (eg, single electron field, multiple electron fields, or 2D photons)*, *including imaging guidance, when performed)* describes the delivery of a low-complexity form of radiation to a cancer or tumor and includes any imaging that is used during the session to ensure the radiation beam is accurately targeting the cancer.

Revised CPT code 77407 *(Radiation treatment delivery; Level 2, single isocenter (eg, 3D or IMRT), photons, including imaging guidance, when performed)* describes the delivery of a more complex form of radiation using a single central point of radiation (isocenter) with high-energy photons which may be delivered through 3D conformal radiation therapy (3D–CRT) or Intensity-Modulated Radiation Therapy (IMRT) and includes any imaging that is used during the session.

Revised CPT code 77412 *(Radiation treatment delivery; Level 3, multiple isocenters with photon therapy (eg, 2D, 3D, or IMRT) OR a single isocenter photon therapy (eg, 3D or IMRT) with active motion management, OR total skin electrons, OR mixed electron/ photon field(s), including imaging guidance, when performed)* describes the most complex radiation treatment delivery where multiple points of focus (isocenters) are used with photon therapy (2D, 3D, or IMRT) or a single isocenter is used but with active motion management or specialized techniques like total skin electrons or mixed electron/photon beams are performed and includes any imaging that is used during the session.

For the CY 2026 OPPS/ASC final rule with comment period, we used the following crosswalk methodology to make assignments for these codes. For CPT code 77407, we imputed all CY 2024 claims in CPT code 77407, the bottom 50 percent (with respect to total estimated cost) of single claims from CPT code 77412, and all of the claims from CPT code 77385 (90 FR 53595 through 53596).

For CPT code 77412, we imputed the highest 50 percent (with respect to total estimated cost) of claims in 77412, and all of the claims from 77386. As a result of this crosswalking of claims, we continued to assign CPT code 77407 to APC 5622 (Level 2 Radiation Therapy), which currently has a geometric mean cost of around $423 and reassigned CPT code 77412 to APC 5623 (Level 3 Radiation Therapy), which currently has a geometric mean cost of around $592 (90 FR 53595 through 53596).

For the CY 2027 OPPS/ASC proposed rule, we proposed to continue to assign CPT code 77402 to APC 5621 (Level 1 Radiation Therapy), status indicator 'S', CPT code 77407 to APC 5622 (Level 2 Radiation Therapy), status indicator 'S', and CPT code 77412 to APC 5623 (Level 3 Radiation Therapy), status indicator 'S'.

We received public comments on this proposal. The following is a summary of the comments we received and our responses.

Comment: Many commenters expressed concern that CMS's proposed APC assignments for these codes do not adequately reflect the procedures described by the revised codes and does not provide sufficient payment. Commenters reminded us that these revised codes include 3D conformal and IMRT treatment delivery that were previously described by deleted CPT codes 77385 and 77386.

A commenter suggested that we reassign 77402, 77407, and 77412 to the next highest APC, with many additional commenters requesting that, at a minimum, we reassign CPT code 77407 to APC 5623 (Level 3 Radiation Therapy). Another commenter suggested that we delete 77407 altogether so there is a two tier structure for radiation therapy versus the current three tier

structure. This commenter stated CPT code 77402 can remain the lower-level treatment delivery code and 77412 can serve as the principal code for external-beam treatment delivery.

A number of commenters expressed concern about the methodology used to crosswalk historical claims data to the revised CPT codes and asked us to revise the methodology we used in the CY 2026 OPPS/ASC final rule with comment period. A commenter provided an example of an alternative methodology of crosswalking the historical claims data to the revised codes stating that their example reflects real world data. They went on to state that if we were not inclined to update the crosswalking methodology that we used in last year's rule, we should consider reassigning CPT 77407 to a higher APC because the costs associated with this service (since it includes IMRT delivery) is much higher than the current payment. Commenters are concerned that the proposed APC assignment for CPT codes 77407 and 77412 undervalue these services.

A commenter requested a retroactive payment correction for 2026 claims by reprocessing claims and issuing lump sum payments to facilities and providers.

Response: We thank the commenters for their input. We are not persuaded by the comments to revise our crosswalking methodology that we articulated in the CY 2026 OPPS/ASC final rule with comment period. We note that for CY 2027, we use CY 2025 claims data for ratesetting so the impact of our crosswalking methodology will not be evident in the claims data until the CY 2028 rule. We reviewed the claims data for these codes and noted the following:

- CPT code 77402 has geometric mean cost of approximately $169 based on 5,169 single frequency claims;
- CPT code 77407 has a geometric mean cost of approximately $423 based on 1,165,573 single frequency claims; and
- CPT code 77412 has a geometric mean cost of approximately $592 based on 1,235,088 single frequency claims.

We are persuaded by the commenters that we should reassign CPT code 77407 to APC 5623 (Level 3 Radiation Therapy). We believe that since the revised CPT code 77407 includes the deleted IMRT services (which both had geometric mean costs of over $500), it is appropriate to reassign 77407 to APC 5623. We believe CPT codes 77402 and 77412 are in the appropriate APCs.

We are not able to provide payments to recoup the difference between a prior APC payment rate and the one that will be in effect beginning January 1, 2027.

We note that we review the APC assignments for all items and services paid under the OPPS on an annual basis. We will continue to reevaluate the APC assignments for CPT codes 77402, 77407 and 77412 in the next rulemaking cycle.

In summary, after consideration of the public comments we received, we are finalizing our proposal with modification, to assign CPT code 77407 to APC 5623 (Level 3 Radiation Therapy). Table 40 shows the finalized APC assignment and status indicator for these procedure codes. We refer readers to Addendum B to this final rule with comment period for the payment rates for all codes reportable under the OPPS. In addition, we refer readers to Addendum D1 to this final rule with comment period for the status indicator definitions for all codes reported under the OPPS. Addenda B and D1 are available via the internet on the CMS website.

TABLE 40: PROPOSED AND FINAL CY 2027 APC AND SI ASSIGNMENTS FOR CPT CODES 77402, 77407, AND 77412

CPT Code	Long Descriptor	CY 2027 Proposed OPPS APC, SI	CY 2027 Final OPPS APC, SI
77402	Radiation treatment delivery; Level 1 (eg, single-electron field, multiple-electron fields, single isocenter 2D photons), including imaging guidance, when performed	5621, S	5621, S
77407	Radiation treatment delivery; Level 2, single-isocenter (eg, 3D or IMRT), photons, including imaging guidance, when performed	5622, S	5623, S
77412	Radiation treatment delivery; Level 3, multiple isocenters with photon therapy (eg, 2D, 3D, or IMRT) or a single-isocenter photon therapy (eg, 3D or IMRT) with active motion management, or total skin electrons, or mixed-electron/photon field(s), including imaging guidance, when performed	5623, S	5623, S

30. Radiation Treatment Planning Software (MAXPOINT), CPT Code 1025T (APC 5612)

Effective January 1, 2026, CPT code 1025T *(Alternating electric fields dosimetry and delivery-simulation modeling, creation and selection of patient-specific array layouts, and placement verification)* describes a 3D treatment planning software that is used to aid in electrode placement for Tumor Treatment Fields (TTFields) therapy utilization called MAXPOINT. The service creates individualized transducer array layouts for the treatment of various cancers using TTFields. For CY 2027, we proposed to assign CPT code 1025T to APC 5611 (Level 1 Therapeutic Radiation and Treatment Preparation) with a proposed payment rate of $137.32. Since the code was made effective in 2026, we do not currently have available claims data to use for ratesetting.

MAXPOINT presented at the August 2026 meeting of the Advisory Panel on Outpatient Payment (HOP Panel). The HOP Panel recommended to reassign CPT code 1025T to APC 5612 (Level 2 Therapeutic Radiation and Treatment Preparation) for CY 2027.

We received public comments on this proposal. The following is a summary of the comments we received and our responses.

Comment: Commenters asked CMS to reconsider the proposed APC 5611 assignment for the CPT code 1025T and requested we reassign the code to APC 5613 (Level 3 Therapeutic Radiation Treatment Preparation). The commenters stated that the proposed APC assignment for CPT code 1025T does not accurately describe the MAXPOINT technology and that the planning software's mechanism of action involves advanced computational analysis, which is similar to other codes assigned to APC 5613. Commenters explained that there are similarities between codes in APC 5613 and the MAXPOINT technology, including services assigned to APC 5613 that generate 3D maps and provide complex computational analysis.

Response: We thank the commenters for their input. At this time, we do not have claims data to provide additional information to assess the appropriate APC assignment for CPT code

1025T. However, we agree with commenters, and the HOP Panel, that APC 5611 may not be an appropriate APC assignment for CPT code 1025T at this time. We see similarities between CPT code 1025T and other more complex services in APC 5612, including CPT code 77285. Therefore, we are not finalizing our proposal to assign CPT code 1025T to APC 5611 as proposed. For CY 2027, we are finalizing an APC assignment for CPT code 1025T to APC 5612 in line with the HOP Panel's recommendation. We will continue to evaluate, on an annual basis, additional data as it becomes available to inform future decisions regarding the APC assignment and payment rate for CPT code 1025T. Refer to Table 41 for the code descriptor, APC assignment, and status indicator assignment for CPT code 1025T.

The final CY 2027 payment rates for CPT code 1025T can be found in Addendum B to this final rule with comment period. In addition, we refer readers to Addendum D1 to this final rule with comment period for the status indicator (SI) definitions for all codes reported under the OPPS. Addenda B and D1 are available via the internet on the CMS website.

TABLE 41: PROPOSED AND FINAL CY 2027 OPPS APC AND SI ASSIGNMENT FOR CPT CODE 1025T

HCPCS Code	Long Descriptor	Proposed CY 2027 APC, SI	Final CY 2027 APC, SI
1025T	Alternating electric fields dosimetry and delivery-simulation modeling, creation and selection of patient-specific array layouts, and placement verification	5611, S	5612, S

31. Scalp Cooling Preparation and Pre-Cooling Service, CPT 97007 - 97009 (APC 1494)

Scalp cooling is a service furnished during chemotherapy to prevent or minimize hair loss, a common side effect of chemotherapy treatment for cancer. The service is furnished in two parts. On a different date of service than the chemotherapy session, the patient's head is measured and a scalp cooling cap is individually fitted to the patient. On the day of chemotherapy administration, the service includes a precooling and preparation period of approximately 30 minutes prior to chemotherapy initiation, placement and maintenance of the

cooling cap during chemotherapy infusion, and a post-infusion cooling period following discontinuation of chemotherapy, as clinically appropriate.

Effective January 1, 2026, the scalp cooling service is described by three Category I CPT codes:

- 97007 – Mechanical scalp cooling, including individual cap supply with head measurement, fitting, and patient education.
- 97008 – Mechanical scalp cooling; including hair preparation, individual cap placement, therapy initiation, and precooling period).
- 97009 – Mechanical scalp cooling; provided after discontinuation of chemotherapy, each 30 minutes (List separately in addition to code for primary procedure).

For CY 2026, we assigned the initial cap supply and fitting service, described by CPT code 97007, to APC 1516 (New Technology – Level 16 ($1,401-$1,500) with a payment rate of $1,450.50 and status indicator "S." We assigned CPT codes 97008 and 97009 to status indicator "N" for CY 2026. As provided in the CY 2026 OPPS FR, we explained that we believed the costs associated with the scalp cooling service are appropriately captured within the packaged payment for chemotherapy treatment. Therefore, we packaged payment for CPT codes 97008 and 97009 with the primary chemotherapy service performed at the same time (90 FR 53597).

However, for CY 2027, we acknowledged that the resources required to furnish CPT code 97008 may not be fully captured when packaged. Specifically, we recognized that there is an additional 30 minutes of chair and nursing time, prior to the initiation of chemotherapy, when CPT code 97008 is furnished. Therefore, we proposed to assign CPT code 97008 to APC 1495 (New Technology – Level 1D ($31-$40)) with a status indicator of "S" for CY 2027.

We received public comments on this proposal. The following is a summary of the comments we received and our responses.

Comment: Commenters stated that the proposed APC assignment for CPT code 97008 does not fully capture the costs of the preparation and pre-cooling portion of the scalp cooling

service. Commenters estimated the actual cost of the service at approximately $500, compared to the proposed payment rate of $35.50. Commenters noted that scalp cooling must be furnished by a specialized oncology nurse and described the associated resources, including room preparation, filling the coolant reservoir, hair preparation, administration of pre-service medications, operation of the device, period patient monitoring, and ongoing patient support.

Response: We thank the commenters for their input. Having reviewed the described resources submitted by commenters in consultation with our medical officers for this supportive service, we do not believe it would be appropriate for Medicare to compensate the 30 minute period during which the patient and device are prepared for scalp cooling at approximately $500 per session. The resources described by commenters, including setting up the room and device, preparing the patient's hair, periodic monitoring and patient support, are consistent in clinical intensity with other short-duration, nursing-supported services paid for under the OPPS. In determining the proposed payment rate for CPT code 97008, we looked to chemotherapy infusion services (including CPT code 96415), which reflect hourly resource costs for comparable clinical monitoring and support activities furnished by specialized oncology staff. Applying that hourly rate on a pro-rated basis to the 30 minute duration of CPT code 97008 yields a resource valuation consistent with our proposed rate. Accordingly, we continue to believe it is appropriate to assign CPT code 97008 to APC 1495 (New Technology – Level 1D ($31-$40)) with a status indicator of "S" for CY 2027. Therefore, we are finalizing the APC and status indicator assignments for CPT code 97008 as proposed.

We refer readers to section III.C. and addendum B to this final rule for the payments regarding CPT code 97007 for CY 2027. The final CY 2027 OPPS payment rate for all codes payable under the OPPS can be found in Addendum B to this proposed rule. In addition, we refer readers to Addendum D1 to this final rule for the status indicator meanings for all codes reported under the OPPS. Addendum D1 Is available via the internet on the CMS website.

Ophthalmology Related Services

32. Administration of Lacrimal Ophthalmic Insert Into Lacrimal Canaliculus, CPT Code 68841 (APC 5503)

HCPCS code J1096 (*Dexamethasone, lacrimal ophthalmic insert, 0.1 mg*), describes the drug Dextenza, which is a drug indicated for "the treatment of ocular inflammation and pain following ophthalmic surgery" and for "the treatment of ocular itching associated with allergic conjunctivitis."[22] Dextenza is administered via a natural opening in the eyelid (called the punctum) and delivers a tapered dose of dexamethasone to the ocular surface for up to 30 days. CPT code 68841 (*Insertion of drug-eluting implant, including punctal dilation when performed, into lacrimal canaliculus, each*) describes the insertion of the implant to administer Dextenza.

For CY 2026, we assigned CPT code 68841 to APC 5503 with OPPS status indicator of 'Q1' (STV Packaged Codes), which typically means there is a packaged APC payment if this code is billed on the same claims as a HCPCS code assigned to status indicator 'S', 'T', or 'V' (90 FR 53592).

For CY 2027, we proposed to continue to assign CPT code 68841 to APC 5503 (Level 3 Extraocular, Repair, and Plastic Eye Procedures) and status indicator 'Q1' (STV-Packaged Codes; Paid under OPPS).

We received public comments on this proposal. The following is a summary of the comments we received and our responses.

Comment: We heard from several commenters, who requested that we assign CPT code 68841 to APC 5503 with a different status indicator that allows for separate payment in the ASC setting. Commenters requested that CMS revise the status indicator to 'J1' (Hospital Part B Services Paid Through a Comprehensive APC; Paid under OPPS) to allow for separate ASC payment. A commenter opined that Dextenza replaces the use of self-administered eye drops, which carry adherence and administration challenges – particularly among older patients with

[22]See Package Insert. *https://dailymed.nlm.nih.gov/dailymed/lookup.cfm?setid=7514e6b8-c33f-4fbf-8810-ef520e1eb4bd.*

dexterity, vision, or mobility limitations. The commenter also stated for cost-sensitive ASCs, the lack of payment for the procedure is a disincentive to use Dextenza and requires beneficiaries to use alternatives such as eye drops.

The commenters did not agree with CMS that the fact that CPT code 68841 was performed as a standalone procedure a small percentage of the time was adequate justification for assigning a 'Q1' status indicator. A commenter stated that CMS is treating this procedure (CPT 68841) differently than about 75 other procedures, such as CPT codes 66030 (*Injection, anterior chamber of eye (separate procedure); medication*) and 0699T (*Injection, posterior chamber of eye, medication*) that are assigned to APC 5503, which have 'J1' status indicators. The commenter further states that not making CPT code 68841 separately payable due to a low level of single frequency claims, treats this code differently than similar situations. The commenter also used Exparel (described by HCPCS code J0666) as an example of a non-opioid post-surgical treatment for which the insertion procedure (CPT code 64415) has as low a frequency claim rate as CPT code 68841 and has a status indicator 'T' that allows for separate payment in the ASC setting. The commenters requested that we revise the status indicator to 'J1' to allow separate payment in the ASC setting and facilitate better treatment of ocular pain and itching.

Response: We thank the commenters for their input but disagree regarding the appropriate status indicator for this service. For CY 2027, the OPPS payment rates were proposed based on available CY 2025 claims data. We note that CPT code 68841 does not have any single frequency claims out of the 4,619 total frequency claims. We believe this data, combined with the clinical nature of this procedure, once again reinforces our belief that CPT code 68841, the administration of Dextenza, is not furnished independently of a surgical procedure and should be packaged into the primary ophthalmic procedure with which the drug and the drug administration procedure are associated.

In summary, after consideration of the public comments we received, we are finalizing our proposal without modification to assign CPT code 68841 to APC 5503 (Level 3 Extraocular, Repair, and Plastic Eye Procedures) and 'Q1'. In addition, based on the OPPS assignments, we are finalizing an ASC payment indicator of 'N1' (Packaged service/item; no separate payment made) for CPT code 68841 for CY 2027.

The final CY 2027 payment rates for this code can be found in Addendum B to this final rule with comment period. In addition, we refer readers to Addendum D1 to this final rule with comment period for the SI definitions for all codes reported under the OPPS. Addenda B and D1 are available via the internet on the CMS website.

33. Implantation of Drug-Releasing Device, CPT Codes 0660T, 0661T (APC 5492)

Trabecular bypass procedures are used for the treatment of glaucoma and may be performed along with cataract surgery or as a stand-alone procedure. Another glaucoma treatment involves the implantation of a device that releases a drug into the eye. CPT codes 0660T and 0661T describe the implantation of a device that releases a drug into the eye.

CPT code 0660T (*Implantation of anterior segment intraocular nonbiodegradable drug-eluting system, internal approach*) and CPT code 0661T (*Removal and reimplantation of anterior segment intraocular nonbiodegradable drug-eluting implant*) became effective July 1, 2021. These codes became payable in OPPS in 2024 after the implantable articles used in each procedure received FDA marketing authorization.

For CY 2027, we proposed to maintain their current payment assignments to APC 5492 (Level 2 Intraocular Procedures) and status indicator of 'J1'. We received one public comment on these codes.

Comment: The commenter supported the APC assignment for both CPT codes 0660T and 0661T but requested that we revise the status indicator assignment to 'S' (Procedure or Service, Not Discounted When Multiple; Paid under OPPS; separate APC payment) for both codes noting that the drug used with this procedure (iDose TR® (travoprost intracameral

implant)) will be coming off of pass-through July 1, 2027. Upon the expiration of pass-through, HCPCS code J7355 would no longer be paid separately, and the drug would be packaged with the procedure subject to the OPPS comprehensive packaging policy. The commenter states that the cost of iDose TR® is greater than the payment rate for APC 5492 and lack of adequate payment will likely lead to reduced access for beneficiaries.

Response: We appreciate the commenter's input. We note that CPT code 0660T has a geometric mean cost of $10,545 based on 165 single frequency claims and also has 165 multiple frequency claims. CPT code 0661T has a geometric mean cost of $7,237 based on one single frequency claim and has one additional multiple frequency claim. We believe that this procedure is often done with another ophthalmic procedure and do not believe that we should revise the status indicator from 'J1' to an 'S' so as to avoid our packaging policy under OPPS.

After consideration of the public comment, we are finalizing our proposal, without modification, to maintain the APC and status indicator assignments for CPT codes 0660T and 0661T to APC 5492 (Level 2 Intraocular Procedures) and status indicator of 'J1'. The final CY 2027 payment rates for these codes can be found in Addendum B to this final rule with comment period. In addition, we refer readers to Addendum D1 to this final rule with comment period for the SI definitions for all codes reported under the OPPS. Addenda B and D1 are available via the internet on the CMS website.

34. Implantation of Scaffolding Allograft, CPT 1084T

The AMA CPT Editorial created CPT code 1084T *(Implantation of scaffolding allograft to reinforce the suprachoroidal space)* to replace CPT X588T. We note that this code initially was to be effective January 1, 2027, and was included in Addendum B of the CY 2027 OPPS/ASC proposed rule; however, the AMA revised its 'release and effective date' schedule for Category III CPT codes, and the new effective date is October 1, 2026.

This new code describes an ophthalmic procedure that enhances aqueous outflow with scaffolding allografts in the uveoscleral space to lower intraocular pressure using the alloflo™

uveo device. For CY 2027, we proposed to assign 1084T to APC 5492 (Level 2 Intraocular Procedures) and status indicator 'J1'. We received a public comment on this APC assignment.

Comment: We received one comment from the manufacturer requesting that we reassign CPT code 1084T to APC 5493 (Level 3 Intraocular Procedures) using CPT codes 0671T *(Insertion of anterior segment aqueous drainage device into the trabecular meshwork, without external reservoir, and without concomitant cataract removal, one or more)* and 0449T *(Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; initial device)* as crosswalk codes. The manufacturer also requested that we designate CPT code 1084T as a device-intensive procedure in the ASC and assign a HCPCS-specific device offset of $4,485 or in the alternative, apply the applicable APC-level device offset.

The procedure uses the alloflo™ uveo platform, which consists of two to three permanently implanted scleral allograft bio-tissue implants and the single-use AlloSert™ micro-interventional uveoscleral system used to access the outflow space and to insert the implants. The commenter states the implantables and the delivery-device cost is approximately 78 percent of the geometric mean cost of APC 5493.

The commenter cites clinical and resource similarities to other services that are assigned to APC 5493, including 0617T and 0449T, noting that these procedures are ab-interno, clear-cornea implant procedures that treat open-angle glaucoma by placing one or more implants into an aqueous-outflow pathway to lower intraocular pressure. The commenter also states that CPT code 1084T is more resource-intensive than the two suggested crosswalk codes, noting that the intraservice time is longer than that of the other two procedures.

Response: We appreciate the commenter's input. In determining the appropriate APC placement for new CPT codes, we rely on input from a variety of sources, including, but not limited to, review of the resource costs and clinical similarity of the service to existing procedures, input from CMS medical advisors, as well as information from interested parties.

Based on our review of the clinical characteristics of the procedure, we believe that CPT code 1084T is more similar clinically and in terms of resource requirements and procedure costs to the procedures assigned to APC 5492 (Level 2 Intraocular Procedures). For the device-intensive request and our response, we refer readers to section IV.B and XIII.C.4 of this final rule with comment period.

We remind readers that we review, on an annual basis, the APC assignments for all items and services paid under the OPPS and we will continue to monitor the claims data as it becomes available.

In summary, after consideration of the public comments we received, we are finalizing our proposal without modification, to assign CPT code 1084T to APC 5492 (Level 2 Intraocular Procedures). The final CY 2027 payment rates for this code can be found in Addendum B to this final rule with comment period. In addition, we refer readers to Addendum D1 to this final rule with comment period for the SI definitions for all codes reported under the OPPS. Addenda B and D1 are available via the internet on the CMS website.

35. Patient-Initiated Remote Retinal Optical Coherence Tomography (OCT) Scans, CPT Codes 0604T – 0606T

CPT codes 0604T-0606T describe patient-initiated remote retinal optical coherence tomography (OCT) scans.

In the CY 2027 OPPS/ASC proposed rule, we proposed to continue to assign CPT codes 0604T-0606T to status indicator “E1”.

We received one public comment on this proposal.

Comment: The commenter requested that CMS change the status indicators for each of these codes from “E1” to “B” for 2027. The home OCT services described by CPT codes 0604T and 0605T are only furnished through an independent diagnostic testing facility (IDTF), while the service described by CPT code 0606T is only furnished in the physician office, and these services are not furnished in the hospital outpatient department.

The commenter stated that status indicator "E1" has been erroneously interpreted by some Medicare administrative contractors (MACs) as meaning that the service is non-payable in any outpatient site of service, including the physician office. According to the commenter, this interpretation is incorrect. The commenter believes that the best way to clear up this misunderstanding would be to assign status indicator "B" (Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x)) to each of CPT codes 0604T, 0605T, and 0606T in the 2027 OPPS/ASC final rule.

Response: We thank the commenter for their input, and we agree with the commenter. We have received several MAC inquiries earlier and in response to these inquiries, we are changing the status indicator for CPT codes 0604T, 0605T and 0606T from status indicator "E1" to "B" in the October 2026 update of the Integrated Outpatient Coding Editor (I/OCE) and in the October 2026 Update of the Addendum B that was posted to the CMS website.

For this final rule with the comment period, we are finalizing our proposal with modification and are assigning CPT codes 0604T, 0605T and 0606T to status indicator "B".

Table 42 shows the finalized status indicator for the procedure codes.

We refer readers to Addendum D1 of this final rule with comment period for the SI meanings for all codes reported under the OPPS. Addenda B and D1 are available via the internet on the CMS website.

TABLE 42: FINAL CY 2027 OPPS STATUS INDICATOR ASSIGNMENT FOR CPT CODES 0604T, 0605T AND 0606T

CPT Code	Long Descriptor	Final CY 2027 OPPS SI
0604T	Optical coherence tomography (oct) of retina, remote, patient-initiated image capture and transmission to a remote surveillance center, unilateral or bilateral; initial device provision, set-up and patient education on use of equipment	B
0605T	Optical coherence tomography (oct) of retina, remote, patient-initiated image capture and transmission to a remote surveillance center, unilateral or bilateral; remote surveillance center technical support, data analyses and reports, with a minimum of 8 daily recordings, each 30 days	B
0606T	Optical coherence tomography (oct) of retina, remote, patient-initiated image capture and transmission to a remote surveillance center, unilateral or bilateral; review, interpretation and report by the prescribing physician or other qualified health care professional of remote surveillance center data analyses, each 30 days	B

36. Evacuation of Meibomian Glands, Using Heat Delivered Through Wearable, Open-Eye Eyelid Treatment Devices and Manual Gland Expression, Bilateral CPT 0563T (APC 5501)

CPT code 0563T describes evacuation of meibomian glands, using heat delivered through wearable, open-eye eyelid treatment devices and manual gland expression, bilateral. TearCare® is a technology-enabled interventional therapy for meibomian gland disease (MGD) and dry eye disease (DED) that continuously heats all four eyelids to a therapeutic temperature to melt or liquefy hardened oil obstructions in the meibomian glands, followed by physician-performed manual evacuation of the glands.

DED is a chronic affliction of the ocular surface. In the human eye, meibum, aqueous, and mucus form the three layers of tear film, which is the fluid that keeps the eye moist and serves the critical function of protecting the cornea. Meibomian glands are important oil producing glands located within each of the four eyelids. When healthy, these glands produce a clear liquid oil called meibum, which is expressed with every blink, coats the tear with oil, and prevents the tear from evaporating prematurely and exposing the cornea. In patients with MGD,

the meibomian glands become diseased and inflamed and the meibum hardens. Obstructed meibomian glands cannot produce healthy new liquid meibum, leaving the tear uncoated and resulting in accelerated tear evaporation and an exposed cornea. This evaporative cascade is the leading cause of dry eye disease.

In the 2027 ASC/OPPS proposed rule, we proposed to continue to assign CPT code 0563T to status indicator "Q1" and APC 5733 (Level 3 Minor Procedures) with proposed payment rate of $66.91.

We received several public comments related to our proposal. The following is a summary of the comments we received.

Comments: The commenters requested that we reassign CPT code 0563T from APC 5733 to APC 5503 (Level 3 Extraocular, Repair and Plastic Eye Procedures) with status indicator "J1" and proposed payment rate of $2,808.31. They stated that they do not believe that the current assignment appropriately reflects either the clinical nature of the procedure or the resources required to furnish it. TearCare® requires specialized capital equipment, single-use bilateral treatment components, treatment of all four eyelids, clinical staff and treatment-room resources, followed by physician-performed manual evacuation of the meibomian glands. The single-use treatment components alone have a cost that substantially exceeds the proposed APC 5733 payment.

They also pointed out that TearCare® is performed predominantly in the physician-office setting, where utilization does not generate an OPPS facility claim. Therefore, the limited HOPD claims reflect where TearCare® is currently performed rather than the resources required to furnish the procedure. They stated they do not believe these limited claims provide a representative basis for determining the appropriate APC assignment for CPT 0563T and those limited claims could have been filed in error. This is particularly important because the current APC payment, in their opinion, does not adequately recognize the resources required to furnish

the procedure in the HOPD and may create a barrier for providers seeking to offer TearCare® to Medicare beneficiaries in other settings of care.

According to one of the commenters, the procedure requires dedicated equipment (SmartHub); bilateral, single-use Smartlid devices, a tool to clear glands, and additional supplies; in addition to clinical labor time for pre-service, intraservice, and post-service activities involving approximately 60 minutes. Based on these costs, the estimated hospital resource costs to perform the procedure will exceed $1,800 per procedure.

Response: We appreciate the commenters' input. We agree with the commenters that a family of APCs that describe Extraocular Procedures is more clinically appropriate for CPT code 0563T. However, because there has only been minimal claims data since CY 2020, (only 2 single claims in CY 2023 and CY 2025 final rules) and there are only 2 single claims and 3 total claims for this procedure in the claims available for ratesetting in this final rule, we concluded that the data doesn't support a payment increase of around $2,520.00. Therefore, we are assigning CPT code 0563T to Level 1 Extraocular, Repair and Plastic Eye Procedures for CY 2027.

In summary, after consideration of the public comments we received, we are not adopting our proposal as final. Instead, we are adopting a final APC assignment for CPT code 0563T to APC 5501 (Level 1 Extraocular, Repair and Plastic Eye Procedures) with status indicator "T" for CY 2027 as reflected in Table 43 of this final rule with comment period.

We reiterate that we analyze our claims data on an annual basis to establish the annual OPPS payment rates. Once we have data, we will reevaluate and, if necessary, reassign the code to appropriate APC based on the latest claims data.

Finally, the final payment rates for the codes can be found in Addendum B to this final rule with comment period. In addition, we refer readers to Addendum D1 of this final rule with comment period for the SI definitions for all codes reported under the OPPS. Addenda B and D1 are available via the internet on the CMS website.

TABLE 43: FINAL CY 2027 APC AND STATUS INDICATOR ASSIGNMENT FOR CPT CODE 0563T

HCPCS Code	Long Descriptor	Final CY2027 OPPS APC, SI
0563T	Evacuation of meibomian glands, using heat delivered through wearable, open-eye eyelid treatment devices and manual gland expression, bilateral	5501, T

Orthopedic Related Services

37. Application of Rigid Total Contact Leg Cast, CPT Code 29445 (APC 5102)

CPT code 29445 describes a procedure of applying a Total Contact Leg Cast. Total contact casting ("TCC" – which is pressure offloading) is an integral part of the standard of care for diabetic foot ulcer (DFU) management, alongside with vascular management, infection management, and sharp debridement, deemed as the "VIPS" of DFU care. The use of TCC is often associated with higher healing rates, faster healing times, lower infection rates, and fewer amputations.

TCC is commonly applied after a debridement or grafting procedure during the same office or clinic visit to protect the wound site from ongoing pressure, which could further delay healing.

In the CY 2027 ASC/OPPS proposed rule, we proposed to continue to assign CPT code 29445 to status indicator "T' (Procedure or service, multiple procedure reduction applies; with a separate APC payment under OPPS) and APC 5102 (Level 2 Strapping and Cast Application) with proposed payment rate of $331.21.

At the August 24, 2026, HOP Panel Meeting, a presenter advised the Panel to request that CMS reassign CPT code 29445 (*Application of rigid total contact leg cast*) to status indicator "S" (Procedure or Service, Not Discounted When Multiple; with a separate APC payment under OPPS). Based on the information presented at the meeting, the Panel recommended that CMS make that reassignment.

We received one comment related to CPT code 29445.

Comment : The commenter stated that CPT coding guidance allows for debridement (CPT codes 11042-11047, 97597- 97598) as well as the application of CTPs (CPT codes 15271-15278) on the same date of service as the application of TCC (CPT code 29445). The cast improves the ability of the wound to heal. If a wound debridement is performed (CPT codes 11042-11047, 97597- 97598), any primary or secondary dressing materials used to cover the wound would be included in the debridement and would not be separately reported. However, a TCC is not considered a wound dressing and is not included in the debridement procedure. Therefore, the cast application should be coded in addition to the code for the appropriate level of debridement, if performed, and should be assigned to status indicator "S" because the application of a TCC is labor intensive and the cost of the product is not insignificant.

Response: We thank the commenter for their input. Per our evaluation of the service and an input from our medical advisors, we determined that there are other clinical procedures that involve an application of cast, such as an application of short leg cast, described by CPT code 29405 or an Unna boot that is also used for leg ulcer treatment, that is described by CPT code 29580, that are assigned to status indicator "T". Therefore, we believe that status indicator "T" is appropriately assigned to TCC. As a result, we are maintaining our status indicator assignment as proposed for CY 2027.

We refer readers to Addendum D1 to this final rule with comment period for the SI meanings for all codes reported under the OPPS. Addendum D1 is available via the internet on the CMS website.

38. Arthrocentesis, Aspiration, and/or Injection of Joint, CPT Codes 20604 and 20611 (APC 5441)

CPT codes 20604, 20606, and 20611 describe arthrocentesis, aspiration, and / or injections of small, intermediate, or major joints with ultrasound guidance. The long descriptors are listed below along with their proposed APC and status indicator assignments.

● 20604 - *Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); with ultrasound guidance, with permanent recording and reporting*. CPT code 20604 is assigned to APC 5441 (Level 1 Nerve Injections) and status indicator 'T'.

● 20606 - *Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); with ultrasound guidance, with permanent recording and reporting*. CPT code 20606 is assigned to APC 5442 (Level 2 Nerve Injections) and status indicator 'T'.

● 20611 - *Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting*. CPT code 20611 is assigned to APC 5441 (Level 1 Nerve Injections) and status indicator of 'T'.

For CY 2027, we proposed to maintain the APC and status indicator assignments for these codes. Below is a summary of the comment and our response.

Comment: We received one comment requesting that we reassign CPT codes 20604 and 20611 to APC 5442 (Level 2 Nerve Injections). The commenter noted that there are three CPT codes in this series that include ultrasound guidance and two of those codes (CPT codes 20604 and 20611) are assigned to APC 5441 (Level 1 Nerve Injections), but the third code (CPT code 20606) is assigned to APC 5442 (Level 2 Nerve Injections). The commenter stated that they would expect the CPT codes "with ultrasound guidance" to be assigned to the higher APC.

Response: We thank the commenter for their input. The OPPS payment rates were proposed based on available 2025 claims data. Our claims data shows that APC 5441 (Level 1 Nerve Injections) has a geometric mean cost (GMC) of $320 and APC 5442 (Level 2 Nerve Injections) has a geometric mean cost of $748. We reviewed each of the three CPT codes and note that CPT 20604 has a GMC of $415 based on 1,883 single frequency claims; CPT 20606 has GMC of $506 based on 2,455 single frequency claims; and CPT code 20611 has a GMC of $362 based on 41,333 claims.

While we understand the commenter's rationale to assign all three codes that include ultrasound guidance to the same APC, we believe that reassigning CPT codes 20604 and 20611 to APC 5442 (Level 2 Nerve Injections) would result in overpayments based on the codes GMCs— $415 and $362 respectively, compared to the GMC of APC 5442 which is $748. We believe that CPT codes 20604 and 20611 are assigned to an appropriate APC.

As a reminder, we review on an annual basis, the APC items and services paid under OPPS. If we believe that a code or codes are more appropriately paid under a different APC, we will propose a reassignment during the next rulemaking cycle.

After consideration of the public comment we received, we are finalizing our proposal without modification to continue to assign CPT codes 20604 and 20611 to APC 5441. The final CY 2027 payment rates for these codes can be found in Addendum B to this final rule with comment period. In addition, we refer readers to Addendum D1 to this final rule with comment period for the SI definitions for all codes reported under the OPPS. Addenda B and D1 are available via the internet on the CMS website.

39. Arthroscopy, Knee, Surgical; with Meniscus Repair (Medial or Lateral), CPT Code 29882 (APC 5113)

CPT code 29882 describes an arthroscopic surgical procedure of the knee used to repair a torn meniscus in either the medial (inner) or lateral (outer) compartment.

For CY 2027, we proposed to continue to assign CPT code 29882 to APC 5113 (Level 3 Musculoskeletal Procedures) with a proposed payment rate of $3,855.98 and status indicator "J1".

We received several public comments related to CPT code 29882. The following is a summary of the comments we received.

Comments: Commenters recommended moving CPT code 29882 from APC 5113 to APC 5114, as this would be a better fit for this arthroscopic meniscal repair procedure, separating these repairs from less costly debridement or meniscectomy procedures grouped in APC 5113.

They stated that geometric mean costs of CPT code 29882 are $6,612, which is significantly closer to the geometric mean cost ($8,004) of APC 5114. CPT code 29882 costs are $3,000 higher than the geometric mean costs of APC 5113, where this code currently resides.

Response: We thank the commenters for their input; however, we respectfully disagree with the information presented. Given that any claims data in CY 2025 would be from before the service was payable in the OPPS, it would be difficult to rely on the claims data to determine the APC assignment for this code.

After clinical review and input from our CMS Medical Officers, we continue to believe that CPT code 29882 is appropriately assigned to APC 5113 based on clinical and resource similarity with other codes in that APC.

We remind readers that we review, on an annual basis, the APC assignments for all items and services paid under the OPPS. In summary, after consideration of the public comments we received, we are finalizing our proposal without modification. The final CY 2027 payment rate for this code can be found in Addendum B to this final rule with comment period. Addendum B is available via the internet on the CMS website.

40. Fusion of Foot Bones, CPT Code 28740 (APC 5114)

CPT code 28740 (Arthrodesis, midtarsal or tarsometatarsal, single joint) describes the fusion of foot bones. In the CY 2027 OPPS/ASC proposed rule, we proposed to continue to assign CPT code 28740 to APC 5114 (Level 4 Musculoskeletal Procedures) with a status indicator of "J1" (Hospital Part B Services Paid Through a Comprehensive APC; Paid under OPPS) and proposed payment rate of $8,566.15.

We received a public comment on this proposal. The following is a summary of the comment we received and our response.

Comment: A commenter stated that the assignment of CPT code 28740 to APC 5114 may represent a violation of the 2 times rule, which may impede access to care for beneficiaries. The commenter recommended that CMS consider a volume threshold of 500 single major claims

(or the existing greater or equal to 99 claims that constitute greater than or equal to the 2 percent criterion) as the standard for designating an item or service "significant" for purposes of the 2 times rule. The commenter requested that we reassign CPT code 28740 to APC 5114 (Level 5 Musculoskeletal Procedures) to resolve the alleged 2 times rule violation.

Response: We appreciate the commenter's input. As discussed in section III.B. of this final rule with comment period, for purposes of reviewing APCs for determining violations of the two-times rule, we consider a procedure code cost significant when it has more than 1,000 single-major claims or when it has more than 99 single major claims and accounts for at least 2 percent of the single major claims used to establish the APC cost.

Based on our review of the updated claims data available for this final rule with comment period, CPT code 28740 has a geometric mean cost of approximately $12,571 based on 549 single claims. However, these claims do not meet the 2 percent threshold of claims used to establish ratesetting for APC 5114. Therefore, CPT code 28740 does not meet the significance threshold used in our evaluation of the two-times rule. The lowest-cost significant procedure in APC 5114 has a geometric mean cost of approximately $5,862.49, while the highest-cost significant procedure has a geometric mean cost of approximately $10,510.96. Consequently, we did not identify a violation of the two-times rule for APC 5114.

After consideration of the public comment, we are finalizing our proposal without modification to assign CPT code 28740 to APC 5114 with status indicator "J1" for CY 2027. The final CY 2027 payment rates for this code can be found in Addendum B to this final rule with comment period. In addition, we refer readers to Addendum D1 to this final rule with comment period for the status indicator definitions for all codes reported under the OPPS. Addenda B and D1 are available via the internet on the CMS website.

41. Hip Arthroplasty Revision Procedures, CPT Codes 27134, 27137, and 27138 (APC 5115)

For CY 2026, CMS removed the revision of hip arthroplasty procedures described by CPT code 27134 (Revision of total hip arthroplasty; both components, with or without autograft

or allograft), CPT code 27137 (Revision of total hip arthroplasty; acetabular component only, with or without autograft or allograft), and CPT code 27138 (Revision of total hip arthroplasty; femoral component only, with or without allograft) from the IPO list as part of the first phase of the elimination of the list. For CY 2026, we assigned CPT codes 27134, 27137, and 27138 to APC 5115 (Level 5 Musculoskeletal Procedures). For CY 2027, we proposed to continue to assign these codes to APC 5115, with a proposed payment rate of around $14,629.

We received one public comment on this proposal. The following is a summary of the comment we received and our response.

Comment: A commenter requested that we reassign CPT codes 27134, 27137, and 27138 to APC 5116 (Level 6 Musculoskeletal Procedures) with a proposed payment rate of $20,224. The commenter stated that hospital inpatient knee and hip revision procedures are more resource-intensive and are assigned to a higher MS-DRG payment than the primary procedure in the hospital inpatient setting.

Response: We thank the commenter for their input. Our updated claims data shows that CPT codes CPT codes 27134, 27137, and 27138 have geometric mean costs of $14,967, $13, 206, and $12,279 respectively. Additionally, we believe that these procedures are appropriately assigned to APC 5115, as hip arthroplasty and other revision procedures are currently in this APC. Therefore, due to the available claims data and clinical similarity to other procedures in APC 5115, we are finalizing our proposal to continue to assign CPT codes 27134, 27137, and 27138 to APC 5115 for CY 2027.

We note that we will monitor the claims data and update the payment rate in future rulemaking based on the available claims, as these codes were previously on the IPO list. The final CY 2027 payment rate for the code can be found in Addendum B to this final rule with comment period. We also refer readers to Addendum D1 to this final rule with comment period for the SI meanings for all codes reported under the OPPS. Addenda B and D1 are available via the internet on the CMS website.

42. Limb Cryocompression Therapy, APCs 1069T and 1070T

CPT Codes 1069T (placeholder code X601T) *(Initial fitting, measurement, therapy education, glove/boot supplies))* and 1070T (placeholder code X602T) *(Cryocompression treatment setup, coolant/supplies, oncology nurse time))* describe a supportive care service that combines cooling and intermittent pneumatic compression of the limbs during chemotherapy to reduce the incidence and severity of chemotherapy-induced peripheral neuropathy. Both codes will become effective January 1, 2027.

For CY 2027, CMS proposed to assign CPT code 1069T to status indicator "S" and APC 5735 (Level 5 Minor Procedures) with a proposed payment rate of $487.07. CMS proposed to assign CPT code 1070T to status indicator "S" APC 5732 (Level 2 Minor Procedures) with a proposed payment rate of $41.98.

We received a public comment on this proposal. The following is a summary of the comment we received and our response.

Comment: We received a comment from the manufacturer of the Limb Cryocompression System, which is used to furnish the fitting and cooling service described by CPT codes 1069T and 1070T, requesting that we finalize alternative APC assignments for both codes that more closely align with the resources used to furnish the service. Specifically, the commenter requested that we reassign CPT code 1069T to APC 1561 (New Technology - Level 24 ($3001-$3500)) with a proposed payment rate of $3250.50 or APC 1562 (New Technology - Level 25 ($3501-$4000)) with a proposed payment rate of $3750.50, and that we reassign CPT 1070T to APC 5734 (Level 4 Minor Procedures) with a proposed payment rate of $152.43.

Response: We thank the commenter for their input. At this time, we do not believe that the device utilized to furnish the service has FDA marketing authorization. Therefore, we are not finalizing our proposal at this time. For CY 2027, we are finalizing to assign CPT codes 1069T and 1070T to status indicator "E1" until such time that we are able to confirm that the

device has FDA marketing authorization. Refer to Table 44 for the code descriptors and status indicator assignments for CPT codes 1069T and 1070T.

In addition, we refer readers to Addendum D1 to this final rule with comment period for the status indicator (SI) definitions for all codes reported under the OPPS. Addendum D1 is available via the internet on the CMS website.

TABLE 44: PROPOSED AND FINAL CY 2027 OPPS APC AND SI ASSIGNMENTS FOR CPT CODES 1069T AND 1070T

HCPCS Code	Long Descriptor	Proposed CY 2027 APC, SI	Final CY 2027 SI
1069T	Initial fitting, measurement, therapy education, glove/boot supplies	5735, S	E1
1070T	Cryocompression treatment setup, coolant/supplies, oncology nurse time	5735, S	E1

43. Revision of Total Knee Arthroplasty, with or without Allograft; 1 Component, CPT Code 27486 (APC 5115)

CPT code 27486 describes a revision, repair, or reconstruction of a total knee replacement involving one component (with or without an allograft). In the 2027 ASC/OPPS proposed rule, we proposed to continue assigning CPT code 27486 to APC 5115 (Level 5 Musculoskeletal Procedures) with status indicator "J1" and a proposed payment rate of $14,628.91 for CY 2027. We received one public comment related to CPT code 27486.

Comment: The commenter was concerned that an assignment to APC 5115 does not account for the significant resource demands of the revision of total joint arthroplasty procedures and they believed that the geometric mean cost associated with CPT code 27486 is more closely aligned with APC 5116 (Level 6 Musculoskeletal Procedures) than with the currently proposed assignment to APC 5115. Therefore, the commenter urged CMS to assign total knee revision procedure to the more appropriate APC 5116.

Response: We thank the commenter for their input. CPT code 27486 has an updated geometric mean cost of $9,014.40 in the final rule data, which is less than half than the geometric mean cost of $18,825.67 of APC 5116. The geometric mean cost of APC 5115 is $13,545.46.

Even though any claims data in CY 2025 would be from before the service was payable in the OPPS, and it would be difficult to rely on the claims data to determine the APC assignment for this code, we still continue to believe that CPT 27486 is more closely aligned with APC 5115. Additionally, there are other clinically similar revision procedure codes assigned to APC 5115. Therefore, we think that our proposal to assign CPT code 27486 to APC 5115 is appropriate for CY 2027 and we are finalizing it without modification.

The final CY 2027 payment rate for the code can be found in Addendum B to this final rule with comment period. Addendum B is available via the internet on the CMS website.

44. TOPS System, CPT Code 0202T (APC 5117)

For CY 2026, CMS removed CPT code 0202T (*Posterior vertebral joint(s) arthroplasty (eg, facet joint[s] replacement), including facetectomy, laminectomy, foraminotomy, and vertebral column fixation, injection of bone cement, when performed, including fluoroscopy, single level, lumbar spine*) from the IPO list. This procedure was assigned to APC 5115 (Level 5 Musculoskeletal Procedures) based on clinical and resource utilization.

We received one public comment on this proposal. The following is a summary of the comment we received and our response.

Comment: One commenter requested that CMS reassign CPT code 0202T to APC 5117 (Level 7 Musculoskeletal Procedures) based on its claims data and clinical similarity to CPT codes 22630 (*Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace, lumbar*) and 22633 (*Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace, lumbar*).

Response: We thank the commenter for their input. After further review, we agree with the commenter that CPT code 0202T does share clinical similarity to CPT codes 22630 and 22633. We also note that our available claims CPT code 0202T showed 6 claims with a

geometric mean cost of around $32,538. While this is a very low number of claims, it could show that the resource cost of CPT code 0202T may better align with the payment for APC 5117. Therefore, due to its clinical and resource similarity, we are finalizing our proposal with modification to reassign CPT code 0202T from APC 5115 to APC 5117, as reflected in Table 45 below. The final CY 2027 payment rate for the code can be found in Addendum B to this final rule with comment period. We also refer readers to Addendum D1 to this final rule with comment period for the SI meanings for all codes reported under the OPPS. Addenda B and D1 are available via the internet on the CMS website.

TABLE 45: PROPOSED AND FINAL CY 2027 OPPS APC AND SI ASSIGNMENTS FOR CPT CODE 0202T

CPT Code	Long Descriptor	Proposed CY 2027 APC, SI	Final CY 2027 APC, SI
0202T	Posterior vertebral joint(s) arthroplasty (eg, facet joint[s] replacement), including facetectomy, laminectomy, foraminotomy, and vertebral column fixation, injection of bone cement, when performed, including fluoroscopy, single level, lumbar spine	5115, J1	5117, J1

Pulmonary Related Services

45. Insertion of Endobronchial Valves, CPT Code 31647 (APC 5155)

CPT code 31647 (*Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), initial lobe*) describes a procedure used for conditions such as severe emphysema or persistent bronchopleural air leaks, where a device is placed to control airflow into a portion of the lung. For the CY 2027 OPPS/ASC proposed rule, we proposed to continue to assign the procedure to APC 5155 (Level 5 Airway Endoscopy) and status indicator J1, which has a payment rate of around $7,710.

We note that at the August 24, 2026, HOP Panel Meeting, a presentation was made requesting the reassignment of CPT code 31647 from APC 5155 to New Technology APC 1575 (New Technology - Level 38 ($10,001-$15,000) with a payment rate of $12,500.50. Based on

the information presented at the meeting, the Panel recommended CMS create a new Level 6 Airway Endoscopy APC.

We received public comments on this proposal. The following is a summary of the comments we received and our responses.

Comment: Commenters recommended that CMS reassign CPT code 31647 from APC 5155 to New Technology APC 1575 (New Technology - Level 38 ($10,001-$15,000)). The commenters noted that the cost of the procedure exceeds the payment by approximately $3,000 and expressed concern that this discrepancy would result in patient access to the procedure being limited, particularly considering that the alternatives for severe emphysema patients involve much more invasive and expensive treatment options. The commenter stated that the reassignment to a New Technology APC was necessary because the APC assignment 5155 does not appropriately account for the resources involved as reflected by CMS data.

One commenter claimed that the geometric mean costs for CPT code 31647 remains consistent and well above the geometric mean cost for the APC into which it maps (APC 5155). While acknowledging that there is not a 2-times rule violation (given the number of single frequency claims for the procedure), the commenter noted that the GMC for CPT code 31647 is significantly above the GMC of the other procedures assigned to APC 5155 and more than double for many procedures in the APC 5155.

The commenter also stated that they considered an alternative clinical APC but could not identify a clinically and resource cohesive clinical APC into which to move it. The commenter stated that with no appropriate or higher clinical APC to use as an alternative, CMS should assign the procedure to a new technology APC that more closely aligns with its GMC. The commenter concluded that APC 1575 is the appropriate new technology APC for the service given that the GMC for CPT code 31647 has been in the $11,000– $12,000 range for the past 4 plus years and the GMC is $11,456 in the 2025 claims data that CMS released. Another commenter stated that the GMC for 31647 has remained consistently high over multiple years

and outpatient claims are likely to remain steady, ranging from 72 to 88 claims. The commenter noted that the concern is underscored by the fact that the lowest geometric mean cost of a significant procedure in APC 5155 for CY 2027 is $5,481. The commenter stated that CMS previously received a recommendation from the HOP panel suggesting reassignment of CPT 31647 to New Tech APC 1575 and the commenter supports that recommendation as an interim measure until a permanent APC solution can be established.

Response: As recognized by one of the commenters, APC 5155 does not currently have a 2 times rule violation in the final rule data, and APC 5155 appears to be the best clinical fit for CPT code 31647 of any existing clinical APC.

After consideration of the public comments we received and discussion and input from our Medical Officers, we are finalizing our proposal without modification to assign CPT code 31647 to APC 5155. We examined the HOP panel recommendation and decided not to create a new APC (Level 6 Airway Endoscopy). We note that a new APC Level 6 would have less than 1000 claims and claims for CPT code 31647 have been stable from year to year and have 95 single frequency claims.

We acknowledge the commenters' concerns and rationale for reassigning CPT code 31647 to New Tech APC 1575 (New Technology Level 38), but we disagree with the reassignment. In part, we do not believe that an assignment to a new technology APC is an appropriate crosswalk because this is not a new technology.

We review the APC assignments for all items and services paid under the OPPS on an annual basis. We will reevaluate the APC assignment for CPT code 31647 in the next rulemaking cycle.

In summary, after consideration of the public comments we received, we are finalizing our proposal without modification to assign CPT code 31647 to APC 5 (Level 5 Airway Endoscopy).

The final CY 2027 payment rates for this code can be found in Addendum B to this final rule with comment period. In addition, we refer to Addendum D1 to this final rule with comment period for the SI definitions for all codes reported under the OPPS. Addenda B and D1 are available via the internet on the CMS website.

46. RejuvenAir System, CPT Code 1040T

CPT code 1040T (Bronchoscopy, flexible, with bronchial cryotherapy, 1 lung, including trachea, when performed) describes flexible bronchoscopy with bronchial cryotherapy of one lung, including the trachea, when performed. For CY 2027, we proposed to assign CPT code 1040T to status indicator "E1" (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)).

We received a public comment on this proposal. The following is a summary of the comment we received and our response.

Comment: A commenter discussed the appropriate OPPS payment classification for CPT code 1040T. The commenter stated that the RejuvenAir system, which is used to furnish the service described by CPT code 1040T, has received FDA Breakthrough Device Designation and that a Premarket Approval application was submitted to FDA in January 2026, but the device has not yet received FDA approval. The commenter acknowledged CMS's proposed assignment of status indicator "E1" and stated that, once FDA approval is obtained, the commenter intends to notify CMS so that CMS can assign an appropriate payable status indicator and APC. The commenter emphasized the importance of establishing an appropriate APC assignment following FDA approval to support hospital payment and beneficiary access to the service.

Response: We thank the commenter for its input. Because the medical device associated with CPT code 1040T has not received marketing authorization from the FDA, we are unable to determine the appropriate APC assignment for the service at this time. Therefore, we are maintaining the status indicator assignment of "E1" for CPT code 1040T. We look forward to

hearing from the manufacturer when FDA marketing authorization has been obtained. At that time, we will evaluate the appropriate status indicator and APC assignment for CPT code 1040T.

In summary, after consideration of the public comment that we received, we are finalizing the status indicator assignment of "E1" for CPT code 1040T without modification. The final CY 2027 status indicator for this code can be found in Addendum B to this final rule with comment period. In addition, we refer readers to Addendum D1 to this final rule with comment period for the status indicator definitions for all codes reported under the OPPS. Addenda B and D1 are available via the internet on the CMS website.

Skin Related Procedures

47. Electromagnetic Therapy for Ulcers, HCPCS Code G0329

HCPCS code G0329 (Electromagnetic therapy, to one or more areas for chronic stage iii and stage iv pressure ulcers, arterial ulcers, diabetic ulcers and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care as part of a therapy plan of care) was created in Transmittal 124, dated March 19, 2004, CR 3149), and made effective on July 1, 2004. HCPCS code G0329 was assigned to status indicator "A" in the CY 2005 OPPS final rule (69 FR 66135) and has continued to be assigned that status indicator under the OPPS since that time.

Comment: A commenter requested that CMS make available data on the claims and cost data used to develop the geometric mean cost for G0329 and to evaluate whether the APC the code is assigned to meets the criteria for the universal low volume APC policy.

Response: As we noted earlier in this section, HCPCS code G0329 was proposed to continue to be assigned a status indicator of "A", indicating that the code is paid under a fee schedule or payment system other than the OPPS. Under that designation, there would not be an OPPS APC assignment, and therefore OPPS ratesetting for developing OPPS payment weights for that code and associated policies like the universal low volume policy would not be applicable. Further, we note that HCPCS code G0329 is included on the list of therapy services

at *https://www.cms.gov/medicare/coding-billing/therapy-services/annual-therapy-update.*

We continue to believe that the assignment of status indicator "A" for HCPCS code G0329 is appropriate and therefore are finalizing the assignment for the CY 2027 OPPS.

After consideration of the public comments received, we are finalizing the assignment of status indicator of "A" for HCPCS code G0329 in the CY 2027 OPPS.

48. UltraMIST System Wound Care Service, CPT Code 97610 (APC 5051)

CPT code 97610 *(Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day)* first became effective January 1, 2014, and describes a wound care service using ultrasound. For CY 2027, we proposed to assign CPT code 97610 to APC 5051 (Level 1 Skin Procedures) and status indicator "Q1." For CY 2027, CPT code 97610 has a geometric mean cost of $221.36 based on 2,013 single frequency claims. CPT code 97610 has 4,378 total frequency claims for CY 2027.

We received public comments on this proposal. The following is a summary of the comments we received and our responses.

Comment: Commenters requested that we not finalize the proposed APC and status indicator assignments for CPT code 97610. The manufacturer of the UltraMIST System, which may be described by CPT code 97610, requested that CMS revise the status indicator from "Q1" to "T" and the APC assignment from APC 5051 (Level 1 Skin Procedures) to APC 5052 (Level 2 Skin Procedures). The UltraMIST System consists of a wand that delivers low-frequency ultrasound energy through a fine, sterile saline mist without touching the wound directly. Regarding the status indicator request, the manufacturer requested that we revise the status indicator to "T" for CY 2027 based on a crosswalk to CPT code 97597, which the commenter claimed was the closest clinical sibling of CPT code 97610. The commenter explained that the proposed status indicator assignment of Q1 would exclude most of the code's claims for ratesetting, since 54 percent of the claims for CPT code 97610 are total frequency claims, and

therefore represent claims where the CPT code 97610 is billed alongside another service. Another commenter requested that assign CPT code 97610 to status indicator "S" to allow for more accurate claims collection specific to the service.

Regarding the proposed APC assignment, commenters requested that we revise the APC assignment for CPT code 97610 from APC 5051 to APC 5052 to better align resource use and costs to more comparable wound treatment codes, like CPT codes 97610 (Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters) and 97608 (Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters), which we proposed to assign to APC 5052.

Response: We thank the commenters for their feedback. Regarding the status indicator for CPT code 97610, we believe that a crosswalk to the status indicator for a debridement service as recommended by commenters (e.g. CPT code 97597, which is assigned to status indicator "T"), is appropriate in terms of clinical and resource similarity. Regarding the APC assignment for CPT code 97610, while we acknowledge that the service is often provided at the same time as other procedures, we note that the $196.40 geometric mean cost based on the 3,778 single frequency claims aligns closely with the geometric mean cost of the proposed APC 5051, which is approximately $221. Therefore, we are declining to finalize a revised APC assignment for CPT code 97610 and will continue to evaluate the claims data in future years.

In summary, after consideration of the public comments we received, we are finalizing our proposals with modifications. Specifically, we are finalizing a revised status indicator of "T" for CPT code 97610 and finalizing assignment of CPT code 97610 to APC 5051 as proposed.

Refer to Table 46 for the code descriptor, APC assignment, and status indicator assignment for CPT code 97610 for CY 2027.

The final CY 2027 payment rates for this code can be found in Addendum B to this final rule with comment period. In addition, we refer readers to Addendum D1 to this final rule with comment period for the status indicator (SI) definitions for all codes reported under the OPPS. Addenda B and D1 are available via the internet on the CMS website.

TABLE 46: PROPOSED AND FINAL CY 2027 OPPS APC AND STATUS INDICATOR ASSIGNMENTS FOR ULTRAMIST SYSTEM WOUND CARE SERVICE

HCPCS Code	Long Descriptor	Proposed CY 2027 APC, SI	Final CY 2027 APC, SI
97610	Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day	5051, Q1	5051, T

Sleep Studies

49. Unattended Sleep Study, CPT Code 95846, (APC 5723)

CPT code 95846 (placeholder code 95X20) (Unattended sleep study, set-up, data acquisition and technical analysis; high complexity, 11 or more channels) describes a high-complexity unattended sleep study. CPT code 95846 is currently assigned to APC 5722 (Level 2 Diagnostic Tests and Related Services) with a proposed payment of around $247, and a status indicator of 'S' (Significant Procedures, Not Discounted when Multiple. Paid under OPPS; separate APC payment)

We received public comments on this proposal. The following is a summary of the comments we received and our responses.

Comment: Several commenters requested that CMS reassign CPT code 95846 from APC 5722 (Level 2 Diagnostic Tests and Related Services) to a higher-level APC. Commenters stated that CPT code 95846, which describes a high-complexity unattended sleep study involving 11 or more channels, requires greater resources than CPT code 95844 (95X19) and is also assigned to APC 5722, which describes a moderate-complexity unattended sleep study involving 5 to 10

channels. Commenters stated that the high-complexity service requires more sophisticated equipment and supplies, additional physiologic sensors and channels, greater software and data processing capabilities, and additional technical resources.

Commenters stated that because CPT codes 95844 and 95846 are new for CY 2027, historical claims data for predecessor sleep study codes may not adequately reflect the resource differences between the newly established complexity levels. Commenters requested that CMS assign CPT codes 95844 and 95846 to separate APCs and consider available cost information and other supporting evidence in determining the appropriate APC assignments. A commenter specifically requested that CMS reassign CPT code 95846 to APC 5723 (Level 3 Diagnostic Tests and Related Services), while maintaining CPT code 95844 in APC 5722. The commenter further stated that APC 5723 would better reflect the clinical and resource characteristics of the high-complexity unattended sleep study and provided information regarding the costs associated with furnishing the service in support of the requested reassignment.

Response: We thank the commenters for their input. After consideration of the public comments and further review of the clinical and resource characteristics of CPT code 95486, we agree with the commenters that CPT code 95486 should be assigned to a higher-level APC than CPT code 95844. We believe that the greater number of channels and physiologic parameters associated with the high-complexity unattended sleep study described by CPT code 95486, as well as the additional equipment, supplies, and technical resources associated with furnishing the service, support assignment to APC 5723 (Level 3 Diagnostic Tests and Related Services). We believe that APC 5723 more appropriately reflects the clinical and resource characteristics of the service.

Therefore, after consideration of the public comments we received, we are finalizing with modification our proposal and assigning CPT code 95846 to APC 5723 (Level 3 Diagnostic Tests and Related Services) with status indicator “S” for CY 2027. We will continue to monitor

the claims data for these new codes as the data become available and reevaluate their APC assignments in future rulemaking, as appropriate.

The final CY 2027 payment rates for these codes can be found in Addendum B to this final rule with comment period. In addition, we refer readers to Addendum D1 to this final rule with comment period for the status indicator definitions for all codes reported under the OPPS. Addenda B and D1 are available via the internet on the CMS website.

TABLE 47: PROPOSED AND FINAL CY 2027 OPPS APC AND SI ASSIGNMENT FOR CPT CODE 95846

CPT Code	Long Descriptor	Proposed CY 2027 APC, SI	Final CY 2027 APC, SI
95846	Unattended sleep study, set-up, data acquisition and technical analysis; high complexity, 11 or more channels that generate at least 9 parameter categories	5722, S	5723, S

Spinal and Brain Procedures

50. Central Nervous System and Spinal Services, CPT Codes 62350, 61720, 63741, and 63744 (APCs 5432 through 5433)

For CY 2027 ASC/OPPS proposed rule, we proposed to continue to assign CPT code 63744- *Replacement, irrigation or revision of lumbosubarachnoid shunt* to APC 5432 (Level 2 Nerve Procedures) with status indicator "J1" and proposed payment rate of $3,934.73.

We proposed to continue assigning the following CPT codes to APC 5433 (Level 3 Nerve Procedures) with status indicator "J1" and proposed payment rate of $9,926.55:

- 61720-*Creation of lesion by stereotactic method, including burr hole(s) and localizing and recording techniques, single or multiple stages; globus pallidus or thalamus.*
- 62230-*Replacement or revision of cerebrospinal fluid shunt, obstructed valve, or distal catheter in shunt system.*
- 62350-*Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; without laminectomy.*

- 63741-*Creation of shunt, lumbar, subarachnoid-peritoneal, -pleural, or other; percutaneous, not requiring laminectomy.*

We received public comments related to our proposal.

Comment: The following is a summary of the comments we received. The commenters recommended that we reassign CPT code 62350 to APC 5114 (Level 4 Musculoskeletal Procedures). They also recommended reassigning CPT code 61720 to APC 5461 (Level 1 Neurostimulator and Related Procedures) and the following CPT codes to APC 5462 (Level 2 Neurostimulator and Related Procedures): 62230, 63741 and 63744.

Some commenters stated that this APC reassignment would place these services with procedures that share more comparable anatomy, technology, workflow, and hospital resource requirements. Other commenters pointed out that these changes would strengthen APC integrity and better align payment classifications with the actual services furnished in the hospital outpatient setting. They urged CMS to perform the APC reassignments to prevent central nervous system and spinal services from diluting the clinical integrity of APCs 5432 and 5433. One of the commenters has conducted the following analysis that according to the commenter demonstrated that:

- CPT 62350 aligns exceptionally well with APC 5114. It falls near the center of the APC cost distribution and demonstrates excellent resource homogeneity.

- CPT 61720 demonstrates strong alignment with APC 5461. The CPT geometric mean cost is only 13.2 percent above the APC 5461 benchmark and dramatically closer than its current APC assignment.

- CPT 63744 aligns closely with APC 5462 and is positioned near the center of the APC cost distribution.

- CPT 63741 demonstrates improved alignment with APC 5462 and falls within the established APC cost range, although this is a low-volume service.

● CPT 62230 falls comfortably within the APC 5462 cost distribution and exhibits cost characteristics consistent with procedures currently assigned to APC 5462.

Response: We wanted to thank the commenters for their input. Based on our review of the claims data, and recommendations from CMS's Medical Officers, we don't believe that these procedures should be reassigned to other clinical APC families or moved to other Nerve Procedure APC Levels.

We reviewed each code individually. In the claims available for OPPS ratesetting for this final rule, CPT code 62350 has an estimated geometric mean cost of $8,025.50 based on 271 single claims. The geometric mean cost of APC 5433 (Level 3 Nerve Procedures) is $9,156.83. We believe that the proposed placement of CPT code 62350 in APC 5433 remains appropriate based on its geometric mean cost relative to that of the APC. Therefore, we are finalizing our proposal without modification to assign CPT code 62350 to APC 5433 for CY 2027.

In the claims available for OPPS ratesetting for this final rule, CPT code 61720 has an estimated geometric mean cost of $4,318.70 based on 7 single claims. The geometric mean cost of APC 5433 is $9,156.83. Because of such a low volume of claims for this service, we believe that CPT code 61720 is appropriately placed in APC 5433 for CY 2027 and will continue to monitor claims data as more claims become available in future years. As a result, we are finalizing assignment of CPT code 61720 to APC 5433 for CY 2027.

In the claims available for OPPS ratesetting for this final rule, CPT code 62230 has an estimated geometric mean cost of $8,310.25 based on 339 single claims. The geometric mean cost of APC 5433 is $9,156.83. Therefore, we believe that the proposed placement of CPT code 62230 in APC 5433 is still appropriate for CY 2027 and are finalizing our proposal to assign CPT code 62230 to APC 5433 for CY 2027.

In the claims available for OPPS ratesetting for this final rule, CPT code 63741 has an estimated geometric mean cost of $10,755.50 based on 9 single claims. The geometric mean cost of APC 5433 is $9,156.83. Because we only have 9 single claims, we think that CPT code

63741 is in line with the geometric mean cost of APC 5433 for CY 2027 but will continue to monitor claims data as more updated claims become available. As a result, we are finalizing our proposed assignment of CPT code 63741 to APC 5433 for CY 2027.

In the claims available for OPPS ratesetting for this final rule, CPT code 63744 has an estimated geometric mean cost of $8,471.68 based on 12 single claims. The geometric mean cost of APC 5432 (Level 2 Nerve Procedures) is $4,248.97. Since we only have 12 claims, we believe that APC 5432 remains a good fit for CPT code 63744 for CY 2027 based on clinical coherence and will monitor claims data as more updated claims become available in future years.

Therefore, we are finalizing without modification our proposal to assign CPT code 63744 to APC 5432 for CY 2027.

We refer readers to Addendum B of this final rule with comment period for the payment rates for all codes reported under the OPPS. Addendum B is available via the internet on the CMS website.

Surgical Procedures

51. Diaphragmatic Hernia Repair, CPT Code 39542 (APC 5342)

Effective January 1, 2027, the AMA CPT Editorial Panel created CPT code 39542 (Repair of nontraumatic diaphragmatic hernia via laparotomy), which was previously described by placeholder code 39XX3. CPT code 39542 describes the procedure for nontraumatic diaphragmatic hernia repair via a laparotomy approach. For CY 2027, we proposed to assign CPT code 39542 to APC 5342 (Level 2 Abdominal/Peritoneal/Biliary and Related Procedures), with a proposed payment rate of around $7,715.

We received one public comment on this proposal. The following is a summary of the comment we received and our response.

Comment: One commenter requested that we reassign CPT code 39542 to APC 5362 (Level 1 Laparoscopy and Related Services), which had a proposed payment rate of around

$12,300. The commenter stated that this procedure had similar clinical and resource utilization as other diaphragmatic procedures assigned to APC 5362.

Response: We thank the commenter for their input. After careful review, we continue to believe that assignment of CPT code 39542 to APC 5342 is appropriate due to its similarity to other laparotomy procedures in this APC. We note that since this is a new code, we will not have claims data available until CY 2029 rulemaking. We will monitor the claims data and update the payment rate in future rulemaking based on the available claims.

The final CY 2027 payment rate for the code can be found in Addendum B to this final rule with comment period. We also refer readers to Addendum D1 to this final rule with comment period for the SI meanings for all codes reported under the OPPS. Addenda B and D1 are available via the internet on the CMS website.

52. Radiofrequency Ablation of Lumpectomy Cavity, CPT Code 1955T

Effective October 1, 2026, the AMA CPT Editorial Panel created CPT code 1055T (Intraoperative radiofrequency ablation of lumpectomy cavity, unilateral, including applicator placement and removal (List separately in addition to code for primary procedure)). Based on the OPPS packaging policy, we assigned CPT code 1055T to status indicator "N" (packaged) for in the October 2026 quarterly update.

We received one public comment on this proposal. The following is a summary of the comment we received and our response.

Comment: A commenter requested that CMS assign CPT code 1055T to APC 1575 (New Technology – Level 38 ($10,001-$15,000)) and status indicator "S". The commenter stated that this assignment would ensure beneficiary access to the procedure and allow CMS to obtain hospital claims data for the procedure.

Response: We thank the commenter for their input. We note that CPT code 1055T is an add-on code. Add-on codes are always performed in addition to the primary service or procedure, not reported as a stand-alone code. As specified under regulation 42 CFR

419.2(b)(18), add-on codes are generally packaged under the OPPS, and payment for the codes are bundled with the primary codes. Consequently, CPT code 1055T is not paid separately under the OPPS and its payment is packaged into payment for the primary code. Therefore, we are finalizing our proposal to assign CPT code to status indicator "N" for CY 2027.

We refer readers to Addendum D1 to this final rule with comment period for the SI meanings for all codes reported under the OPPS. Addenda D1 is available via the internet on the CMS website.

Technology-Enabled Care

53. Digital Mental Health Treatment (DMHT) Services, HCPCS Code G0552 (APC 5012)

HCPCS code G0552 (Supply of digital mental health treatment device and initial education and onboarding, per course of treatment that augments a behavioral therapy plan) describes the supply of a digital mental health treatment device and initial patient education and onboarding. HCPCS code G0552 is currently assigned to APC 5012 (Clinic Visits and Related Services), with a proposed CY 2027 payment of approximately $148, and a status indicator of 'V' (Clinic or Emergency Department Visit).

We received public comments on this proposal. The following is a summary of the comments we received and our response.

Comment: Commenters requested that CMS reconsider the proposed assignment of HCPCS code G0552 (Supply of digital mental health treatment device and initial education and onboarding, per course of treatment that augments a behavioral therapy plan) to APC 5012 (Clinic Visits and Related Services). Commenters stated that the assignment of HCPCS code G0552 to APC 5012 does not appropriately reflect the clinical characteristics or hospital resources associated with furnishing a DMHT device.

Commenters stated that HCPCS code G0552 differs from remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM) services assigned to APC 5012 because HCPCS code G0552 includes the supply of an FDA-authorized digital treatment device in

addition to initial education and onboarding. Commenters explained that DMHT devices deliver a therapeutic intervention to treat or alleviate a mental health condition, whereas RPM and RTM devices generally monitor a patient's status or response to treatment. Commenters also stated that the device supply for HCPCS code G0552 is furnished for an entire course of treatment, rather than being separately reported on a recurring basis.

Commenters further stated that the hospital costs associated with furnishing DMHT devices substantially exceed the payment rate for APC 5012. Commenters also stated that CMS's proposed payment policy for Software as a Medical Service (SaMS) supports recognizing hospital expenditures for access to proprietary software as a resource cost under the OPPS, even though DMHT devices are not included within the proposed definition of SaMS.

Commenters recommended that CMS reassign HCPCS code G0552 to a higher-paying APC that more appropriately reflects the clinical and resource characteristics of the service. One commenter suggested APC 5735 (Level 5 Minor Procedures) or APC 5723 (Level 3 Diagnostic Tests and Related Services), or, alternatively, the establishment of a new Level 4 Health and Behavioral Services APC 5824.

Response: We thank the commenters for their recommendations and the information provided regarding the clinical characteristics and costs associated with furnishing DMHT devices. We continue to believe that APC 5012 (Clinic Visits and Related Services) is the most appropriate APC assignment for HCPCS code G0552 at this time. As discussed in in the CY 2025 OPPS/ASC final rule with comment period (89 FR 94087 through 94088), we believe that the DMHT services described by HCPCS codes G0552, G0553, and G0554 are clinically similar to other services assigned to APC 5012, and we believe that maintaining these services within the same APC continues to be appropriate based on the information currently available to us.

We acknowledge the commenters' concerns regarding the costs associated with the DMHT device included in HCPCS code G0552 and appreciate the additional cost information submitted by the commenters. However, we do not believe that the information submitted

provides a sufficient basis at this time to reassign HCPCS code G0552 to APC 5723 or APC 5735, or to establish a new Level 4 Health and Behavioral Services APC.

As additional claims data become available for HCPCS code G0552, we will continue to evaluate the clinical and resource characteristics of the service and consider whether a different APC assignment may be appropriate in future rulemaking. Therefore, after consideration of the public comments, we are finalizing our proposal to continue to assign HCPCS code G0552 to APC 5012 (Clinic Visits and Related Services) for CY 2027.

Urology Related Services

54. Clearance of Renal Calculi by Ultrasonic Propulsion, CPT Code 1054T (APC 5373)

The CPT Editorial Panel created CPT code X559T (now replaced with CPT code 1054T) to describe a new procedure to clear residual fragments of kidney stones out of the kidney by delivering low amplitude, low frequency focused ultrasound that pushes and propels the fragments towards the uretero-pelvic junction post-lithotripsy. The long descriptor for CPT code 1054T is below.

- 1054T - *Focused non-shock wave ultrasonic propulsion of residual stone fragment(s) post-lithotripsy, unilateral, including ultrasound guidance, fragment(s) less than or equal to 5 mm.*

For CY 2027, we proposed to assign CPT code 1054T to APC 5373 (Level 3 Urology and Related Services). Since the CY 2027 OPPS/ASC proposed rule was published, the AMA revised the effective date for this code to October 1, 2026. We received public comment on this service.

Comment: The commenter requested that we assign CPT code 1054T to APC 5374 (Level 4 Urology and Related Services) stating that the total resource costs are $3,765 citing the intra-operative overhead costs are $3,720 based on 60 minutes of procedure time. The commenter notes the geometric mean cost for APC 5374 is $3,797 and CPT code 1054T should therefore, be assigned to APC 5374.

Response: We thank the commenter for their input. We note that this procedure is performed after the lithotripsy has already been completed and question the amount of intraoperative time cited for clearing stone fragments. Based on our review of the service, as well as input from our medical advisors, we believe CPT code 1054T is appropriately assigned to APC 5373.

As we do every year, we will monitor the claims data and reevaluate the APC assignment for this code in the next rulemaking cycle to determine if a more appropriate APC assignment is warranted.

In summary, after consideration of the public comment we received, we are finalizing our proposal without modification, to assign CPT code 1054T to APC 5373 (Level 3 Urology and Related Services) and a status indicator of J1. The final CY 2027 payment rates for this code can be found in Addendum B to this final rule with comment period. In addition, we refer readers to Addendum D1 to this final rule with comment period for the SI definitions for all codes reported under the OPPS. Addenda B and D1 are available via the internet on the CMS website.

55. Cystourethroscopy with Lithotripsy and Vacuum Aspiration of Kidney, HCPCS Codes C9761 and C0814 (APCs 5375 and 5376)

HCPCS code C9761 (*Cystourethroscopy, with ureteroscopy and/or pyeloscopy, with lithotripsy, and ureteral catheterization for steerable vacuum aspiration of the kidney, collecting system, ureter, bladder, and urethra if necessary, with use of steerable ureteral catheter or suction-integrated ureteroscope*) became effective October 1, 2020 and describes a minimally invasive procedure used to break up and remove kidney stone fragments and dust by use of a continuous irrigation and vacuum system. The long descriptor was revised in CY 2023 to include "must use a steerable ureteral catheter" and we further revised the long descriptor to include "suction-integrated ureteroscope" effective July 1, 2026, after meeting with the specialty society.

We also established HCPCS code C8014 (Cystourethroscopy, with ureteroscopy and/or pyeloscopy, with lithotripsy, including use of a suction enabled ureteral access sheath, with irrigation (if performed) effective July 1, 2026, to describe these cystourethroscopy procedures where a suction-enabled ureteral access sheath is used to vacuum kidney stone fragments. We assigned HCPCS code C8014 to APC 5375 (Level 5 Urology and Related Procedures) and status indicator 'J1' as we believe this procedure with this device has clinical and resource similarities to other procedures assigned to APC 5375.

For CY 2027, the OPPS payment rates are proposed based on available CY 2025 claims data. For the CY 2027 proposed rule, we found a total of 3,516 single frequency claims and a geometric mean cost of approximately $9,472 for HCPCS code C9761. For CY 2027, we proposed to maintain the APC assignment of 5376 (Level 6 Urology and Related Procedures) and status indicator of 'J1' for HCPCS code C9761.

For CY 2027, we proposed to maintain the APC and status indicator assignment for HCPCS code C8014. We currently have no claims data for ratesetting purposes as this is a new code.

We received public comments on these two HCPCS codes. Below is a summary of the comments and our responses.

Comment: A commenter suggested that we consolidate both C-codes into one single technology-neutral code to describe suction-assisted ureteroscopic and/or pyeloscopic lithotripsy and if we did not consolidate the two C-codes, provide exclusive coding instructions for each of these HCPCS codes. The commenter explained that both of these C-codes describe suction-assisted stone-fragment evacuation during cystourethroscopy with ureteroscopy and/or pyeloscopy with lithotripsy and are furnished during the same procedure, through the same anatomic pathway, and for the same purpose. The commenter believes the device distinction is not enough of a meaningful difference to require separate HCPCS codes or have a different APC assignment. The commenter cites studies supporting their position that the performance between

a flexible and navigable suction access sheath (FANS) and the CVAC system described by C9761. The commenter then went on to say that if CMS continues to maintain both HCPCS codes, C9761 and C8014 should be assigned to the same APC. The commenter requested that CMS publish clear coding instructions with illustrative examples distinguishing between the three types of devices: 1) a suction-enabled ureteral access sheath (i.e., FANS); 2) a steerable vacuum-aspiration ureteral catheter (i.e., CVAC system); and 3) a suction-integrated ureteroscope noting that additional coding guidance would support accurate coding and reduce claims denials.

Another commenter requested that we reassign C8014 to APC 5376 (Level 6 Urology and Related Services stating that the reassignment would be more appropriate, both clinically and based on resource utilization. The commenter noted that there are a number of complex kidney stone procedures in APC 5376, including HCPCS code C9761. The commenter believes that because we do not yet have claims data available for C8014 for our standard geometric mean cost (GMC) methodology, clinical coherence with existing APC assignments should receive significant consideration in evaluating the appropriate APC placement, such as C9761 as a crosswalk. In addition, the commenter provided their analysis of claims data to support their belief that C8014 would be more appropriately assigned to APC 5376.

Another commenter supported the creation of HCPCS code C8014 and its APC assignment to APC 5375 (Level 5 Urology and Related Services). They believe that the creation of this code will help CMS measure utilization, resources, and costs separately from the service described by HCPCS code C9761 and refine payment as we begin to have claims data.

The commenter expressed concerns regarding the revised long descriptor for C9761 stating that the revised language causes some further confusion with cases involving a suction-capable ureteroscope (also commonly referred to as a direct in-scope suction (DISS) ureteroscope), with or without a suction-enabled ureteral access sheath. The commenter requested clarification regarding the term “integrated” and suggested that there be a

documentation-based framework that articulates three different care pathways to distinguish the type of technology used (or not used), including 1) the standard ureteroscopy/lithotripsy pathway; 2) the suction-enabled access sheath pathway; and 3) the steerable-vacuum aspiration pathway. The commenter states that the clinical literature does not support the equivalency of suction-capable ureteroscopes and suction-enabled access sheaths are equivalent to the steerable renal vacuum-aspiration service represented by HCPCS code C9761.

This commenter believes that our coding clarification should distinguish the device predicate from the service predicate and further clarification is necessary for payment accuracy, beneficiary protection, and program integrity. The commenter suggests that HCPCS C9761 is coded when the services actually provided are less resource intensive. To remedy these concerns, the commenter requested that CMS issue provider communication explaining the three types of care pathways to distinguish the types of technology used and define "suction-integrated ureteroscope" in functional terms, or in the alternative, revise the current long descriptors to provide clarity regarding the service described by the code.

Response: We appreciate the input and recommendations from the interested parties. Over the years we have heard from interested parties regarding concerns about providers utilizing HCPCS code C9761 to describe the ureteroscopy/lithotripsy procedure with a suction-enabled ureteral access sheath and the potential program integrity concerns that raises when C9761 is assigned to a higher APC because of the underlying device costs. To remedy these concerns, we created C8014 to specifically describe the ureteroscopy/lithotripsy procedures with suction-enabled sheaths and assigned it to what we believe is an appropriate APC. We then heard from the American Urological Association who then informed us that there is a third type of device (suction-integrated ureteroscope) that is used to vacuum stone fragments during ureteroscopy/lithotripsy procedures. As a result, we revised the descriptor language to include this device in the descriptor for C9761.

We do not believe that we should at this time consolidate these two HCPCS codes into one single technology neutral code and assign it to APC 5376. While we understand the rationale, we do not want to create further coding confusion since we just created C8014 to distinguish suction-enabled sheaths from steerable vacuum catheters and suction-integrated ureteroscopes. We believe the descriptor language is clear and that there is enough of a difference in costs that warrants separate coding. In addition, we do not believe both HCPCS codes should be assigned to the same APC.

In response to the comments regarding coding guidance and MLN education, we have stated in past rules that we do not provide coding guidance, as it is out of scope for the OPPS/ASC final rule with comment period (89 FR 94122) and if hospitals have questions about appropriate coding that they cannot resolve on their own, the appropriate first step would be to review the HCPCS codes or consult their Medicare Administrative Contractor (MAC) for their jurisdiction. We refer readers to MLN Matters MM14477 (OPPS July 2026 Update) for information regarding the creation of C8014 and the descriptor revision for C9761.

In summary, after consideration of the public comments we received, we are finalizing our proposal without modification, to assign HCPCS code C9761 to APC 5376 (Level 6 Urology and Related Procedures) and a status indicator of 'J1' and HCPCS code C8014 to APC 5375 (Level 5 Urology and Related Procedures) and a status indicator of 'J1'. As we do every year, we will monitor the claims data and reevaluate the APC assignments for these codes in the next rulemaking cycle to determine if more appropriate APC assignments are warranted.

The final CY 2027 payment rates for these codes can be found in Addendum B to this final rule with comment period. In addition, we refer readers to Addendum D1 to this final rule with comment period for the status indicator definitions for all codes reported under the OPPS. Addenda B and D1 are available via the internet on the CMS website.

56. Optilume BPH Catheter System, CPT Code 52443 (APC 5376)

Effective January 1, 2026, the AMA CPT Editorial Panel created CPT code 52443 (Cystourethroscopy with initial transurethral anterior prostate commissurotomy with a nondrug-coated balloon catheter followed by therapeutic drug delivery into the prostate by a drug-coated balloon catheter, including transrectal ultrasound and fluoroscopy, when performed). For CY 2027, we proposed to continue to assign CPT code 52443 to APC 5376 (Level 6 Urology and Related Services) with a proposed payment rate of around $10,797.

We received one public comments on this proposal. The following is a summary of the comment we received and our response.

Comment: A commenter requested that CMS reassign CPT code 52443 to APC 5377 (Level 7 Urology and Related Services). The commenter stated that CPT code 52443 would better align with procedures assigned to APC 5377. Additionally, the commenter stated that claims data showed that CPT code 52443 had a geometric mean cost of around $12,712.

Response: We thank the commenter for their input. Since CPT code 52443 was new for CY 2026, we note that we will not have any claims data for this code until CY 2028 rulemaking and we are unable to confirm the claims data stated by the commenter. After further review, we believe that CPT code 52443 is appropriately assigned to APC 5376. Therefore, we are finalizing our proposal to assign CPT code 52443 to APC 5376 (Level 6 Urology and Related Services) for CY 2027.

We note that we will monitor the claims data and update the payment rate in future rulemaking based on the available claims. The final CY 2027 payment rate for the code can be found in Addendum B to this final rule with comment period. We also refer readers to Addendum D1 to this final rule with comment period for the SI meanings for all codes reported under the OPPS. Addenda B and D1 are available via the internet on the CMS website.

57. Permanent Prostatic Urethral Stent, CPT Code 52282 (APC 5375)

The ProVee® System is indicated to treat obstructive lower urinary tract symptoms (LUTS) secondary to benign prostatic hyperplasia (BPH) in men with prostatic urethral lengths

greater than or equal to 3.75 cm and prostatic volumes between 30 cc and 80 cc. The insertion of a permanent prostatic urethral stent procedure, represented by CPT code 52282 (Cystourethroscopy, with insertion of permanent urethral stent), became effective January 1, 1998, and describes the insertion of a permanent urethra stent using an endoscope. This procedure offers another therapy option for select patients with lower urinary tract symptoms (LUTS) secondary to BPH.

For CY 2026, we assigned CPT code 52282 to APC 5374 (Level 4 Urology and Related Services) with a payment rate of $3,601.33 based on its geometric mean cost of approximately $3,775, which was calculated using the available 115 single frequency claims from the CY 2024 claims data.

For the CY 2027 OPPS/ASC proposed rule, we reviewed the CY 2025 claims submitted between January 1, 2025 through December 31, 2025, that were processed on or before December 31, 2025, for CPT code 52282 and found 109 single frequency claims available for ratesetting, with a resulting geometric mean cost of $4,005 (91 FR 41810). We noted that there has not been an FDA authorized permanent prostatic urethral stent on the US market for approximately 9 years until a permanent prostatic urethral stent received their FDA PMA approval in late 2025. Therefore, we believed the report claims for CPT code 52282 did not accurately represent the device and service cost associated with inserting a permanent prostatic urethral stent. Based on our examination of device and service costs associated with a permanent prostatic urethral stent, we believed it was appropriate to move CPT code 52282 to APC 5375 (Level 5 Urology and Related Services) from APC 5374 (Level 4 Urology and Related Services) because CPT code 52282 shares more resource cost and clinical homogeneity with procedures in APC 5375. Specifically, we believed CPT code 52282 shares resource and clinical homogeneity with HCPCS code C9739 (Cystourethroscopy, with insertion of transprostatic implant; 1 to 3 implants). Therefore, for CY 2027, we proposed to reassign CPT code 52282 from APC 5374

(Level 4 Urology and Related Services) to APC 5375 (Level 5 Urology and Related Services) (91 FR 41810).

Comment: We received twelve comments on our proposal. Two commenters supported our proposal to move CPT code 52282 from APC 5374 to 5375. 10 commenters requested that we move CPT code 52282 to APC 5376 (Level 6 Urology and Related Services). Some of these commenters additionally requested device-intensive status for CPT 52282. The commenters requesting reassignment of CPT code 52282 from APC 5374 to 5376 state that C9739 (Cystourethroscopy, with insertion of transprostatic implant; 1 to 3 implants) is not the appropriate comparator because fewer than 4 implants is not how the ProVee therapy is performed. They state that the appropriate comparators are CPT code 53865 for the iTIND stent, CPT code 0941T for the Zenflow Stent/Scaffold and HCPC code C9740 for the UroLift procedure which are assigned to 5376. These commenters state that 52282 and these procedures share the same indication — lower urinary tract symptoms secondary to BPH — the same anatomic target, the same cystoscopic transurethral access, the same facility footprint, and the same recovery and follow-up pattern.

Response: We thank the commenters for their detailed analysis and recommendation. As we indicated in the proposed rule, prior to the permanent prostatic urethral stent that received FDA authorization in late 2025, there had not been an FDA authorized permanent prostatic urethral stent on the US market for approximately 9 years. Consequently, we do not believe that the reported claims for CPT code 52282 accurately represent the device and service cost associated with inserting a permanent prostatic urethral stent. Given the uncertainty of the existing claims data, we think we should wait for additional, more representative data before adjusting the payment rate for CPT code 52282 beyond APC 5375.

Regarding the commenters that requested device-intensive status for CPT 52282. We refer readers to sections IV.B and XIII.C.4 of this final rule with comment period for our response those requests.

After consideration of the public comments we received and discussion and input from our Medical Officers, we are finalizing our proposal without modification for the APC assignment for CPT code 52282. We note that we review the APC assignments for all items and services paid under the OPPS on an annual basis. We will reevaluate the APC assignments for CPT code 52282 in the next rulemaking cycle.

We refer readers to Addendum B of this final rule with comment period for the payment rates for all codes reportable under the OPPS. Addendum B is available via the internet on the CMS website.

58. Transperineal Laser Ablation of Prostate, CPT Codes 0714T and 0867T (APC 5375)

Both CPT codes 0714T (*Transperineal laser ablation of benign prostatic hyperplasia, including imaging guidance; prostate volume less than 50 mL*) and CPT code 0867T (*Transperineal laser ablation of benign prostatic hyperplasia, including imaging guidance; prostate volume greater or equal to 50 mL*) describe the destruction of benign prostate tissue using laser ablation.

For CY 2027, we proposed to maintain the APC assignments for CPT codes 0714T and 0867T to APC 5375 (Level 5 Urology and Related Services). We received public comment on these codes.

Comment: We received one comment requesting that we reassign CPT codes 0714T and 0867T to APC 5376 (Level 6 Urology and Related Services) because these codes have clinical and resource homogeneity with CPT code 55873 (*Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring))* which is assigned to APC 5376.

Response: We thank the commenter for the input. We note that the current geometric mean cost for CPT code 0714T is $5,234 based on two single frequency claims and we have no claims data for CPT code 0867T. After evaluation of the service, as well as input from our medical advisors, we are not persuaded that CPT code 55873 is a more appropriate crosswalk code for CPT codes 0714T and 0867T. We do not believe that CPT codes 0714T and 0867T

should be reassigned to APC 5376. As we do every year, we will monitor the claims data and reevaluate the APC assignments for these codes in the next rulemaking cycle to determine if a more appropriate APC is warranted.

In summary, after consideration of the public comments we received, we are finalizing our proposal without modification to assign CPT codes 0714T and 0867T to APC 5375 (Level 5 Urology and Related Services).

The final CY 2027 payment rates for these codes can be found in Addendum B to this final rule with comment period. In addition, we refer readers to Addendum D1 to this final rule with comment period for the SI definitions for all codes reported under the OPPS. Addenda B and D1 are available via the internet on the CMS website.

Miscellaneous Issues

59. APC Assignments for Devices Coming Off of Transitional Payment Pathways

For CY 2027, we proposed to continue our device pass-through and new technology APC policies unchanged from CY 2026. We note that these are meant to serve as temporary, transitional payment pathways prior to permanent payment through assignments to clinical APCs.

Comment: We received comments requesting that CMS take a comprehensive view to determine appropriate APC assignments for services with expiring pass-through status or following assignments to new technology APCs. Commenters requested that CMS define a transition pathway from pass-through or new technology APC status to permanent payment, including clearer criteria, timelines, data requirements and advance notice. Regarding new technology APCs, we received comments requesting that initial assign to new technology APCs should be based on the best available information, and that services should remain assigned to new technology APCs until there is sufficient cost information to support a reassignment to a clinical APC. Commenters believe this period may be longer than 3 years. Commenters requested that Medicare teams collaborate to determine appropriate payment and to collect

accurate claims data for services with expiring passthrough. Commenters asked us to evaluate the effect of expiration of transitional device pass-through payment on total resources of the service before making an APC assignment.

Response: We thank the commenters for sharing their perspectives. We are considering whether changes are necessary to ensure that our payment methodologies appropriately account for services coming off of a transitional payment pathway, like new technology APCs and pass-through. We will consider the commenters' suggestions for future rulemaking.

60. Bone Mass Measurement: Biomechanical Computed Tomography (BCT) Analysis

There are five existing CPT codes (0554T, 0555T, 0556T, 0557T, and 0558T) that describe biomechanical computed tomography (BCT) analysis. These codes became effective July 1, 2019, and have not been covered by Medicare as a preventive service until recently. On May 26, 2026, CMS issued Transmittal 13752 announcing the BCT codes (when used for diagnostic purposes) are now covered by National Coverage Determination (NCD) 150.3 Bone (Mineral) Density Studies with a retroactive date of January 1, 2024. Beneficiary copays are waived with most preventive services. We received one comment.

Comment: The commenter noted that Transmittal 13752 indicated a waiver of patient copays for the BCT services, but the proposed CY 2027 Addendum B file did not indicate that the patient copays were waived.

Response: We appreciate the comment. This error has been corrected. We refer readers to the October 2027 Addendum B which can be found on the CMS website for the payment rates for these codes. This change is also reflected in the addenda to this final rule with comment period.

61. Nerve Repair Procedure (APC 5433)

CPT code 64910 (*Nerve repair; with synthetic conduit or vein allograft (eg, nerve tube), each nerve*) describes a type of nerve repair procedure with a graft. This CPT code was created by the AMA and became effective January 1, 2007. CPT code 64910 is currently assigned to

APC 5433 (Level 3 Nerve Procedures) with a status indicator of 'J1'. For CY 2027, we proposed to maintain the payment assignments for CPT code 64910.

Comment: We received one comment on this code requesting that we revise the short descriptor to read "Nerve repair w/conduit" to more accurately reflect the conduit-focused nature of the procedure.

Response: We appreciate the commenter's input; however, CPT code descriptors are owned and copyrighted by the AMA and therefore this comment is out of scope for OPPS. We refer the reader to the AMA for the process on submitting a formal CPT Code Change Application to request a descriptor revision.

62. Suggested Drug-Intensive Procedure Policy

Comment: We received two comments requesting that CMS evaluate the impact of implementing a drug-intensive procedure policy, analogous to the current device-intensive procedure policy, for ASC payment purposes. Commenters stated that this suggested drug-intensive procedure policy would allow ASC rates to accurately reflect costly drugs that are packaged into procedures, when drug cost is a large share of the procedure's cost but is not separately paid. The commenter further suggested that CMS could compute ASC rates by holding the drug portion neutral, similar to how devices are held neutral, which would maintain consistency and fairness in payment policy, preserve ASC access, and avoid site-of-service shifts driven by underpayment.

Response: We thank the commenters for this suggestion and will consider it in future rulemaking.

63. APC Specific Comments That Support the Proposed APC Assignment

Each year, in accordance with section 1833(t)(9)(A) of the Act, we review and revise the services within each APC group and the APC assignments under the OPPS. As a result of our annual review of the services and the APC assignments, we may reassign some services to another APC or maintain the current APC assignment.

Comment: Commenters supported the following proposed CY 2027 assignments for various HCPCS and CPT codes and requested that CMS finalize the payment assignments for CY 2027 as proposed.

Response: We thank the commenters for their input.

Therefore, for CY 2027, we are finalizing without modification the APCs and status indicators for the HCPCS codes listed in Table 48. The final CY 2027 payment rates for the codes listed below can be found in Addendum B to this final rule with comment period. In addition, we refer readers to Addendum D1 to this final rule with comment period for all codes reported under the OPPS. Addenda B and D1 are available via the internet on the CMS website.

TABLE 48: FINAL CY 2027 APC AND STATUS INDICATOR ASSIGNMENTS FOR VARIOUS CPT AND HCPCS CODES

HCPCS/CPT Code	Long Descriptor	Final CY 2027 SI	Final CY 2027 APC
0505T	Endovenous femoral-popliteal arterial revascularization, with transcatheter placement of intravascular stent graft(s) and closure by any method, including percutaneous or open vascular access, ultrasound guidance for vascular access when performed, all catheterization(s) and intraprocedural roadmapping and imaging guidance necessary to complete the intervention, all associated radiological supervision and interpretation, when performed, with crossing of the occlusive lesion in an extraluminal fashion	S	1580
0671T	Insertion of anterior segment aqueous drainage device into the trabecular meshwork, without external reservoir, and without concomitant cataract removal, one or more	J1	5493
0730T	Trabeculotomy by laser, including optical coherence tomography (OCT) guidance	J1	5493
0786T	Insertion or replacement of percutaneous electrode array, sacral, with integrated neurostimulator, including imaging guidance, when performed	J1	5464
0885T	Colonoscopy, flexible, with initial transendoscopic mechanical dilation (eg, nondrug-coated balloon) followed by therapeutic drug delivery by drug-coated balloon catheter for colonic stricture, including fluoroscopic guidance, when performed	J1	5331
0930T	Electrophysiologic evaluation of cardiac contractility modulation-defibrillator leads, including defibrillation-threshold evaluation (induction of arrhythmia, evaluation of sensing and therapy for arrhythmia termination), at time of initial implantation or replacement with testing of cardiac contractility modulation-defibrillator pulse generator	N	n/a
C9781	Arthroscopy, shoulder, surgical; with implantation of subacromial spacer (e.g., balloon), includes debridement (e.g., limited or extensive), subacromial decompression, acromioplasty, and biceps tenodesis when performed	J1	5115

HCPCS/CPT Code	Long Descriptor	Final CY 2027 SI	Final CY 2027 APC
G0460	Autologous platelet rich plasma or other blood-derived product for non-diabetic chronic wounds/ulcers, including as applicable phlebotomy, centrifugation or mixing, and all other preparatory procedures, administration and dressings, per treatment	T	5054
G0465	Autologous platelet rich plasma (prp) or other blood-derived product for diabetic chronic wounds/ulcers, using an fda-cleared device for this indication, (includes as applicable administration, dressings, phlebotomy, centrifugation or mixing, and all other preparatory procedures, per treatment)	T	5054
G0574	Management of new patient with dementia residing in an eligible residential care community, for use only in a medicare-approved cmmi model (services must be furnished within a patient's eligible residential care community, including assisted living facilities, board and care homes, or other qualifying residential settings where dementia care services are provided)	M	n/a
G0575	Management of established patient with dementia residing in an eligible residential care community, for use only in a medicare-approved cmmi model (services must be furnished within a patient's eligible residential care community, including assisted living facilities, board and care homes, or other qualifying residential settings where dementia care services are provided)	M	n/a
52284	Cystourethroscopy, with mechanical urethral dilation and urethral therapeutic drug delivery by drug-coated balloon catheter for urethral stricture or stenosis, male, including fluoroscopy, when performed	J1	5375
55882	Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation; with insertion of transurethral ultrasound transducer for delivery of thermal ultrasound, including suprapubic tube placement and placement of an endorectal cooling device, when performed	J1	5377
61715	Magnetic resonance image guided high intensity focused ultrasound (MRgFUS), stereotactic ablation of target, intracranial, including stereotactic navigation and frame placement, when performed	J1	5463
61885	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array	J1	5465
64568	Open implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator	S	1580
66711	Ciliary body destruction; cyclophotocoagulation, endoscopic, without concomitant removal of crystalline lens	J1	5491
66987	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; with endoscopic cyclophotocoagulation	J1	5492

HCPCS/CPT Code	Long Descriptor	Final CY 2027 SI	Final CY 2027 APC
66988	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); with endoscopic cyclophotocoagulation	J1	5492
66989	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; with insertion of intraocular (eg, trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more	J1	5493
66991	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); with insertion of intraocular (eg, trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more	J1	5493
76978	Ultrasound, targeted dynamic microbubble sonographic contrast characterization (non-cardiac); initial lesion	S	5572

IV. OPPS Payment for Devices

A. Pass-Through Payment for Devices

1. Beginning Eligibility Date for Device Pass-Through Status and Quarterly Expiration of Device Pass-Through Payments

a. Background

The intent of transitional device pass-through payment, as implemented at 42 CFR 419.66, is to facilitate access for beneficiaries to the advantages of new and truly innovative devices by allowing for adequate payment for these new devices while the necessary cost data is collected to include the costs for these devices into the procedure APC rate (66 FR 55861). Under section 1833(t)(6)(B)(iii) of the Act, OPPS transitional pass-through payment status for a device category are limited to a period of not less than 2 years but not more than 3 years.

In the CY 2017 OPPS/ASC final rule with comment period, in accordance with section 1833(t)(6)(B)(iii)(II) of the Act, we amended § 419.66(g) to provide that the pass-through eligibility period for a device category begins on the first date on which pass-through payment is made under the OPPS for any medical device described by such category (81 FR 79654). In addition, in the CY 2017 OPPS/ASC final rule with comment period, we finalized a policy to allow for quarterly expiration of pass-through payment status for devices to afford a pass-through payment period that is as close to a full 3 years as possible for all pass-through payment devices (81 FR 79655). We also established a policy to package the costs of the devices that are no longer eligible for pass-through payments into the costs of the procedures with which the devices are reported in the claims data used to set the payment rates (67 FR 66763). We refer readers to the CY 2017 OPPS/ASC final rule with comment period (81 FR 79648 through 79661) for a full discussion of the current device pass-through payment policy.[23]

b. Expiration of Transitional Pass-Through Payments for Certain Devices

[23] To apply for OPPS transitional device pass-through status, applicants complete an application that is subject to the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501 et seq.). This collection (CMS-10052) has an OMB control number of 0938-0857 and an expiration date of June 30, 2029.

As stated earlier, section 1833(t)(6)(B)(iii) of the Act requires that, under the OPPS, a category of devices be eligible for transitional pass-through payments for at least 2 years, but not more than 3 years. Currently, 21 device categories are eligible for pass-through payment. These devices are listed in Table 49, previously published as Table 29 of the CY 2027 OPPS/ASC proposed rule (91 FR 41815 through 41816), where we detail the expiration dates of pass-through payment status for each of the 21 devices currently receiving device pass-through payment.

TABLE 49: DEVICES WITH PASS-THROUGH STATUS EXPIRING IN 2026, IN 2027, IN 2028, OR IN 2029

HCPCS Code	Long Descriptor	Pass-Through Effective Date	Pass-Through Expiration Date
C1600	Catheter, transluminal intravascular lesion preparation device, bladed, sheathed (insertable)	01/01/2024	12/31/2026
C1601	Endoscope, single-use (*i.e.* disposable), pulmonary, imaging/illumination device (insertable)	01/01/2024	12/31/2026
C1602	Orthopedic/device/drug matrix/absorbable bone void filler, antimicrobial-eluting (implantable)	01/01/2024	12/31/2026
C1603	Retrieval device, insertable, laser (used to retrieve intravascular inferior vena cava filter)	01/01/2024	12/31/2026
C1604	Graft, transmural transvenous arterial bypass (implantable), with all delivery system components	01/01/2024	12/31/2026
C1605	Pacemaker, leadless, dual chamber (right atrial and right ventricular implantable components), rate-responsive, including all necessary components for implantation	07/01/2024	06/30/2027
C1606	Adapter, single-use (*i.e.* disposable), for attaching ultrasound system to upper gastrointestinal endoscope	07/01/2024	06/30/2027
C8000	Support device, extravascular, for arteriovenous fistula (implantable)	10/01/2024	09/30/2027
C1735	Catheter(s), intravascular for renal denervation, radiofrequency, including all single use system components	01/01/2025	12/31/2027
C1736	Catheter(s), intravascular for renal denervation, ultrasound, including all single use system components	01/01/2025	12/31/2027

HCPCS Code	Long Descriptor	Pass-Through Effective Date	Pass-Through Expiration Date
C1737	Joint fusion and fixation device(s), sacroiliac and pelvis, including all system components (implantable)	01/01/2025	12/31/2027
C1738	Powered, single-use (i.e. disposable) endoscopic ultrasound-guided biopsy device	01/01/2025	12/31/2027
C1739	Tissue marker, uniquely detectable and identifiable with probe/sensor, any method (implantable), with delivery system	01/01/2025	12/31/2027
C9610	Catheter, transluminal drug delivery with or without angioplasty, coronary, non-laser (insertable)	01/01/2025	12/31/2027
C1740	Leadless electrode, transmitter, battery (all implantable), for sequential left ventricular pacing	10/01/2025	09/30/2028
C1741	Anchor/screw for bone fixation, absorbable (implantable)	10/01/2025	09/30/2028
C1742	Pressure monitoring system, compartmental intramuscular (implantable), continuous, including all components (e.g., introducer, sensor), excludes mobile (wireless) software application	10/01/2025	09/30/2028
C1607	Neurostimulator, integrated (implantable), rechargeable with all implantable and external components including charging system	01/01/2026	12/31/2028
C1608	Prosthesis, total, dual mobility, first carpometacarpal joint (implantable)	01/01/2026	12/31/2028
C1743	Scaffold, endovascular non-coronary, resorbable drug eluting, with delivery system (implantable)	04/01/2026	03/31/2029
C1609	Vertebral device, motion-preserving, with screw fixation	07/01/2026	06/30/2029

2. New Device Pass-Through Applications for CY 2027

a. Background

Section 1833(t)(6) of the Act provides pass-through payments for devices, and section 1833(t)(6)(B) of the Act requires CMS to use categories to determine the eligibility of devices for pass-through payments. As part of implementing the statute through regulations, we continue to believe that pass-through payments for devices that offer substantial clinical improvement are important to ensure that hospitals can provide Medicare beneficiaries with access to the

advantages of the new technology. Conversely, we have noted that the need for additional payments for devices that offer little or no clinical improvement over previously existing devices is less apparent. In such cases, these devices can still be used by hospitals, and hospitals will be paid for them through appropriate APC payment. Moreover, a goal is to target pass-through payments for devices where cost considerations are most likely to interfere with patient access (66 FR 55852; 67 FR 66782; and 70 FR 68629).

As specified in regulations at § 419.66(b)(1) through (3), to be eligible for transitional pass-through payment under the OPPS, a device must meet the following criteria:

- If required by FDA, the device must have received FDA approval or clearance (except for a device that has received an FDA investigational device exemption (IDE) and has been classified as a Category B device by FDA), or meet another appropriate FDA exemption; and the pass-through payment application must be submitted within 3 years from the date of the initial FDA marketing authorization, if required, unless there is a documented, verifiable delay in U.S. market availability after FDA marketing authorization is granted, in which case CMS will consider the pass-through payment application if it is submitted within 3 years from the date of market availability;

- The device is determined to be reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body part, as required by section 1862(a)(1)(A) of the Act; and

- The device is an integral part of the service furnished, is used for one patient only, comes in contact with human tissue, and is surgically implanted or inserted (either permanently or temporarily), or applied in or on a wound or other skin lesion.

As finalized in CY 2026 OPPS/ASC final rule with comment period, skin substitutes with an approved Biologics License Application (BLA) will be considered under transitional drug pass-through payment status, and skin substitutes with FDA Premarket approval (PMA) or FDA 510(k) clearance will continue to be evaluated under transitional device pass-through payment

status (90 FR 53636).

In addition, according to § 419.66(b)(4), a device is not eligible to be considered for device pass-through payment if it is any of the following: (1) equipment, an instrument, apparatus, implement, or item of this type for which depreciation and financing expenses are recovered as depreciable assets as defined in Chapter 1 of the Medicare Provider Reimbursement Manual (CMS Pub. 15-1); or (2) a material or supply furnished incident to a service (for example, a suture, customized surgical kit, or clip, other than a radiological site marker).

Separately, we use the following criteria, under § 419.66(c), to determine whether a new category of pass-through payment devices should be established. The device to be included in the new category must—

- Not be appropriately described by an existing category or by any category previously in effect established for transitional pass-through payments, and was not being paid for as an outpatient service as of December 31, 1996;
- Have an average cost that is not "insignificant" relative to the payment amount for the procedure or service with which the device is associated as determined under § 419.66(d) by demonstrating: (1) the estimated average reasonable cost of devices in the category exceeds 25 percent of the applicable APC payment amount for the service related to the category of devices; (2) the estimated average reasonable cost of the devices in the category exceeds the cost of the device-related portion of the APC payment amount for the related service by at least 25 percent; and (3) the difference between the estimated average reasonable cost of the devices in the category and the portion of the APC payment amount for the device exceeds 10 percent of the APC payment amount for the related service (with the exception of brachytherapy and temperature-monitored cryoablation, which are exempt from the cost requirements as specified at § 419.66(c)(3) and (e)).

To meet the cost criterion for device pass-through payment status, a device must pass all three tests of the cost criterion for at least one APC. We generally use the lowest APC payment

rate applicable for use with the nominated device when we assess whether a device meets the cost significance criterion, thus increasing the probability the device will pass the cost significance test (69 FR 65775), and we calculate the device offset amount at the HCPCS/CPT code level (81 FR 79657); and

- Demonstrate a substantial clinical improvement, that is, the device to be included in the category has demonstrated that it will substantially improve the diagnosis or treatment of an illness or injury or improve the functioning of a malformed body part compared to the benefits of a device or devices in a previously established category or other available treatment, or, for devices for which pass-through payment status will begin on or after January 1, 2020, as an alternative pathway to demonstrating substantial clinical improvement, a device is part of the FDA's Breakthrough Devices Program and has received marketing authorization for the indication covered by the Breakthrough Device designation.

In the CY 2016 OPPS/ASC final rule with comment period, we changed our device pass-through evaluation and determination process. Device pass-through applications are still submitted to CMS through the quarterly process, but the applications are subject to notice and comment rulemaking in the next applicable OPPS annual rulemaking cycle. Under this process, all applications preliminarily approved during quarterly review will automatically be included in the next applicable OPPS annual rulemaking cycle, while applicants whose submissions are not approved during quarterly review will have the option of being included in the next applicable OPPS annual rulemaking cycle or withdrawing their application from consideration. Under this notice-and-comment process, applicants may submit new evidence, such as clinical trial results published in a peer-reviewed journal or other materials, for consideration during the public comment process for the proposed rule. This process allows those applications that we are able to determine meet all of the criteria for device pass-through payment under the quarterly review process to receive timely pass-through payment status, while still allowing for a transparent, public review process for all applications (80 FR 70417 through 70418).

In the CY 2023 OPPS/ASC final rule with comment period, we finalized our policy to publicly post online OPPS device pass-through applications received on or after March 1, 2023, beginning with the issuance of the CY 2025 OPPS/ASC proposed rule and for each OPPS rulemaking thereafter. We refer readers to the CY 2023 OPPS/ASC final rule with comment period (87 FR 71934 through 71938) for a full discussion of the policy to publicly post OPPS device pass-through applications.

In the CY 2020 OPPS/ASC final rule with comment period, we finalized an alternative pathway for devices that are granted a Breakthrough Device designation (84 FR 61295) and receive FDA marketing authorization for the indication covered by the Breakthrough Device designation. Under this alternative pathway, devices that are granted an FDA Breakthrough Device designation are not evaluated in terms of the current substantial clinical improvement criterion at § 419.66(c)(2) for the purposes of determining device pass-through payment status but do need to meet the other requirements for pass-through payment status in our regulation at § 419.66. Devices that are part of the Breakthrough Devices Program, have received FDA marketing authorization for the indication covered by the Breakthrough Devices designation, and meet the other criteria in the regulation can be approved through the quarterly process and announced through that process (81 FR 79655). Proposals regarding these devices and whether pass-through payment status should continue to apply are included in the next applicable OPPS rulemaking cycle.

As discussed in the FY 2027 IPPS/LTCH PPS proposed rule (91 FR 19457 through 19459), we proposed to repeal the alternative pathway for new technology add-on payment and OPPS device pass-through applications and require all applicants for new technology add-on payments and OPPS device pass-through payments to demonstrate that they meet the same eligibility requirements to receive add-on payments and/or pass-through payments. Specifically, we proposed that all applications received for OPPS device pass-through payment status on or after October 1, 2026, including all applications received through the remainder of the CY 2028

OPPS application cycle ending on March 1, 2027, and applications received for subsequent calendar years would have to demonstrate that the technology met the requirements currently reflected at § 419.66(c)(2)(i). OPPS device pass-through payment applications submitted as of September 30, 2026, for devices that are part of the FDA's Breakthrough Devices Program and received FDA marketing authorization for the indication covered by the Breakthrough Device designation would be evaluated and could be approved under the alternative pathway, provided that all other criteria have been met. Existing device category codes established based on the approval, either preliminary or via a final determination made in an OPPS/ASC final rule, including any device category codes established for approved alternative pathway applications received as of September 30, 2026, would continue to be eligible for device pass-through payment status and would remain in effect for at least 2 years, but no more than 3 years, consistent with § 419.66(g). Previously existing device category codes that were no longer eligible for device pass-through payment status would remain unchanged. We proposed to revise paragraph § 419.66(c)(2)(ii) to reflect this proposed policy. If finalized as proposed, the change would go into effect on October 1, 2026 (91 FR 19458).

In the FY 2027 IPPS/LTCH PPS final rule (91 FR 49767 through 49789; 91 FR 50346 through 50347), we finalized our policy, with modification, that, unless specifically exempted, all applications received for device pass-through payment status on or after October 1, 2026, including all applications received through the remainder of the CY 2028 application cycle ending on March 1, 2027, and applications received for subsequent calendar years will have to demonstrate that the technology met the requirements currently reflected at § 419.66(c)(2)(i).

We also finalized our policy that device pass-through payment applications submitted to CMS as of September 30, 2026, for devices that are part of the FDA's Breakthrough Devices Program that received FDA marketing authorization for the indication covered by the Breakthrough Device designation will be evaluated and could be approved under the alternative pathway, provided that all other criteria have been met. In addition, we finalized a limited

exception for a new device that had received FDA Breakthrough Device designation as of September 30, 2026, and has received marketing authorization for the indication covered by the Breakthrough Device designation. Such devices will remain eligible to apply for device pass-through payment under the alternative pathway, which will continue to accept applications for CYs 2028 and 2029. As such, in order to be considered for the limited exception, CMS must receive a complete application for eligible devices under the limited exception no later than March 1, 2028.

In the FY 2027 IPPS/LTCH PPS final rule, we also finalized that existing device category codes established based on the approval, either preliminary or via a final determination made in an OPPS/ASC final rule, including any device category codes established for approved alternative pathway applications received as of September 30, 2026, will continue to be eligible for device pass-through payment status and would remain in effect for at least 2 years, but no more than 3 years, consistent with § 419.66(g). We stated that previously existing device category codes that were no longer eligible for device pass-through payment status would remain unchanged.

We finalized revisions, with modifications, to paragraph § 419.66(c)(2)(ii) to reflect the finalized policy, effective October 1, 2026.

More details on the requirements for device pass-through payment applications are included on the CMS website in the application form itself at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/passthrough_payment.html*, in the "Downloads" section.

b. Applications Received for Device Pass-Through Status for CY 2027

We received 19 applications by the March 2, 2026, quarterly deadline, which was the last quarterly deadline for applications to be received in time to be included in the CY 2027 OPPS/ASC proposed rule. Of the applications, we received five in the second quarter of 2025, eight in the third quarter of 2025, one in the fourth quarter of 2025, and five in the first quarter of

2026. Six applications subsequently withdrew.

We discussed the 13 complete applications, 10 under the alternative pathway and 3 under the traditional pathway, that we received by the March 2, 2026 deadline (as set out in section IV.2.b. of CY 2027 OPPS/ASC proposed rule (91 FR 41818 through 41846)), including seven applications that were preliminarily approved for device pass-through payment status during the quarterly review process. We are addressing these 13 applications in this final rule with comment period. We do not include in this final rule with comment period the description and discussion of new device category for transitional pass-through payment status applications that were withdrawn or ineligible for CY 2027, nor do we summarize or respond to public comments received regarding these applications. We are finalizing pass-through payment status for all seven preliminary approvals in this final rule, and we are approving two additional applications.

Applications received after the March 2026 deadline for the remaining 2027 quarters (the quarters beginning June 1, September 1, and December 1 of 2026) through March 1, 2027, if any, will be discussed in the CY 2028 OPPS/ASC proposed rule. We note that the quarterly application process and requirements have not changed because of the addition of rulemaking review. Detailed instructions on submission of a quarterly device pass-through payment application are included on the CMS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/catapp.pdf*.

(1) Preliminary Approvals

Seven applications were preliminarily approved for device pass-through payment status during the quarterly review process for CY 2027: The MY01 Continuous Compartmental Pressure Monitor, RemeOs™ Screw LAG Solid, WiSE® CRT System, SetPoint System, TOUCH® CMC 1 Prosthesis, Esprit™ BTK Everolimus Eluting Resorbable Scaffold System, and TOPS™ System. We refer readers to the CY 2027 OPPS/ASC proposed rule cited in Table 50 in this section for a complete summary of each of these device pass-through applications. As discussed in section IV.2.b.1. of the CY 2027 OPPS/ASC proposed rule (91 FR 41818 through

41835), we invited public comment on whether we should finalize approval for device pass-through payment status for these seven applications.

Comment: Several commenters expressed their support for approval of device pass-through payment for one or multiple of the preliminarily approved device pass-through applications, including the MY01 Continuous Compartmental Pressure Monitor, RemeOs™ Screw LAG Solid, WiSE® CRT System, SetPoint System, TOUCH® CMC 1 Prosthesis, Esprit™ BTK Everolimus Eluting Resorbable Scaffold System, and TOPS™ System.

Response: We appreciate the commenters' input and recognize their support for the approval of the MY01 Continuous Compartmental Pressure Monitor, RemeOs™ Screw LAG Solid, WiSE® CRT System, SetPoint System, TOUCH® CMC 1 Prosthesis, Esprit™ BTK Everolimus Eluting Resorbable Scaffold System, and TOPS™ System. We have taken these comments into consideration in our final determination of pass-through payment status for the device pass-through applications.

After consideration of the public comments we received and our review of the device pass-through applications, we have determined the MY01 Continuous Compartmental Pressure Monitor, RemeOs™ Screw LAG Solid, WiSE® CRT System, SetPoint System, TOUCH® CMC 1 Prosthesis, Esprit™ BTK Everolimus Eluting Resorbable Scaffold System, and TOPS™ System meet the requirements for device pass-through status described at § 419.66. We are finalizing our approvals for device pass-through payment status for these seven applications under the alternative pathway for devices that have an FDA Breakthrough Device designation and have received FDA marketing authorization for the indication covered by the Breakthrough Device designation.

TABLE 50: FINAL STATUS FOR DEVICES PRELIMINARILY APPROVED FOR DEVICE PASS-THROUGH PAYMENT STATUS DURING THE QUARTERLY REVIEW PROCESS FOR CY 2027

Devices	CY 2027 OPPS/ASC Proposed Rule Citation	Final Status	Pass-through Effective Date
MY01 Continuous Compartmental Pressure Monitor	91 FR 41822 through 41823	Approved	10/01/2025
RemeOs™ Screw LAG Solid	91 FR 41826 through 41827	Approved	10/01/2025
WiSE® CRT System	91 FR 41832 through 41835	Approved	10/01/2025
SetPoint System	91 FR 41827 through 41827	Approved	01/01/2026
TOUCH® CMC 1 Prosthesis	91 FR 41831 through 41832	Approved	01/01/2026
Esprit™ BTK Everolimus Eluting Resorbable Scaffold System	91 FR 41820 through 41821	Approved	04/01/2026
TOPS™ System	91 FR 41820 through 41831	Approved	07/01/2026

(2) Alternative Pathway Device Pass-Through Applications

(a) Altius® Direct Electrical Nerve Stimulation System

Neuros® Medical, Inc. submitted an application for a new device category for transitional pass-through payment status for the Altius® Direct Electrical Nerve Stimulation System (the Altius® System) for CY 2027. According to the applicant, the Altius® System is an implantable neuromodulation system that provides continuous, high frequency, high amplitude nerve stimulation to either the sciatic nerve or both the tibial and common peroneal nerves by directly stimulating targeted nerves via implanted cuff electrode leads that are wrapped circumferentially around target nerves in the amputated leg. The applicant stated that the Altius® System consists of the (1) Altius® Implantable Pulse Generator (IPG), which is implanted in the abdomen; (2) Altius® Cuff Electrode Leads; (3) Altius® Battery Charger and alternating current (AC) adapter; (4) Altius® Patient Controller, which allows the patient to activate the IPG to initiate therapy; (5) Programming Wand, which is used by the provider to program and set stimulus therapy parameters; and (6) Programmer Application Personal Computer (PAPC), which includes physician programming software. The applicant is seeking a new device category for transitional pass-through payment status for only the Altius® IPG and the Altius® Cuff Electrode Lead components of the Altius® System. The applicant stated that the Altius® IPG is a rechargeable neurotransmitter device that is implanted in the abdomen and when activated, generates a

continuous high frequency, high amplitude alternating current electrical stimulus (5kHz and 10kHz) via the Altius® Cuff Electrode Leads, which are circumferentially wrapped, anchored, and implanted around the nerve(s). Per the applicant, the "alternating" nature of the delivered electrical stimulus refers to the direct electrical stimulation of the circumferential electrodes within a lead distributed in an alternating fashion across these electrodes.

Table 51 provides an overview of the transitional device pass-through payment status application for the Altius® System and CMS's preliminary assessment. For additional details provided by the applicant, please refer to the online application posting available at *https://mearis.cms.gov/public/publications/device-ptp/DEP250530FMCYD*.

TABLE 51: ALTIUS® SYSTEM APPLICATION OVERVIEW

Device Pass-through Criteria	Applicant Statements	Preliminary CMS Assessment
Newness Criterion	*FDA Marketing Authorization:* PMA approval - August 26, 2024 *Application submitted to CMS:* May 30, 2025	No concerns.
Breakthrough Device Designation	*FDA Indication:* Altius® System is an aid in the management of chronic intractable phantom and residual lower limb post-amputation pain in adult amputees. *Breakthrough Device designation:* Altius® System is an aid in the management of chronic intractable pain of the lower limb of adult amputees. This device received FDA Breakthrough Device designation under the trade name Altius® High Frequency Nerve Block System. The trade name was later updated to the Altius® Direct Electrical Nerve Stimulation System.	No concerns.
§ 419.66(b)(3)	Device is integral, used for one patient only, comes in contact with human tissue, and is surgically implanted.	No concerns.
§ 419.66(b)(4)	Device is not equipment, an instrument, apparatus, implement, or item of this type for which depreciation and financing expenses are recovered as depreciable assets, and is not a material or supply furnished incident to a service.	No concerns.
Device Category	Device category codes C1822 (Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system), C1778 (Lead, neurostimulator (implantable)), C1767 (Generator, neurostimulator (implantable), non-rechargeable), C1787 (Patient programmer, neurostimulator), C1816 (Receiver and/or transmitter, neurostimulator (implantable)), C1820 (Generator, neurostimulator (implantable), with rechargeable battery and charging system), C1823 (Generator, neurostimulator (implantable), non-rechargeable, with transvenous sensing and stimulation leads), C1825 (Generator, neurostimulator (implantable), non-rechargeable, with carotid sinus baroreceptor stimulation lead(s)), C1826 (Generator, neurostimulator (implantable), includes closed feedback loop leads and all implantable components, with rechargeable battery and charging system), C1827 (Generator, neurostimulator (implantable), non-rechargeable, with implantable stimulation lead and external paired stimulation controller), and	See following discussion.

	C1883 (Adapter/extension, pacing lead or neurostimulator lead (implantable) do not describe the device.	
Cost Criteria	The cost for eligible device components of Altius® System (the Altius® IPG and Altius® Cuff Electrode Lead(s)) is $41,000.00 or $52,000.00, depending on whether the patient requires one or two cuff electrodes.[1] The cost of the Altius® IPG is $30,000.00 and the cost of each Altius® Cuff Electrode Lead is $11,000.00. For cost significance requirements:[2] HCPCS code: 64575 APC code: 5463 CY 2026 device offset amount: $7,697.89 CY 2026 APC payment rate: $11,384.04 The Altius® IPG with one Altius® Cuff Electrode Lead: Requirement #1: ($41,000.00 / $11,384.04) x 100 = 360.15%. Requirement #2: ($41,000.00 / $7,697.89) x 100 = 532.61% Requirement #3: (($41,000.00 - $7,697.89) / $11,384.04) x 100 = 292.53% The Altius® IPG with two Altius® Cuff Electrode Leads: Requirement #1: ($52,000.00 / $11,384.04) x 100 = 456.78%. Requirement #2: ($52,000.00 / $7,697.89) x 100 = 675.51% Requirement #3: (($52,000.00 - $7,697.89) / $11,384.04) x 100 = 389.16%	No concerns.

1. The applicant conducted cost calculations for both the Altius® IPG with one Altius® Cuff Electrode Lead ($41,000.00) and the Altius® IPG with two Altius® Cuff Electrode Leads ($52,000.00). We considered both costs as the estimated reasonable cost to assess whether the Altius® System meets the cost significance requirements.
2. For its cost calculations, the applicant selected HCPCS code 64590 in APC 5464 and based its calculations on CY 2026 data. As we explained in the CY 2005 OPPS final rule with comment period (69 FR 65775), we generally use the lowest APC payment rate applicable for use with the nominated device when we assess whether a device meets the cost significance criterion, thus increasing the probability the device will pass the cost significance test. Beginning in CY 2017, we calculate the device offset amount at the HCPCS/CPT code level instead of the APC level (81 FR 79657). For our calculations, we used APC 5463, which we believe has the lowest applicable APC payment rate ($11,384.04) related to the HCPCS codes provided by the applicant, and HCPCS code 64575 in APC 5463, which has a device offset amount of $7,697.89, at the time the application was received. Based on our initial assessment for the CY 2027 OPPS/ASC proposed rule, we stated using the APC payment rate of $11,384.04 and the device offset amount of $7,697.89 would result in the Altius® System meeting the cost significance requirements.

We invited public comment on whether the Altius® System meets the newness criterion at § 419.66(b)(1) and whether the Altius® IPG and the Altius® Cuff Electrode Lead components meet the eligibility criteria at § 419.66(b)(3) and (4).

We did not receive public comments regarding whether the Altius® System meets the newness criterion at § 419.66(b)(1) or whether the Altius® IPG and the Altius® Cuff Electrode Lead components meet the eligibility criteria at § 419.66(b)(3) and (4).

We received the application for device pass-through payment status for the Altius® System within 3 years of the date of FDA PMA approval. Based on our review of the

application, we have determined that the Altius® System meets the newness criterion at § 419.66(b)(1) and that the Altius® IPG and the Altius® Cuff Electrode Lead components meet the eligibility criteria at § 419.66(b)(3) and (4).

In the CY 2027 OPPS/ASC proposed rule, we noted regarding the device category eligibility criterion at § 419.66(c)(1), with respect to the Altius® IPG and Altius® Cuff Electrode Lead components, that the applicant stated that no existing (current or previous) device pass-through payment categories appropriately describe the nominated device components. Per the applicant, the existing pass-through codes C1778 (Lead, neurostimulator (implantable)) and C1822 (Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system) do not describe the Altius® IPG and the Altius® Cuff Electrode Lead components because these codes (1) are not specifically indicated for treating chronic intractable lower limb amputation pain; (2) are not capable of delivering continuous, high amplitude, high frequency alternating current; (3) do not use circumferentially wrapped and anchored cuff electrode leads to provide direct energy delivery to the targeted nerves; and (4) do not allow for physician-pre-programmed therapy delivery controlled by the patient using the patient stimulation controller. The applicant also stated that devices described by C1778 do not make direct contact with the target nerve; instead, they deliver stimulation to the general region of the pain, unlike the Altius® Cuff Electrode Leads. The applicant added that existing devices described by C1822 deliver low-amplitude, rectangular pulses per second to general or peripheral areas to increase nerve activity and produce pain relief, whereas the Altius® IPG provides continuous, high-amplitude sinusoidal waveform stimulation to decrease target nerve activity and produce on-demand pain relief. The applicant stated that the Altius® System, including the Altius® IPG and Altius® Cuff Electrode Lead components, is the only FDA-authorized neuromodulation system indicated as an aid in the management of chronic intractable phantom and residual lower limb post-amputation pain in adult amputees.

Based on the description the applicant provided, we stated that the Altius® IPG is a

rechargeable neurotransmitter device that generates a continuous high frequency, high amplitude alternating electrical stimulus (5kHz and 10kHz) via the Altius® Cuff Electrode Leads, which are circumferentially wrapped, anchored, and implanted around the nerve(s), and therefore, could be appropriately described by C1778 (Lead, neurostimulator (implantable)) and C1822 (Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system), respectively. Specifically, we stated our belief that the pass-through payment category C1778 may appropriately describe the Altius® Cuff Electrode Lead component because the pass-through payment category describes any device that is an implantable neurostimulator lead. Additionally, we stated our belief that the pass-through payment category C1822 may appropriately describe the Altius® IPG because the category includes implantable neurostimulator pulse generators that deliver high-frequency stimulation (including approximately 10 kHz) and are rechargeable using an external charging system. Further, we stated that C1822 does not describe the amplitude, pulse frequency, or waveform of the stimulation generated by the device. We noted that CMS does not establish pass-through device categories for the purpose of describing specific devices, but rather, device categories are intended to encompass all devices that can be appropriately described by a category. In this context, we stated that we believed that the Altius® IPG and the Altius® Cuff Electrode Lead components may be appropriately described by C1778 and C1822. We also stated that, after reviewing the information provided by the applicant, we were unable to determine that the Altius® System, inclusive of the Altius® IPG and the Altius® Cuff Electrode Lead components, meets the device category eligibility criteria, and therefore, we proposed to deny transitional pass-through payment status for CY 2027.

We invited public comment on whether the Altius® IPG and the Altius® Cuff Electrode Lead components meet the device category eligibility criterion at § 419.66(c)(1). We also invited public comments on our proposal to deny transitional pass-through payment status for the Altius® System, inclusive of the Altius® IPG and the Altius® Cuff Electrode Lead components

for CY 2027.

Comment: A few commenters expressed their support for the denial of device pass-through payment for the Altius® System, stating that the nominated device does not meet all the criteria needed to qualify for transitional pass-through payment.

Response: We appreciate the commenters' input. We have taken these comments into consideration in our final determination for pass-through payment status for the Altius® System.

Comment: The applicant and many commenters requested that CMS approve device pass-through payment for the Altius® System. The applicant and these commenters stated that denying pass-through payment for the Altius® System would create major financial barriers for hospitals and surgical centers, resulting in fewer offering the device, and therefore, limiting Medicare patients' access to a proven, non-opioid treatment for severe post-amputation pain. In addition, the applicant and commenters stated that the Altius® System offers a meaningful safety and quality-of-life benefit, as well as directly supporting CMS and the broader public health system's ongoing priorities to expand non-opioid pain therapies.

The applicant and commenters stated that they believe there are no existing device categories or categories previously in effect that appropriately describe the Altius® System. In response to our concerns that the Altius® IPG and the Altius® Cuff Electrode Lead components may be appropriately described by C1778 and C1822, the applicant and commenters stated that, in the proposed rule, CMS misclassified the Altius® System under C codes for legacy spinal cord stimulation (SCS) and peripheral nerve stimulation (PNS) devices, specifically C1778 (Lead, neurostimulator implantable) and C1822 (generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system). The applicant and commenters stated that neither C1778 and C1822, nor any existing neurostimulator codes, adequately describe the Altius® System because it is a fundamentally new type of device. The applicant and commenters reiterated that the Altius® System is an FDA Breakthrough-designated therapy engineered specifically to deliver an on-demand, high-frequency, high-amplitude alternating

current and circumferential electric nerve conduction block.

The applicant and several commenters stated that the Altius® System represents a distinct technology class defined by a unique mechanism of action (neurostimulation that results in a complete electrical nerve block), a unique electrode design (360° circumferential cuff surgically wrapped around the sciatic nerve or its main branches through a dedicated open surgical implant), and a unique energy delivery profile (high blocking amplitude in a continuous alternating current (5-10k Hz) in 30 minute). The applicant and commenters compared the Altius® System's mechanism of action to that of legacy SCS and PNS devices which rely on percutaneous leads placed near a nerve that stimulate the nerve at a low amplitude and frequency (10-100 Hz) in discrete pulses using a field effect to produce paresthesia intended to mask pain. The applicant and commenters stated that paresthesia cannot override the constant, high-frequency ectopic firing of a damaged peripheral neuroma, eventually rendering these legacy devices ineffective. The applicant and commenters stated that the Altius® System deadens nerve endings in a completely different way than current peripheral and spinal cord stimulators, and, as a result, no existing device categories describe the nominated device and its novel therapy. The applicant and commenters further explained that implanting the Altius® Cuff Electrode Lead, a full circumferential cuff, requires an open surgical procedure under general anesthesia in an ambulatory surgical center or hospital outpatient department, rather than the quick needle-based placement used for standard leads done in office.

In addition, the applicant stated that existing OPPS Ambulatory Payment Classifications (APCs) for general neurostimulators reflect low-cost, percutaneously-inserted needle lead systems and do not cover the additional expenses associated with the Altius® System. The applicant stated that, by stating C1822 appropriately describes the Altius® IPG, CMS is equating high-frequency spinal cord generators that deliver low-amplitude pulsed direct current into the epidural space to alter central gating without blocking nerve conduction with the Altius® IPG's high-amplitude alternating current generator that produces a true peripheral nerve conduction

block. According to the applicant, by stating that C1778 appropriately describes the Altius® Cuff Electrode Lead components, CMS is also equating percutaneous lead wires place adjacent to tissues with the Altius® Cuff Electrode Lead's 360-degree cuff electrode that is surgically wrapped around the sciatic nerve. The applicant concluded that grouping the Altius® IPG and the Altius® Cuff Electrode Lead components under legacy SCS and PNS codes (C1822 and C1778) mischaracterizes the Altius® System's physics, biology, and clinical reality. The applicant further suggested that CMS create the following new device category code that would appropriately describe the Altius® System: neurostimulator system, peripheral, circumferential nerve block, includes an implanted rechargeable pulse generator (high frequency, high amplitude, alternating current), implanted cuff electrode(s) (wrapped around nerve), and patient controller.

Another commenter stated that the existing HCPCS device categories, including C1778 and C1822 appropriately describe the Altius® System and its components. The commenter stated that, as CMS noted, C1822 does not describe a specific amplitude, pulse frequency, or waveform generated by a device. The commenter stated that rather, HCPCS device categories are intended to encompass all devices that share the relevant functional and technological characteristics, not to distinguish among individual products based on proprietary design features. Further, the commenter stated that the Altius® System's lead design does not appear to be sufficiently unique to warrant creation of a new device category. Per the commenter, other commercially available neurostimulation systems utilize leads that wrap around and anchor to a target nerve. The commenter stated, for example, that LivaNova's VNS Therapy™ System employs a helical lead that coils around the vagus nerve and is secured in place, demonstrating that circumferential nerve-wrapping lead designs are already present in the market and can be appropriately accommodated within existing neurostimulator lead categories. The commenter concluded that distinctions resting on a device's approved indication, electrode geometry, stimulation parameters, control interface, or the physiologic direction of its effect do not identify anything

absent from the current HCPCS framework nor is the analysis altered by Breakthrough Device Designation, which affects only the requirement to demonstrate substantial clinical improvement and does not displace the pass-through requirement at § 419.66(c)(1).

Response: We appreciate the applicant's and commenters' input. After consideration of the public comments we received and further review of the application, we agree with the applicant that there is no existing device category, or category previously in effect, that appropriately describes a neurostimulator system that uses high-frequency, alternating current.

In the proposed rule, we also invited public comment on whether the Altius® IPG and the Altius® Cuff Electrode Lead components meet the cost criterion at § 419.66(d).

We did not receive any comments regarding whether the Altius® IPG and the Altius® Cuff Electrode Lead components meet the cost significance criteria as described at § 419.66(d). Based on our findings from the first, second, and third cost significant tests, we continue to believe the Altius® IPG and the Altius® Cuff Electrode Lead components meet the cost significance criteria specified at § 419.66(d).

After consideration of the public comments we received and our review of the device pass-through application, we have determined that the Altius® System, inclusive of the Altius® IPG and the Altius® Cuff Electrode Lead components, meets the requirements for device pass-through status described at § 419.66. Therefore, we are approving the Altius® System for device pass-through payment status effective January 1, 2027, under the alternative pathway for devices that have an FDA Breakthrough Device designation and FDA marketing authorization for the indication covered by the Breakthrough Device designation.

(b) ProSense® Cryoablation System

IceCure™ Medical Ltd. submitted an application for a new device category for transitional pass-through payment status for the ProSense® Cryoablation System for CY 2027. According to the applicant, the ProSense® Cryoablation System is designed to destroy tissue by the application of extreme cold temperatures utilizing liquid nitrogen for the treatment of breast

cancer for patients with low-risk tumors. The applicant stated that the ProSense® Cryoablation System is comprised of (1) the ProSense® Chassis, (2) an adjustable touch screen, and (3) external accessories, including introducers, liquid nitrogen dewar, holder, foot pedal, and Prosense® Cryoprobes. The applicant is seeking a new device category for transitional pass-through payment status for only the ProSense® Cryoprobe component of the ProSense® Cryoablation System. Per the applicant, the ProSense® Cryoprobe is a rigid probe with a tip that creates ice balls to destroy target tissue through cycles of freezing and thawing.

Table 52 provides an overview of the transitional pass-through payment status application for the ProSense® Cryoablation System and CMS's preliminary assessment. For additional details provided by the applicant, please refer to the online application posting available at *https://mearis.cms.gov/public/publications/device-ptp/DEP251226K6A1C*.

TABLE 52: PROSENSE® CRYOABLATION SYSTEM APPLICATION OVERVIEW

Device Pass-through Criteria	Applicant Statements	Preliminary CMS Assessment
Newness Criterion	*FDA Marketing Authorization:* De Novo authorization - October 3, 2025 *Application submitted to CMS:* December 26, 2025	See following discussion.
Breakthrough Device Designation	*FDA Indication:* The ProSense® Cryoablation System is indicated for the local treatment of breast cancer in patients ≥70 years of age with biologically low-risk tumors ≤1.5 cm in size and treated with adjuvant endocrine therapy, including patients not suitable for surgery for breast cancer treatment. Biologically low-risk breast cancer is defined as unifocal tumor, size ≤1.5 cm, estrogen receptor (ER)-positive, progesterone receptor (PR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, Ki-67<15%, and/or genomic testing indicative of low-risk breast cancer, infiltrating ductal carcinoma (excluding lobular carcinoma, extensive intraductal component, or evidence of lymphovascular invasion), and clinically negative lymph node (N0). *Breakthrough Device designation:* The IceCure ProSense® Cryoablation System is intended for cryogenic destruction of tissue during surgical procedures by the application of extreme cold temperatures. It is indicated for use as a cryosurgical tool in the fields of general surgery, dermatology, neurology (including cryoanalgesia), thoracic surgery, ear, nose, and throat (ENT), gynecology, oncology, proctology, and urology. The system is designed to destroy tissue by the application of extreme cold temperatures including breast cancer, prostate and kidney tissue, liver metastases, tumors, skin lesions, and warts. The system has the following specific indications: • Urology (ablate prostate tissue in cases of prostate cancer and benign prostatic hyperplasia (BPH).	No concerns.

	• Oncology (ablation of cancerous or malignant tissue and benign tumors and palliative intervention). • Dermatology (ablation or freezing of skin cancers and other cutaneous disorders. Palliation of tumors of the skin. Destruction of warts or lesions). • Gynecology (ablation of malignant neoplasia or benign dysplasia of the female genitalia). ENT (Palliation of tumors of the oral cavity and ablation of leukoplakia of the mouth). General Surgery (ablation of leukoplakia of mouth, angiomas, sebaceous hyperplasia, basal cell tumors of the eyelid or canthus area, ulcerated basal cell tumors, dermatofibromas, small hemangiomas, mucocele cysts, multiple warts, plantar warts, hemorrhoids, anal fissures, perianal condylomata, pilonidal cysts actinic and seborrheic keratoses, cavernous hemangiomas, recurrent cancerous lesions. • Palliation of tumors of the rectum, hemorrhoids, anal fissures, pilonidal cysts, and recurrent cancerous lesions. Destruction of warts or lesions. Palliation of tumors of the oral cavity, rectum, and skin). • Thoracic Surgery (ablation of arrhythmic cardiac tissue and cancerous lesions). • Proctology (ablation of benign or malignant growths of the anus and rectum and hemorrhoids). • Breast Cancer: The ProSense® is indicated for use in the treatment of patients with T1 invasive breast cancer and/or patients not suitable for surgical alternatives for the treatment of breast cancer.	
§ 419.66(b)(3)	Device is single-use, is an integral part of the cryoablation procedure, is used in one patient only, is surgically inserted, and comes into contact with human tissue.	No concerns.
§ 419.66(b)(4)	Device is not equipment for which depreciation and financing expenses are recovered as depreciable assets and is not a supply furnished incident to the service.	No concerns.
Device Category	Device category code C2618 (Probe, cryoablation) does not describe the ProSense® Cryoprobe.	See following discussion.
Cost Criteria	The cost of the ProSense® Cryoprobe is $2,550.00. For cost significance requirements: HCPCS code: 0581T APC code: 5091 CY 2025 device offset amount: $1,816.99 CY 2025 APC payment rate: $3,829.28 Requirement #1: ($2,550.00 / $3,829.28) x 100 = 66.59%. Requirement #2: ($2,550.00/ $1,816.99) x 100 = 140.34%. Requirement #3: (($2,550.00 - $1,816.99) / $3,829.28) x 100 = 19.14%.	No concerns.

We stated in the CY 2027 OPPS/ASC proposed rule that, as stated previously, with respect to the newness criterion at § 419.66(b)(1), the device must have received FDA approval or clearance (that is, FDA marketing authorization), and the pass-through payment application must be submitted within 3 years from the date of the initial FDA marketing authorization. We noted that in the CY 2016 OPPS/ASC final rule with comment period, we clarified that we

intended to convey that the 3-year timeframe for submitting a device pass-through payment application would be triggered by the initial FDA approval or clearance, and not by any subsequent FDA approvals or clearances. We specified "initial" FDA clearance or approval in § 419.66(b)(1) because, in some cases, FDA will provide supplemental approvals or new clearances for a device lineage after the initial approval or clearance (80 FR 70420). We further stated in the proposed rule that we received a pass-through payment status application for the ProSense® Cryoablation System on December 26, 2025, which we did not believe was within 3 years of the initial FDA marketing authorization.

We also stated in the proposed rule (91 FR 41825) that the ProSense® Cryoablation System, inclusive of the ProSense® Cryoprobe, was previously cleared on December 20, 2019, in K183213, the 510(k) clearance for the IceCure Family Cryoablation System (IceSense™3, ProSense®, MultiSense).[24] We also noted that the predicate device described in K183213, the IceSense™3 System, was previously cleared on November 29, 2010, in K102360,[25] and the preceding predicate device, the Galil Medical SeedNet Family, was cleared on November 18, 2005, in K052530.[26] We noted that according to K183213, cryoablation is the fundamental technological principle for both the subject IceCure Family of cryotherapy devices and the predicate IceSense™3 System cleared in K102360 and the Galil Medical SeedNet Family cleared in K052530. Finally, we noted that according to K183213, the ProSense® Cryoablation System is a mere rebranding of the cleared IceSense™3 single-probe system cleared in K102360, and the ProSense® Cryoablation System has the same hardware and software components as the IceSense™3 System. We also noted that per K183213, the hardware and

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[24] U.S. Food and Drug Administration. (2019, December 20). *Decision Summary for K183213 [IceCure Family Cryoablation System (IceSense™3, ProSense®, MultiSense)]*. U.S. Department of Health and Human Services. *https://www.accessdata.fda.gov/cdrh_docs/pdf18/K183213.pdf.*

[25] U.S. Food and Drug Administration. (2010, November 29). *510(k) Summary for K102360 [IceCure's IceSense™3 device]*. U.S. Department of Health and Human Services. *https://www.accessdata.fda.gov/cdrh_docs/pdf10/K102360.pdf.*

[26] U.S. Food and Drug Administration. (2005, November 18). *510(k) Summary for K052530 [SeedNet Family]*. U.S. Department of Health and Human Services. *https://www.accessdata.fda.gov/cdrh_docs/pdf5/K052530.pdf.*

software changes introduced since the device was originally cleared on November 29, 2010, in K102360, were analyzed and determined not to require new 510(k) premarket notifications and that the K183213 submission includes the current configuration of the system.

We noted in the CY 2027 OPPS/ASC proposed rule that the October 3, 2025, FDA decision summary for De Novo classification for the ProSense® Cryoablation System includes a new indication for use in the treatment of patients with T1 invasive breast cancer and/or patients not suitable for surgical alternatives for the treatment of breast cancer. We stated that based on the information in K183213, we believed that the initial FDA marketing authorization date for the ProSense® Cryoablation System, inclusive of the nominated ProSense® Cryoprobe component, may be as early as November 18, 2005, or as recent as December 20, 2019. We stated that the applicant submitted the pass-through payment application on December 26, 2025, which was more than 3 years after either November 18, 2005, or December 20, 2019; therefore, we stated we did not believe that the ProSense® Cryoablation System, inclusive of the nominated ProSense® Cryoprobe, meets the newness criterion.

We invited public comment on whether the ProSense® Cryoablation System meets the newness criterion at § 419.66(b)(1).

Comment: A commenter expressed its support for the denial of device pass-through payment for the ProSense® Cryoablation System.

Response: We appreciate the commenter's input.

Comment: The applicant submitted a public comment in support of device pass-through payments for the ProSense® Cryoablation System, noting that the nominated device meets all the transitional device pass-through payment criteria. The applicant also stated that transitional pass-through payment is intended to reduce financial disincentives and for new technology to be adopted so that it provides a substantial clinical improvement to Medicare beneficiaries. The applicant stated that the population for which FDA authorized the ProSense® Cryoablation System is primarily the Medicare population, and without transitional pass-through payment,

hospitals face a disincentive to adopt the only FDA-authorized, non-surgical local treatment for low-risk breast cancer, particularly for women for whom surgery is an unsuitable option. In addition, the applicant stated that CMS establishing a device category effective January 1, 2027, would allow Medicare beneficiaries access to the ProSense® Cryoablation System while hospitals are making adoption decisions.

With respect to the newness criterion at § 419.66(b)(1), the applicant requested that CMS recognize October 3, 2025, as the initial date of FDA marketing authorization and the beginning of the newness period for the ProSense® Cryoablation System. The applicant reiterated that FDA granted the ProSense® Cryoablation System De Novo classification on October 3, 2025, and maintained that this is the initial date of FDA authorization for purposes of device pass-through payment status. The applicant also noted that it submitted its application for transitional pass-through payment on December 26, 2025, within three years of this date. The applicant stated that FDA classified the ProSense® Cryoablation System as a new generic device type under a newly created classification regulation (21 CFR 878.4355): cryoablation device for local treatment of low-risk breast cancer. The applicant added that FDA assigned this device type a new product code, QXW (DEN220077), consistent with section 513(f)(2) of the Federal Food, Drug, and Cosmetic Act which states that the classification shall be the initial classification of the device.

According to the applicant, federal regulations (21 CFR 860.200(a)) state that the purpose of the De Novo process is to classify devices for which there is no legally marketed device on which to base a review of substantial equivalence. The applicant stated that because FDA granted the ProSense® Cryoablation System De Novo authorization, rather than 510(k) clearance, FDA has already determined that there is no legally marketed predicate device for the nominated device. The applicant further stated that FDA's De Novo order created a device type, a classification regulation, and a product code that did not previously exist, and it imposed special controls, including a 400-patient, 30-site post-market surveillance study, that apply to no

prior cryoablation clearance. Additionally, the applicant stated that it is inappropriate for CMS to extrapolate to previous 510(k) devices when FDA has already determined that the device qualifies for De Novo classification. The applicant concluded that CMS should use October 3, 2025, as the initial date of FDA marketing authorization, and recognize that the ProSense® Cryoablation System meets the criteria for the transitional pass-through payment.

Response: We appreciate the applicant's input. After consideration of the public comments we received and our review of the application, we continue to believe that the ProSense® Cryoablation System, including the nominated Prosense® Cryoprobe, received FDA marketing authorization prior to the October 3, 2025 De Novo classification. As previously discussed, the current ProSense® Cryoablation System was included in K183213, cleared on December 20, 2019, and that clearance identified the previously cleared IceSense™3 System in K102360 as its predicate. As we stated in the proposed rule, in the K183213 clearance, FDA stated that the ProSense® Cryoablation System is a rebranding of the IceSense™3 single-probe system in K102360, with the same hardware and software components. Additionally, FDA stated that it analyzed and determined that the hardware and software changes introduced since the IceSense™3 System clearance on November 29, 2010 did not require new 510(k) premarket notifications. The current system and cryoablation technology are traceable through FDA clearances issued on November 18, 2005 (K052530), November 29, 2010 (K102360), and December 20, 2019 (K183213). Therefore, the ProSense® Cryoablation System does not meet the newness criterion described at § 419.66(b)(1) because we received the ProSense® Cryoablation System application for device pass-through payment on December 26, 2025, which is not within 3 years of these prior FDA marketing authorizations.

While the applicant stated that the ProSense® Cryoablation System De Novo classification on October 3, 2025 established a new device type, classification regulation, and product code, and that FDA's order states that the classification is the initial classification of the device, it appears that this De Novo authorization established a new FDA classification for the

device when used for the treatment of certain patients with low-risk breast cancer. Therefore, it does not constitute the initial FDA marketing authorization of this device technology for the purposes of § 419.66(b)(1), because this device technology, including the nominated cryoprobe, had previously received FDA marketing authorization with different indications for use. Although we recognize FDA's regulatory responsibility for determining the appropriate pathway for marketing authorization, CMS applies the requirements at § 419.66(b)(1) in determining whether a device technology meets the newness criterion for device pass-through payment, which does not depend on the type of FDA marketing authorization.

Because we have not received information demonstrating that the device itself is sufficiently different from the previously cleared ProSense® Cryoablation System such that October 3, 2025 should not be considered its initial FDA marketing authorization for purposes of § 419.66(b)(1), we continue to believe that the October 3, 2025, De Novo classification does not restart the newness period.

After consideration of the public comments we received and our review of the application, the ProSense® Cryoablation System does not meet the newness criterion to be considered for device pass-through payment. Therefore, in this final rule with comment period, we will not address whether the technology meets the remaining criteria required for device pass-through payment. We are not approving the ProSense® Cryoablation System for device pass-through payment status for CY 2027 because the technology does not meet the newness criterion at § 419.66(b)(1).

(c) TIDAL™ Fusion Cage System (Ossera™ AFX)

Restor3d submitted an application for a new device category for transitional pass-through payment status for the TIDAL™ Fusion Cage System for CY 2027. According to the applicant, the TIDAL™ Fusion Cage is a single, continuous, porous piece of titanium alloy containing a circular window for an intramedullary nail used during salvage procedures to restore bone length due to bone void, absent bone or surgical resection. The TIDAL™ Fusion Cage System is

composed of the TIDAL™ Fusion Cage and a Disposable Instrument Kit, which includes size trials, cannulated reamers, and inserters. The applicant stated that the TIDAL™ Fusion System is not for standalone use and is intended for use as an accessory to the DynaNail® TTC Fusion System and with an autograft and/or allogenic bone graft.

Table 53 provides an overview of the device category for transitional pass-through payment status application for TIDAL™ Fusion Cage System and CMS's preliminary assessment. For additional details provided by the applicant, please refer to the online application posting available at *https://mearis.cms.gov/public/publications/device-ptp/DEP250529B0B27.*

TABLE 53: TIDAL™ FUSION CAGE SYSTEM APPLICATION OVERVIEW

Device Pass-through Criteria	Applicant Statements	Preliminary CMS Assessment
Newness Criterion	*FDA Marketing Authorization:* 510(k) clearance - March 24, 2025 *Application submitted to CMS:* May 29, 2025	No concerns.
Breakthrough Device Designation	*FDA Indication:* The TIDAL™ Fusion Cage System is intended for use as part of a tibiotalocalcaneal fusion construct in a salvage procedure following failed ankle arthrodesis or failed ankle arthroplasty for patients at risk of limb loss. The TIDAL™ Fusion Cage System is intended for use as an accessory to the DynaNail® TTC Fusion System. The TIDAL™ Fusion Cage System is not intended for standalone use. The TIDAL™ Fusion Cage System is intended for use with autograft and/or allogenic bone graft. *Breakthrough Device designation:* The restor3d Fusion Cage System is intended for tibiotalocalcaneal arthrodesis (fusion) to provide stabilization of the hindfoot and ankle with critical size bone defect, in lieu of bulk allograft in procedures such as: post-traumatic and degenerative arthritis; post-traumatic or primary arthrosis involving both ankle and subtalar joints; revision after failed ankle arthrodesis with subtalar involvement; failed total ankle arthroplasty; non-union ankle arthrodesis; rheumatoid hindfoot; talectomy; avascular necrosis of the talus; neuroarthropathy; neuromuscular disease and severe deformity; osteoarthritis; Charcot foot; and previously infected arthrosis, second degree. The restor3d Fusion Cage System is intended to provide stabilization in long bones of skeletally mature patients, including tibia, femur and humerus, in the presence of critical sized bone defects in lieu of bulk allograft, bone transport or other treatment for segmental defects in procedures such as: stabilization of fractures of the diaphyseal or metaphyseal regions of long bones; malunions and nonunion; osteomyelitis; and periprosthetic fractures. Note: FDA granted Breakthrough Device designation to this device under the trade name restor3d Fusion Cage System, which the applicant later changed to TIDAL™ Fusion Cage System (Ossera™ AFX).	See following discussion.

§ 419.66(b)(3)	Device is integral to the service furnished, used for one patient only, comes in contact with human tissue, and is surgically implanted into the ankle joint for permanent implantation.	No concerns.
§ 419.66(b)(4)	Device is not equipment, an instrument, apparatus, implement, or item of this type for which depreciation and financing expenses are recovered as depreciable assets, and is not a material or supply furnished incident to a service.	No concerns.
Device Category	Device category codes C1776 (Joint device (implantable)) and C1713 (Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)) do not describe the device.	See following discussion.
Cost Criteria	The TIDAL™ Fusion Cage System's total device cost is $32,995.00, consisting of a Fusion Cage ($27,995.00) and a Disposable Instrument Kit ($5,000.00). For cost significance requirements: HCPCS code: 27871 APC code: 5115 CY 2026 device offset amount: $5,973.37 CY 2026 APC payment rate: $13,116.76 Requirement #1: ($27,995 / $13,116.76) x 100 = 213.43%. Requirement #2: ($27,995 / $5,973.37) x 100 = 468.66%. Requirement #3: (($27,995 - $5,973.37) / $13,116.76) x 100 = 167.89%.	See following discussion.

Regarding the Breakthrough Device designation, we noted in the CY 2027 OPPS/ASC proposed rule that restor3d submitted a new technology add-on payment application for FY 2026 for the TIDAL™ Fusion Cage under the alternative pathway, as discussed in the FY 2026 IPPS/LTCH PPS proposed and final rules (90 FR 18200 through 18202; 36817 through 36819). In that final rule, we stated that because the Disposable Instrument Kit was not included in the Breakthrough Device designation, only the TIDAL™ Fusion Cage was eligible for new technology add-on payments under the alternative pathway. We stated, consistent with our decision regarding new technology add-on payment eligibility, we would not consider the Disposable Instrument Kit for transitional pass-through payment status under the alternative pathway because it is not included in the Breakthrough Device designation. We further noted that we would only be discussing the TIDAL™ Fusion Cage in the following paragraphs.

We invited public comment on whether the TIDAL™ Fusion Cage meets the newness criterion at § 419.66(b)(1).

Comment: The applicant submitted a public comment regarding the newness criterion at § 419.66(b)(1) and confirmed that only the TIDAL™ Fusion Cage received both Breakthrough

Device designation and marketing authorization from FDA and reiterated that the TIDAL™ Fusion Cage meets the newness requirement for device pass-through payment.

Response: We appreciate the applicant's input. We received the application for device pass-through payment status for the TIDAL™ Fusion Cage within 3 years of the date of FDA 510(k) clearance. After consideration of the public comments we received and our review of the application, we have determined that the TIDAL™ Fusion Cage meets the newness criterion at § 419.66(b)(1).

In the proposed rule, we also invited public comment on whether the TIDAL™ Fusion Cage meets the eligibility criteria at § 419.66(b)(3) and (4).

We did not receive public comments regarding whether the TIDAL™ Fusion Cage meets the eligibility criteria at § 419.66(b)(3) and (4). Based on our review of the application, we agree with the applicant and have determined that the TIDAL™ Fusion Cage meets the eligibility criteria at § 419.66(b)(3) and (4).

In the CY 2027 OPPS/ASC proposed rule, we noted regarding the device category eligibility criterion at § 419.66(c)(1) that the applicant stated that no existing (current or previous) device pass-through payment categories appropriately describe the TIDAL™ Fusion Cage. Per the applicant, the existing pass-through code C1713 (Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)) does not appropriately describe the TIDAL™ Fusion Cage because C1713 is typically used to represent fixation components, such as an intramedullary nail or other fixation screws, but does not represent the TIDAL™ Fusion Cage.

Based on the description the applicant provided, we stated in the proposed rule that the TIDAL™ Fusion Cage is a porous cage used as part of a limb salvage arthrodesis construct to bridge bone loss or a critical bone defect in the ankle and restore length due to bone void, absent bone, or surgical resection and therefore, could be described by C1713 (Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)). Specifically, we stated our belief that the pass-through payment category C1713 may appropriately describe the TIDAL™ Fusion

Cage because C1713 is defined as implantable pins and/or screws inserted or drilled into bone, principally with the intent to facilitate stabilization or oppose bone-to-bone contact and may include orthopedic plates with accompanying washers or nuts as well as synthetic bone substitutes that may be used to fill bony voids or gaps.[27] In this context, we stated our belief that the TIDAL™ Fusion Cage may be appropriately described by C1713. We also stated that, after reviewing the information provided by the applicant, we were unable to determine that the TIDAL™ Fusion Cage meets the device category eligibility criteria, and therefore, we proposed to deny transitional pass-through payment status for CY 2027.

We invited public comment on whether the TIDAL™ Fusion Cage meets the device category eligibility criterion at § 419.66(c)(1). We also invited public comments on our proposal to deny transitional pass-through payment status for the TIDAL™ Fusion Cage for CY 2027.

Comment: A commenter expressed its support for the denial of device pass-through payment for the TIDAL™ Fusion Cage.

Response: We appreciate the commenter's input.

Comment: The applicant and a few commenters submitted public comments urging CMS to approve device pass-through payments for the TIDAL™ Fusion Cage. A few commenters stated that the TIDAL™ Fusion Cage provides an alternative treatment to certain patients who are at risk of limb loss and without other good treatment options. The commenters added that denying the TIDAL™ Fusion Cage device pass-through payment would limit patients' access to this treatment option. One of these commenters also stated that when a patient loses their leg, besides the physical and mental anguish, the cost for the prosthetic is ever increasing.

With respect to whether the TIDAL™ Fusion Cage may be appropriately described by C1713, the applicant stated that there are no existing categories or categories previously in effect

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[27] Centers for Medicare & Medicaid Services. (2024). *Medicare Claims Processing Manual* (CMS Pub. 100-04), Chapter 4: Part B Hospital (including inpatient hospital part B and OPPS). U.S. Department of Health and Human Services. *https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c04.pdf.*

that appropriately describe the TIDAL™ Fusion Cage. Specifically, the applicant stated that C1713 describes fixation hardware such as anchors, screws, pins, plates, washers, and nuts used to facilitate stabilization or oppose bone-to-bone contact as well as certain conventional synthetic bone substitutes used to fill voids or gaps. The applicant compared this description to the TIDAL™ Fusion Cage, which it stated is an FDA-cleared ankle fusion cage that is a permanent, porous, load-bearing structural spacer used with a tibiotalocalcaneal (TTC) intramedullary rod to reconstruct a critical-size ankle/hindfoot bone defect, restore limb length, and enable salvage fusion in patients at risk of limb loss. The applicant also stated that CMS's preliminary conclusion relies on an overly broad interpretation of C1713 that stretches the device category beyond its natural scope of fixation hardware and void-filling substitutes. The applicant stated that CMS's interpretation of C1713 includes any implant associated with stabilization, fusion, or a bone defect and would result in the device category code inappropriately including a broad range of musculoskeletal reconstructive implants. The applicant stated that this would be inconsistent with the device category eligibility criterion, which asks whether an existing pass-through category appropriately describes the nominated device. According to the applicant, the appropriate question is not whether C1713 can be stretched to cover a device that touches bone or participates in fusion, but rather, whether C1713 appropriately describes the TIDAL™ Fusion Cage. The applicant reiterated that C1713 does not describe the TIDAL™ Fusion Cage because the device is a structural, porous, titanium ankle fusion cage with a central window for an intramedullary nail, used to replace absent bone and restore limb length in limb-salvage TTC fusion and not an anchor, screw, pin, plate, washer, nut, or conventional synthetic bone substitute.

The applicant stated that the TIDAL™ Fusion Cage is not an anchor, screw, pin, or plate. Per the applicant, C1713 describes an anchor/screw for opposing bone-to-bone or soft tissue-to-bone with the defining function of fixation by anchoring, screwing, pinning, drilling, or opposing tissue or bone surfaces. The applicant stated that, by contrast, the TIDAL™ Fusion Cage is not

drilled into bone like a screw or pin, does not attach tendon or soft tissue to bone, and is not a plate, washer, nut, or fixation assembly. The applicant reiterated that the TIDAL™ Fusion Cage is a porous titanium cage with a circular window to contain an intramedullary nail and is used to restore length due to bone void, absent bone, or surgical resection during TTC fusion procedures in patients at risk of limb loss. The applicant stated that the TIDAL™ Fusion Cage's function is categorically different from opposing two tissues or two bone surfaces. The applicant stated that the nominated device is an interpositional, load-bearing reconstructive implant placed where bone is missing, and the intramedullary nail provides the primary internal fixation pathway through the construct while the cage replaces the segmental defect and provides a porous osseointegrative scaffold around the rod.

Furthermore, the applicant stated that CMS should not treat the TIDAL™ Fusion Cage as a conventional synthetic bone substitute used to fill bony voids or gaps under C1713. The applicant stated that CMS uses synthetic bone substitutes to collapse every device used in or around a bone defect into C1713. The applicant further stated that conventional bone void fillers are typically indicated for bony voids or gaps that are not intrinsic to the stability of the bony structure, and many are resorbable materials that are replaced by bone over time.

The applicant noted that FDA's product code for this device is directly relevant to CMS's analysis of C1713 and confirms that a conventional synthetic bone graft or bone-void filler is a different type of device. The applicant stated that FDA classified the TIDAL™ Fusion Cage under product code SAI, Ankle Fusion Cage, under regulation 21 CFR 888.3020. The applicant further stated that FDA's product-code for an ankle fusion cage describes a permanent metal structure that acts as a structural spacer where the defect is intrinsic to stability and limb length. The applicant compared this ankle fusion cage product-code to FDA's separate product classification MQV for Filler, Bone Void, Calcium Compound, regulated under 21 CFR 888.3045, which is defined as a resorbable implant intended to fill bony voids or gaps caused by trauma or surgery that are not intrinsic to the stability of the bony structure. The applicant stated

that treating the TIDAL™ Fusion Cage as a synthetic bone substitute would disregard the separate regulatory identities FDA assigned to these materially different device types. The applicant further explained that the TIDAL™ Fusion Cage is used precisely where the defect is intrinsic to stability, limb length, and salvage reconstruction and that FDA's product classification likewise describes the device as a metal open-space structure that acts as a structural spacer as part of a TTC fusion construct. Additionally, the applicant stated that, although the TIDAL™ Fusion Cage may be packed with autograft or allogenic bone graft, this does not make the cage itself a bone substitute. The applicant noted that labeling for the nominated FDA-cleared device indicates that it is intended for use with autograft and/or allogenic bone graft, confirming, per the applicant, that the cage is the structural implant and the graft is the biologic fusion material.

In addition, the applicant contended that CMS should give substantial weight to FDA's classification because FDA's product-code framework directly addresses devices' technological and clinical identity. The applicant reiterated that the SAI product code for ankle fusion cage describes the device type as a metal cylinder, spherical, or rectangular-box physical state with open space throughout that is used as a structural spacer and an accessory to a TTC intramedullary rod. The applicant explained that it believes this regulatory identity is materially distinct from screws, anchors, pins, plates, washers, nuts, and conventional synthetic bone substitutes. The applicant requested that CMS not deny transitional pass-through payment status for the TIDAL™ Fusion Cage on the basis that it is described by C1713. The applicant stated that a more accurate category would be a new ankle joint fusion device category, such as joint fusion device, ankle, including all system components (implantable).

Other commenters also stated that the nominated device is different from the types of anchors, screws, plates, or bone void fillers classified in existing device categories because it is a structural ankle fusion cage that sits in place of missing bone and permits the leg to carry weight while it heals in. A commenter further described the TIDAL™ Fusion Cage as a porous titanium

spacer and stated that the nominated device restores leg length.

Response: We appreciate the applicant and commenters' input. After consideration of the public comments we received and our review of the application, we agree there is no existing category or category previously in effect that appropriately describes the TIDAL™ Fusion Cage because no pass-through category describes a device that is a structural component used to replace absent bone and restore limb length in an ankle fusion, and not an anchor, screw, pin, plate, washer, nut, or conventional synthetic bone substitute. Based on this information, we have determined that the TIDAL™ Fusion Cage meets the device category eligibility criterion at § 419.66(c)(1).

We also invited public comment on whether the TIDAL™ Fusion Cage meets the cost criterion at § 419.66(d)(3).

Comment: With respect to cost significance criteria, the applicant reiterated that the TIDAL™ Fusion Cage meets all three of the cost significance criteria.

Response: We appreciate the applicant's input. After consideration of the public comments we received and our findings from the first, second, and third cost significant tests, we agree that the TIDAL™ Fusion Cage meets the cost significance criteria specified at § 419.66(d).

After consideration of the public comments we received and our review of the device pass-through application, we have determined that the TIDAL™ Fusion Cage meets the requirements for device pass-through status described at § 419.66. We are approving the TIDAL™ Fusion Cage for device pass-through payment status effective January 1, 2027, under the alternative pathway for devices that have an FDA Breakthrough Device designation and FDA marketing authorization for the indication covered by the Breakthrough Device designation.

(3) Traditional Device Pass-Through Applications

(a) EndoForce™ Connector for Endovascular Venous Anastomosis

Phraxis Inc. submitted an application for a new device category for transitional pass-through payment status for the EndoForce™ Connector for Endovascular Venous Anastomosis

(the EndoForce™ System) for CY 2027. According to the applicant, the EndoForce™ System provides an endovascular method for attachment of a non-autogenous arteriovenous graft (AVG) to a vein in the upper arm in patients with end stage renal disease (ESRD) requiring hemodialysis. Per the applicant, the EndoForce™ System is provided as a sterile, single-use EndoForce™ Connector Delivery System with a pre-mounted EndoForce™ Connector that is attached endovascularly at the venous anastomosis, in conjunction with a standard 6mm expanded polytetrafluoroethylene (ePTFE) vascular access graft, to establish an end-to-end endovascular anastomotic conduit designed to help absorb the shear forces of blood flow at the AVG-vein junction and to provide a physical barrier to the ingress of neointimal hyperplasia.

Table 54 provides an overview of the transitional pass-through payment status application for the EndoForce™ System and CMS's preliminary assessment. For additional details provided by the applicant, please refer to the online application posting available at *https://mearis.cms.gov/public/publications/device-ptp/DEP260228AHPFT.*

TABLE 54: ENDOFORCE™ SYSTEM APPLICATION OVERVIEW

Device Pass-through Criteria	Applicant Statements	Preliminary CMS Assessment
Newness Criterion	*FDA Marketing Authorization*: PMA approval - May 15, 2025. *Application submitted to CMS*: February 28, 2026.	No concerns.
FDA Indication	The EndoForce™ System is indicated to provide an endovascular method for attachment of an AVG to a vein in the upper arm in patients with ESRD requiring hemodialysis. The EndoForce™ Connector is used together with conventional suturing of the graft to the artery during the implantation procedure. The graft is then used for vascular access during hemodialysis.	No concerns.
§ 419.66(b)(3)	Device is integral, used for one patient only, comes in contact with human tissue, and is surgically inserted.	No concerns.
§ 419.66(b)(4)	Device is not equipment, an instrument, apparatus, implement, or item of this type for which depreciation and financing expenses are recovered as depreciable assets, and is not a material or supply furnished incident to a service.	No concerns.
Device Category	Device category codes C1768 (Graft, vascular), C1874 (Stent, coated/covered, with delivery system), C1875 (Stent, coated/covered, without delivery system), C1876 (Stent, non-coated/non-covered, with delivery system), C1877 (Stent, non-coated/non-covered, without delivery system), and C8000 (Support device, extravascular, for arteriovenous fistula (implantable)) do not describe the device.	No concern.

Cost Criteria	The cost of the EndoForce™ System is $5,000.00. For cost significance requirements: HCPCS code: 36830 APC code: 5184 CY 2026 device offset amount: $1,474.69 CY 2026 APC payment rate: $5,685.01 Requirement #1: ($5,000.00 / $5,685.01) x 100 = 87.95%. Requirement #2: ($5,000.00 / $1,474.69) x 100 = 339.05%. Requirement #3: (($5,000.00 - $1,474.69) / $5,685.01) x 100 = 62.01%.	No concerns.
Substantial Clinical Improvement Criterion	Claim #1: Improved Patency, Reduced Intervention Burden, and Reduced AVG Abandonment at 6 months. Claim #2: Improved Patency and Reduced AVG Abandonment. Claim #3: Sustained Patency and Fewer Interventions to Maintain Patency. Claim #4: Improved Cumulative (Secondary Patency) Compared to Sutured AVGs. Claim #5: Improved Cumulative (Secondary Patency) Compared to Mature AV Fistulas. Claim #6: Improved Cumulative Patency Compared to WaveLinQ™. Claim #7: Improved Cumulative Patency Compared to Ellipsys™. Claim #8: Reduced Interventions Compared to Traditional AVGs. Applicant provided one published study assessing the technology, two unpublished studies assessing the technology, and six background documents.	See following discussion.

In the CY 2027 OPPS/ASC proposed rule, we invited public comments on whether the EndoForce™ System meets the newness criterion at § 419.66(b)(1), the eligibility criteria at § 419.66(b)(3) and (4), and the device category eligibility criterion at § 419.66(c)(1).

Comment: The applicant submitted a public comment reiterating that the EndoForce™ System meets the newness, eligibility, and device category eligibility criteria for device pass-through payment.

Response: We appreciate the applicant's input. We received the application for device pass-through payment status for the EndoForce™ System within 3 years of the date of FDA premarket approval. We also agree with the applicant that the EndoForce™ System is an integral part of the service furnished, used for one patient only, comes in contact with human tissue, and is surgically implanted or inserted or applied in or on a wound or other skin lesion. Additionally, we agree with the applicant that the EndoForce™ System is not equipment, an

instrument, apparatus, implement, or item of this type for which depreciation and financing expenses are recovered as depreciable assets, or a material or supply furnished incident to a service. We believe that there is no existing category or category previously in effect that appropriately describes the EndoForce™ System. Therefore, after consideration of the public comments we received and our review of the application, we have determined that the EndoForce™ System meets the newness criterion at § 419.66(b)(1), the eligibility criteria at § 419.66(b)(3) and (4), and the device category eligibility criterion at § 419.66(c)(1).

Regarding the substantial clinical improvement criterion at § 419.66(c)(2), after reviewing the information provided by the applicant, we stated in the CY 2027 OPPS/ASC proposed rule that we had the following concerns regarding whether the EndoForce™ System meets the substantial clinical improvement criterion.

In support of claims one through four and eight, the applicant submitted three studies evaluating the EndoForce™ System: Burgess et al. (2024), Kramer et al. (2026), and Astor et al. (2026), and three background studies: Halbert et al. (2020), Harms et al. (2016), and Woodside et al. (2021), which did not assess the nominated device.[28] In support of claims five through seven, the applicant submitted three background articles (Pisoni et al., 2021; Berland et al., 2019; Hull et al., 2018) which did not assess the nominated device.[29,30,31]

We noted that the Burgess et al. (2024) study is a single-arm, non-randomized study that

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[28] In its application, the applicant submitted unpublished versions of Kramer et al. (2026) and Astor et al. (2026), which we reviewed. Accordingly, we cited these studies in the proposed rule as Kramer et al. (n.d.) and Astor et al. (n.d.). In its public comment discussed later in this section, the applicant cited published versions of these studies and indicated that the published versions did not contain material changes.

[29] Pisoni, R. L., Zepel, L., Zhao, J., Burke, S., Lok, C. E., Woodside, K. J., Wasse, H., Kawanishi, H., Schaubel, D. E., Zee, J., & Robinson, B. M. (2021). International Comparisons of Native Arteriovenous Fistula Patency and Time to Becoming Catheter-Free: Findings From the Dialysis Outcomes and Practice Patterns Study (DOPPS). *American journal of kidney diseases: the official journal of the National Kidney Foundation*, *77*(2), 245–254. *https://doi.org/10.1053/j.ajkd.2020.06.020*.

[30] Berland, T. L., Clement, J., Griffin, J., Westin, G. G., & Ebner, A. (2019). Endovascular Creation of Arteriovenous Fistulae for Hemodialysis Access with a 4 Fr Device: Clinical Experience from the EASE Study. *Annals of vascular surgery*, *60*, 182–192. *https://doi.org/10.1016/j.avsg.2019.02.023*.

[31] Hull, J. E., Jennings, W. C., Cooper, R. I., Waheed, U., Schaefer, M. E., & Narayan, R. (2018). The Pivotal Multicenter Trial of Ultrasound-Guided Percutaneous Arteriovenous Fistula Creation for Hemodialysis Access. *Journal of vascular and interventional radiology: JVIR*, 29(2), 149–158.e5. *https://doi.org/10.1016/j.jvir.2017.10.015*.

analyzed the use of the EndoForce™ System in 158 patients aged 18 and older diagnosed with ESRD scheduled to have an AVG for hemodialysis placed in their upper arm in 10 U.S. institutions between 2018 and 2021 after a 6-month follow-up period.[32] We stated we had several concerns with this study.

Firstly, we stated we were concerned that the study does not provide a comparison to a control group, such as patients treated with standard graft-to-vein sutured anastomosis. Without a comparison to currently available treatments, particularly in the clinical setting where it is most likely to be used, we stated we were unable to assess whether the EndoForce™ System demonstrates substantial clinical improvement over currently available treatments. To demonstrate substantial clinical improvement, we stated we consider supporting evidence, preferably published peer-reviewed clinical trials, that show improved clinical outcomes, such as reduction in mortality, complications, subsequent interventions, future hospitalizations, recovery time, pain, or a more rapid beneficial resolution of the disease process compared to other currently available treatments.

Secondly, we were concerned that the smaller patient population and study design of Burgess et al. (2024), and the lack of stratification by key clinical factors known to affect AVG outcomes, may limit both the reliability of the cumulative patency findings and the generalizability of results to the Medicare population. We stated that stratification factors, such as coronary artery disease, hypertension status, and ipsilateral access placement, which have all been shown to be associated with thrombosis, need for intervention, and cumulative patency would be helpful to assess the outcomes.

In addition, we stated it was unclear to what extent any improvement in cumulative patency is due to use of the EndoForce™ Connector versus the less invasive endovascular

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[32] Burgess, J. S., Beaver, J. D., London, M., Rohan, V., Orland, P., Yevzlin, A., Setum, C., Ross, J., & InterGraft Study Investigators. (2024). Prospective multicenter study of a novel endovascular venous anastomotic procedure and device for implantation of an arteriovenous graft for hemodialysis. *The Journal of Vascular Access*, *25*(4), 1244–1251. *https://doi.org/10.1177/11297298231159691*.

procedure used for implantation. We stated we would welcome additional information on differentiating how the EndoForce™ System's connection to AVG versus the less invasive nature of the endovascular procedure leads to improvements in cumulative patency.

Furthermore, we noted that, in Burgess et al. (2024), the authors compared results to three background studies, Halbert et al. (2020) (submitted in support of claim 4), Harms et al. (2016) (submitted in support of claim 8), and Woodside et al. (2021) (submitted in support of claim 8), none of which directly address the EndoForce™ System.[33,34,35] We questioned the appropriateness of comparing cumulative patency, intervention rates, and AVG abandonment in Burgess et al. (2024) to outcomes reported in the three background studies, as observed differences may be influenced by variations in study design, study location, patient population and characteristics, and study period. Specifically, we stated that Burgess et al. (2024) reports a 6-month cumulative patency of 92 percent in its patient population and compares it to the 80 percent rate reported in Halbert et al. (2020). However, we noted that Halbert et al. (2020) is a meta-analysis of 32 studies conducted across 14 countries between 2007 and 2019, representing 3,381 AVGs placed in patients with chronic kidney disease or ESRD undergoing or preparing for hemodialysis using ePTFE grafts. In contrast, we stated that Burgess et al. (2024) analyzed ESRD patients between 2018 and 2021. Thus, we questioned whether the results in Halbert et al. (2020), which included studies dating back more than a decade, reflect current operative techniques and perioperative care in the U.S. and therefore whether they are an appropriate comparator to Burgess et al. (2024). Similarly, we stated that Harms et al. (2016) is a retrospective study of 599 patients treated between January 2006 and December 2011, and

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[33] Halbert, R. J., Nicholson, G., Nordyke, R. J., Pilgrim, A., & Niklason, L. (2020). Patency of ePTFE Arteriovenous Graft Placements in Hemodialysis Patients: Systematic Literature Review and Meta-Analysis. *Kidney360*, *1*(12), 1437–1446. *https://doi.org/10.34067/kid.0003502020*.

[34] Harms, J. C., Rangarajan, S., Young, C. J., Barker-Finkel, J., & Allon, M. (2016). Outcomes of arteriovenous fistulas and grafts with or without intervention prior to successful use. *Journal of Vascular Surgery*, *64*(1), 155–162. *https://doi.org/10.1016/j.jvs.2016.02.033.*

[35] Woodside, K. J., Repeck, K. J., Mukhopadhyay, P., Schaubel, D. E., Shahinian, V. B., Saran, R., & Pisoni, R. L. (2021). Arteriovenous Vascular Access–Related Procedural Burden Among Incident Hemodialysis Patients in the United States. *American Journal of Kidney Diseases*, *78*(3), 369-379.e1. *https://doi.org/10.1053/j.ajkd.2021.01.019.*

Woodside et al. (2021) is an observational cohort study of 73,027 patients using data from July 2012 to December 2014. We noted that these studies reflect earlier clinical practices and patient populations that differ from those in Burgess et al. (2024), which evaluated patients between 2018 and 2021. We stated that Burgess et al. (2024) compared its reported intervention rate of 1.22 per patient-year to higher rates reported in Harms et al. (2016) and Woodside et al. (2021), 1.58 and 1.87 respectively; however, these comparisons may not be appropriate given the significant differences in study design, time periods and patient populations. We also stated that these earlier studies do not adequately account for changes in clinical practice over time and any observed differences in outcomes are likely confounded by these factors rather than attributable to the technology itself. As such, we stated that these studies may not provide a valid basis for comparison to Burgess et al. (2024).

Moreover, we noted patient populations varied across studies, and it is unclear how these differences may have affected intervention rates per patient-year. We stated, for example, Burgess et al. (2024) included patients with two or fewer previous vascular accesses in the treatment arm, while Woodside et al. (2021) included patients undergoing a first-time AVG placement between dialysis initiation and 1 year. We noted that patients who have had previous hemodialysis access points experience damage to the blood vessels regardless of whether the access point is a central venous catheter, AVG, or AVF.[36,37] Further, we stated having prior vascular access points in the ipsilateral arm has been shown to decrease cumulative patency in Harms et al. (2016). We stated that we would welcome additional studies that control for patients with comparable vascular access placement histories, to more accurately quantify the contributions of the EndoForce™ System to improvements in interventions per patient-year.

Finally, we stated that we were concerned that differences in vascular location for

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[36] Harms, J. C., Rangarajan, S., Young, C. J., Barker-Finkel, J., & Allon, M. (2016). Outcomes of arteriovenous fistulas and grafts with or without intervention prior to successful use. *Journal of Vascular Surgery*, *64*(1), 155–162. *https://doi.org/10.1016/j.jvs.2016.02.033.*

[37] Lok, C. E., Huber, T. S., Orchanian-Cheff, A., & Rajan, D. K. (2024). Arteriovenous access for hemodialysis: A review. *Journal of American Medical Association*, 331(15), 1307–1317. *https://doi.org/10.1001/jama.2024.0535*.

patients in the Burgess et al. (2024) compared to patients in the background studies may influence outcomes and adversely impact comparability of results. Specifically, while Burgess et al. (2024) evaluated patients with upper arm AVGs consistent with the EndoForce™ System's FDA approved indication, we stated that this varied across the comparator studies: Halbert et al. (2020) excluded studies that exclusively assessed lower extremity AVGs, Harms et al. (2016) included patients who had AVGs in the chest and thigh in addition to the upper extremity, and Woodside et al. (2021) did not specify the anatomical location of AVGs. We noted that it was unclear whether some of the studies included patient populations with upper extremity, lower extremity, and chest AVGs. As discussed in greater detail later in this section for the second claim, we stated that it was unclear whether upper extremity and upper arm are used interchangeably. We questioned whether vascular access location influences clinical outcomes, and as such, the results in these background studies may be confounded by inclusion of patients with additional graft locations that could adversely impact the comparability of the results to Burgess et al. (2024).

With regard to the second claim that the EndoForce™ System improves patency and reduces AVG abandonment, the applicant submitted a study by Astor et al. (2026) that compared the primary patency (defined as the time interval from initial implantation until first intervention) and cumulative patency (defined as the time interval between implantation of the graft to abandonment) results from Burgess et al. (2024) to pooled results from a meta-analysis of 34 studies of AVGs implanted using traditional surgical techniques.[38] We expressed concern that Astor et al. (2026) may not demonstrate that the EndoForce™ System substantially improves the diagnosis or treatment of an illness when compared to the benefits of other available treatments. We stated that Astor et al. (2026) reported a high degree of variability among the comparator

[38] Astor, B. C., KMLST Moorthi, Grant, L., & Litchfield, T. (2026). Endovascular AVG venous anastomosis improves cumulative patency compared to traditional sutured anastomosis: a meta-analysis. *Journal of Interventional Nephrology*, *9*(1), 427–434. *https://www.openaccessjournals.com/articles/endovascular-avg-venous-anastomosis-improves-cumulative-patency-compared-to-traditional-sutured-anastomosis-a-metaanalysis-18782.html.*

studies included in the meta-analysis (primary patency I^2=99.44; cumulative patency I^2=99.36), many of which showed similar or higher primary patency (60.21 percent; 95 percent confidence interval (CI): 50.84, 69.59) and cumulative patency (92.08 percent; 95 percent CI: 86.98, 97.18) compared to results from Burgess et al. (2024). We noted that 19 of the 31 studies that provided data on cumulative patency in Astor et al. (2026) did not specifically report 6-month patency outcomes in tables or text; the studies only provided data in survival curves from which the authors of Astor et al. (2026) derived 6-month patency measurements. We stated that the estimated 6-month cumulative patency including all 31 studies was 83.23 percent (95 percent CI: 80.18, 86.28), whereas the 6-month cumulative patency estimated from the 12 studies reporting numerical values was 86 percent (95 percent CI: 81.78, 90.22). We noted that Astor et al. (2026) did not state whether the difference between the 6-month cumulative patency rates of 92 percent in Burgess et al. (2024) and 86 percent was statistically significant. However, we noted the lower 95 percent CI bound reported in Burgess et al. (2024) was 86.98 percent, lower than the upper 95 percent CI bound of 90.22 percent for the 12 studies in Astor et al. (2026) providing numerical data. We also noted that Astor et al. (2026) states that the primary patency for the EndoForce™ System is similar to pooled results from comparator studies (60.21 percent vs 60.35 percent; p=0.75). Additionally, we noted that the 20 percent AVG abandonment rate used as a baseline by Astor et al. (2026) which they report was reduced to 8 percent, comes from a single meta-analysis (Halbert) based on 32 studies from 14 countries conducted between 2007 and 2019. We questioned whether this is an appropriate comparator to the 158 patients treated between 2018 and 2021 in 10 U.S. institutions reported in Burgess et al. (2024).

We also noted that the criteria for comparator studies included in the meta-analysis in Astor et al. (2026) excluded those studies which only assessed lower extremity or chest AVGs. However, we questioned whether some of the studies included patient populations with upper extremity AVGs as well as lower extremity and chest AVGs. We stated that, as previously discussed, vascular access location may influence outcomes, therefore, the results in these

background studies may be confounded by inclusion of patients with additional graft locations that could adversely impact the comparability of the results to Burgess et al. (2024). Additionally, because of the EndoForce™ System's FDA approved indication for use in the upper arm, we questioned whether the comparison is appropriate. Further, we noted it is unclear in the application whether the upper arm means the entire upper extremity, including the forearm (distal to the elbow) or only a portion of the arm (proximal to the elbow). We stated that we would be interested in additional information clarifying the meaning of upper arm to help us evaluate the evidence provided in support of substantial clinical improvement and determine if it is applicable.

With regard to the third claim that the EndoForce™ System sustains patency and requires fewer interventions to maintain patency, the applicant submitted one extended follow-up study (Kramer et al. (2026)) of 37 patients from Burgess et al. (2024), that evaluates the number of interventions performed to achieve cumulative patency for an additional 6 months beyond the most recent intervention.[39] We stated, similar to our concerns regarding Burgess et al. (2024), we were concerned that Kramer et al. (2026) does not provide a control group for comparison. We noted that the authors in Kramer et al. (2026) stated that, since both the EndoForce™ System's pivotal trial (Burgess et al, 2024) as well as this extended follow-up study do not directly compare outcomes to sutured AVGs, a meta-analytic approach to compare endovascular anastomosis of an AVG with a traditional sutured anastomosis may be warranted. We stated that we would welcome additional information directly comparing endovascular anastomosis of an AVG with a traditional sutured anastomosis.

We noted that, like Burgess et al. (2024), the authors of Kramer et al. (2026) compared results to two background studies, Harms et al. (2016) and Woodside et al. (2021), neither of

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[39] Kramer, A., KMLST Moorthi, Grant, L., & Litchfield, T. (2026). Extended Follow-Up of an Endovascular Venous Anastomotic Connector for Arteriovenous Graft Creation in Hemodialysis: A Multicenter Study. *Journal of Interventional Nephrology*, *9*(1), 418–426. *https://www.openaccessjournals.com/articles/extended-followup-of-an-endovascular-venous-anastomotic-connector-for-arteriovenous-graft-creation-in-hemodialysis-a-multicenter-s-18760.html*.

which directly address the EndoForce™ System. As mentioned previously, we questioned whether the comparison of rates of interventions per patient-year in Kramer et al. (2026) to Harms et al. (2016) and Woodside et al. (2021) are appropriate and reflect true improvements or are attributable to differences in study design, patient population, and study period. We noted that Kramer et al. (2026) reported a rate of 1.32 interventions per patient-year in its patient population using the nominated technology and compared it to rates of 1.58 and 1.87 reported in Harms et al. (2016) and Woodside et al. (2021). We stated, however, as previously noted in our discussion of the first claim that the EndoForce™ System improves patency, reduces intervention burden, and reduces AVG abandonment at 6 months, due to the differences in study periods between Kramer et al. (2026) and Harms et al. (2016) and Woodside et al. (2021), we questioned whether the results in the comparator studies, some of which are over a decade old, reflect current operative techniques and latest perioperative care in the U.S. We also stated that, as previously noted in our discussion of the first claim, the extent of variance in vascular access locations of the patient populations assessed in these three studies was unclear. As such, we stated our concern that the results in these background studies may be confounded by inclusion of patients with additional graft locations which could adversely impact the comparability of the results to Kramer et al. (2026).

We also expressed concern about whether the patient population in Kramer et al. (2026), which included 29 active patients at the end of the study period from the 37 patients initially assessed, is powered sufficiently to assess statistical significance, especially compared to Burgess et al. (2024), which included 134 active patients at the end of the study period from the 158 patients initially assessed. We noted that when a study is not adequately powered for the statistical analysis, the statistics may appear artificially inflated and do not reflect confounding effects. We also expressed concern that the cohort in Kramer et al. (2026) was selected and analyzed post-hoc, rather than identified as a variable of interest at the initiation of Burgess et al. (2024) and questioned whether quality of the study was diminished due to selection bias.

Additionally, we questioned whether Kramer et al. (2026) conclusively demonstrates that the EndoForce™ System provides a substantial clinical improvement compared to other available treatments. We noted that Kramer et al. (2026) estimated a cumulative patency of 78.4 percent at 180 days into the extended follow-up period (12 months from AVG implant at the start of Burgess et al. (2024)). We stated that, in comparison, Halbert et al. (2020) reported a 12-month cumulative patency of 70 percent (95 percent CI: 64, 75). We also noted the high degree of variability (I^2=91) among the comparator studies in Halbert et al. (2020), many of which showed similar or higher cumulative patency compared to Kramer et al. (2026). Therefore, we stated we were unable to conclusively attribute the difference in outcomes to the nominated device.

Lastly, we questioned the appropriateness of comparing measures of cumulative patency that are not equally defined. Kramer et al. (2026) compared cumulative patency between participants with and without graft interventions within the 6-month study period discussed in Burgess et al. (2024) and stated that the cumulative patency at 6 months was nearly identical (91.79 percent versus 91.80 percent, respectively). We stated that, in Kramer et al. (2026), for patients without an intervention, time to loss of patency was measured from the date of implant, while for patients with interventions, time to loss of patency was measured from the date of first intervention. We questioned the appropriateness of comparing cumulative patency between AVGs used at first hemodialysis without intervention and those that required intervention prior to first hemodialysis use. We stated, as Harms et al. (2016) notes, intervention prior to first hemodialysis use is associated with a shortened cumulative patency. As such, we questioned if making such comparisons could be potentially misleading.

In support of claims five through seven, that the EndoForce™ System improves cumulative (secondary) patency compared to mature AV fistulas (AVFs), and devices used for AVF creation, including WaveLinQ™, and Ellipsys™, the applicant submitted three background articles (Pisoni et al. (2021); Berland et al. (2019); Hull et al. (2018)) which did not assess the

nominated device. The applicant stated that improvement in AVG patency is comparable to the 6-month cumulative patency associated with mature AVFs (71 to 93 percent) (Liu, P. et al. (2023)). However, we noted that the EndoForce™ System is indicated for attachment of an AVG to a vein, not for the creation of an AVF. We also noted that an AVF involves a direct anastomosis between an artery and a vein, whereas an AVG uses a graft as a conduit between the artery and the vein. Therefore, we questioned whether it is clinically appropriate to compare the EndoForce™ System, a device used for AVG attachment, to mature AVFs and devices used for AVF creation, including WaveLinQ™ and Ellipsys™. Given these fundamental differences in mechanism and clinical use, we questioned whether these claims demonstrate a substantial clinical improvement over existing technologies.

We invited public comment on whether the EndoForce™ System meets the device category criterion at § 419.66(c)(2) and the cost criterion at § 419.66(d)(3).

Comment: A commenter expressed its support for the denial of device pass-through payment for the EndoForce™ System due to their belief that it does not meet all criteria for approval.

Response: We appreciate the commenter's input.

Comment: The applicant and several commenters recommended that CMS approve of device pass-through payment for the EndoForce™ System. These commenters stated that the EndoForce™ System exhibits a genuinely different technological approach to an important and persistent problem in dialysis vascular access compared to traditional hand-sewn venous anastomosis, and therefore, offers a promising opportunity to improve the durability and preservation of permanent dialysis access via an AVG. Commenters stated that, without approval, hospitals may face a financial disincentive or be unable to offer the EndoForce™ System even when the surgeon believes it is the best option for a patient for whom an AVG is the appropriate permanent-access strategy. Commenters expressed concern that this would thereby limit physicians' ability to gain experience with a new technology, restrict patient access,

and impede generation of the broader real-world clinical evidence CMS seeks and is necessary to determine the technology's long-term value. The commenters also stated that, given that important dialysis vascular access and management innovations are slow-developing and infrequent, device pass-through payment status would create disciplined adoption that can allow appropriate Medicare beneficiaries to receive an innovative technology while physicians, investigators, and other interested parties continue to develop evidence regarding its clinical performance and value. In addition, a few commenters stated that approving transitional pass-through payment for the EndoForce™ System would not end the evidence discussion and does not require CMS to conclude that this technology has already established all its potential long-term clinical or economic benefits.

A few commenters stated that, for patients requiring an AVG, preserving a usable graft with fewer interventions per patient-year and avoiding a catheter is not marginal improvement, but rather, is the difference between stable dialysis and another cycle of access failure. These commenters also stated that the EndoForce™ System will reduce disruptions in dialysis care and caregiver burden, while also decreasing frequency of invasive procedures that expose patients to procedural risks; pain, anxiety, and recovery; and additional demands on limited vascular anatomy.

A few commenters stated that the EndoForce™ System is particularly important for Medicare beneficiaries who are unsuitable candidates for a usable AVF and for whom an AVG may be the most appropriate, as it is the most likely to become promptly usable and shortens catheter exposure. Moreover, a commenter stated that providers embrace new technologies, such as the EndoForce™ System, which has the potential to reduce catheter dependence and improve AVG patency, and that beneficiaries deserve the choice of innovations that could improve their access care.

A few commenters agreed with some of CMS's concerns in the CY 2027 OPPS/ASC proposed rule (91 FR 41837 through 41839), specifically regarding the absence of a concurrent

control group, differences among comparator populations and treatment periods, variation in vascular-access history and graft location, and uncertainty regarding the source of the observed clinical benefit, further agreeing that they warrant appropriate caution. However, the commenters stated that the concerns alone do not warrant a negative determination of substantial clinical improvement. The commenters stated that CMS should evaluate the evidence in the clinical context of patients who actually received an AVG and the persistent clinical problem that the EndoForce™ System intends to address. The commenters stated that, in evaluating the evidence for substantial clinical improvement, the available statistical comparisons have recognized limitations, and therefore, CMS should consider the totality of the circumstances, including the nature of the patient population, the historical difficulty of maintaining dialysis vascular access, the burden imposed by repeated access procedures, and the potential significance of reducing those interventions.

Additionally, the commenters suggested that CMS also consider the potential downstream consequences of denying transitional pass-through payment status, including the need for repeated interventions, vascular access-related hospital and outpatient encounters, vascular access failure, catheter exposure, and the cumulative burden these events impose on Medicare beneficiaries and the Medicare program. These commenters also stated that CMS's substantial clinical improvement standard recognizes long-term catheter use and decreased rate of subsequent diagnostic or therapeutic interventions as a clinically important outcome and, from a dialysis patient's perspective, they may be the most important outcomes CMS can consider.

A commenter emphasized the clinical challenges of dialysis vascular access, such as their path-dependent nature and how a functioning graft's loss may consume additional vascular territory, require another access procedure, and return a patient to catheter dependence, and that this patient population has limited options available. The commenter stated that transitional pass-through payment status for the EndoForce™ System would enable its availability for appropriately selected patients while its additional cost is not yet included into payment rates.

Additionally, the commenter stated that device pass-through payment status would not imply that the EndoForce™ System should replace conventional AVG in every patient, but it would permit physicians to consider the technology in the select patients for whom its clinical advantages justify use.

Response: We thank the applicant and commenters for their comments. We have taken these comments into consideration in our final determination for pass-through payment status for the EndoForce™ System.

Comment: In response to our concerns regarding Burgess et al.'s (2024) lack of a control group and differences from the available comparator populations, the applicant commented that, while a study comparing the EndoForce™ System to a control group would be a useful addition to the available evidence, no such study exists at this time. The applicant explained that because of this, its evidence strategy was to rely on comparison to other studies through systematic reviews and meta-analyses. The applicant stated that it provided sufficient information to support an apt and revealing comparison, enabling a reasonable judgement about a complicated issue. Citing a publication on randomized control trials (RCTs), the applicant added that the most rigorous form of a study with a control group is a RCT, and that while RCTs are generally regarded as a methodological gold standard, they can be subject to several forms of bias that are not necessarily defeated by randomization.[40]

The applicant further stated that when meta-analyses are well-specified and review high-quality studies, methodologists place them at the top of the evidence hierarchy and consider them to be likely superior to even randomized clinical trials when well conducted.[41,42] As a result, the applicant stated that CMS should not readily dismiss the evidence available from the

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[40] Msaouel, P. (2021). Impervious to Randomness: Confounding and Selection Biases in Randomized Clinical Trials. *Cancer Investigation*, 1–6. *https://doi.org/10.1080/07357907.2021.1974030*.

[41] Vatkar, A. (2025). Understanding the Levels of Evidence in Medical Research. *J Orthop Case Rep,*15(5):6-9. doi: 10.13107/jocr.2025.v15.i05.5534 *https://pubmed.ncbi.nlm.nih.gov/40351623/.*

[42] Cazzola, M., Stolz, D., Bafadhel, M., & Rogliani, P. (2024). Understanding evidence from randomised controlled trials and meta-analyses: a comparative overview. *European Respiratory Journal*, *63*(5), 2400694–2400694. *https://doi.org/10.1183/13993003.00694-2024*.

comparative studies provided in its application. The applicant noted that Burgess et al. (2024) included patients fitted with sutured AVGs by Halbert et al. (2020) and that Halbert et al. (2020) only included studies in which patients had newly created AVGs, as opposed to graft revisions.

The applicant further stated that the patient population in Halbert et al. (2020) aligns with Burgess et al. (2024) and that the Burgess et al. (2024) study design deliberately enables comparison to previously published studies to provide a meaningful historical comparison. The applicant also stated that it specifically intended for Astor et al. (2026) to provide a direct comparison to Burgess et al. (2024). The applicant reiterated comparisons of 6-month cumulative patency between Burgess et al. (2024) and Halbert et al. (2020), and Burgess et al. (2024) and Astor et al. (2026), which CMS discussed in the CY 2027 OPPS/ASC proposed rule (91 FR 41837 and 41838, respectively).

Additionally, a commenter stated that while differences among comparator populations are important, those differences reflect the clinical reality of AVG recipients, who are a highly heterogeneous population. The commenter added that factors, including prior catheters and accesses, remaining vasculature condition, ipsilateral access history, anatomical location, and comorbidities, can affect both the decision to place a graft and its subsequent performance. The commenter stated that contemporary literature demonstrates the difficulty of consistently accounting for these variables. The commenter cited a 2026 systematic review and meta-analysis of 63 studies and 357,333 patients (Yang et al.),[43] which found substantial clinical and methodological heterogeneity along with inconsistent reporting of variables such as prior AVF or AVG use, first-access status, and prior catheter use. The commenter noted that Yang et al. (2026) could not include several of these clinically important variables into its meta-regression because they are inconsistently reported. The commenter stated that the same variables CMS identified as necessary for comparability (e.g., prior access history, anatomical location,

[43] Yang, C., Yang, W., Xiao, L., Zhu, R., Li, X., Xiang, E., Wang, H., Lou, J., & Gao, Z. (2026). Comparative outcomes of arteriovenous fistulas and grafts in haemodialysis: meta-analysis with subgroup analysis by fistula type and transposition status. *BJS Open*, *10*(2). *https://doi.org/10.1093/bjsopen/zraf165.*

ipsilateral vascular history, and relevant comorbidities) are both clinically consequential and inconsistently reported in contemporary vascular-access literature. The commenter stated that the absence of a study comparing the EndoForce™ System to a concurrent control group remains a meaningful limitation and reduces strong causal inference, but this limitation should not be interpreted to mean that existing conventional-AVG experience has little comparative value or that the submitted evidence is clinically uninformative. Instead, the commenter stated that the lack of a perfect contemporary comparator should affect the weight and certainty assigned to the available evidence.

In response to our concerns about the small patient population in Burgess et al. (2024), the applicant stated that the reliability of the study's findings was not compromised by the patient population's size and that the study team selected the sample size to support FDA premarket approval and intended to provide adequate statistical power to demonstrate that AVG placement with the EndoForce™ System met a pre-specified performance goal of 75 percent cumulative patency at 6 months ($p<0.001$).

Regarding our concerns about lack of stratification in Burgess et al. (2024), the applicant stated that the study's generalizability to the Medicare population is unlikely to be a practical problem as the preponderance of patients requiring vascular access are eligible for Medicare and, while the study did not report patients' insurance status, the provided demographic information comports with the Medicare population. The applicant also stated that the possible stratifications in which CMS expressed interest are among the factors clinicians wrestle with daily in developing patients' treatment plans. The applicant added that the 2019 Kidney Disease Outcomes Quality Initiative (KDOQI) guideline do not specify in detail how physicians should handle such factors but defer to clinicians' judgement to take these factors, among others, into account when dealing with the complex specifics of cases before them.[44] The applicant stated

[44] Lok, C. E., Huber, T. S., Lee, T., Shenoy, S., Yevzlin, A. S., Abreo, K., Allon, M., Asif, A., Astor, B. C., Glickman, M. H., Graham, J., Moist, L. M., Rajan, D. K., Roberts, C., Vachharajani, T. J., & Valentini, R. P. (2020).

that although Burgess et al. (2024) includes information about the extent of a number of diseases and other factors, stratified analysis within the study would have been of questionable value given the sample size. Lastly, the applicant stated its interest in investigating some of these clinical aspects in future research, recognizing that additional reliable studies could help improve clinical practice, but questioned CMS's concern that the available information at present is inadequate to find the EndoForce™ Connector represents substantial clinical improvement relative to other available technologies.

In response to our concern about whether the EndoForce™ Connector is the cause of any cumulative patency improvement or if it can be contributed to the less invasive endovascular procedure used for implantation, the applicant stated that it does not see how these two aspects can be meaningfully separated for investigation because it is the EndoForce™ Connector itself that enables the endovascular approach and no purely endovascular AVG placement procedure, with or without an additional device, is available. A commenter stated that while this is a legitimate causal question, the distinction should not obscure how the EndoForce™ Connector functions in clinical use. The commenter stated that the endovascular implantation method is not a separate, unrelated co-intervention, but the means by which the EndoForce™ Connector performs its FDA-approved function of creating the venous graft attachment. The commenter further stated that the available evidence may not establish whether any observed benefit predominantly results from reduced surgical trauma, altered geometry or hemodynamics, the EndoForce™ Connector's physical characteristics, or some combination of those effects, but the remaining mechanistic uncertainty does not require CMS to treat the EndoForce™ Connector and the procedure as clinically unrelated. The commenter stated that the clinically relevant comparison is between the EndoForce™ System as used according to its FDA indication and the conventional sutured venous anastomosis it replaces.

KDOQI Clinical Practice Guideline for Vascular Access: 2019 Update. *American Journal of Kidney Diseases*, *75*(4), S1–S164. *https://doi.org/10.1053/j.ajkd.2019.12.001*.

In response to our concern about the appropriateness of comparing Burgess et al. (2024) to the three provided background studies (Halbert et al., 2020; Harms et al., 2016; and Woodside et al., 2021) due to differences in study design, study location, and patient population, the applicant stated that Burgess et al. (2024) and Halbert et al. (2020) have very similar population characteristics, outcomes, and other factors, noting that detailed information about the patient populations and other aspects of the studies included in Halbert et al. (2020) are provided in a set of Supplemental Tables available on the journal's website. Further, the applicant stated that Halbert et al. (2020) showed no statistically significant difference across average outcomes in U.S. studies versus those conducted overseas; type of AVG used; observational studies versus randomized controlled trials; and sex, race, or presence of diabetes. The applicant also stated that Halbert et al. (2020) reviewed studies using a bias risk assessment procedure and found no statistically significant difference in bias between the studies.

Moreover, the applicant provided additional information about the population characteristics of studies included in the Astor et al. (2026) meta-analysis and compared them to Burgess et al. (2024), noting that patients included in Burgess et al. (2024) were older (mean age: 58.24 years vs. 62.6 years); had higher rates of diabetes (51.99 percent vs. 62.0 percent, $p=0.013$), higher rates of cardiovascular disease (16.05 percent vs. 49.4 percent, $p<0.001$), higher tobacco use (10.63 percent vs. 14.6 percent, $p=0.12$); and lower rates of hypertension (75.96 percent vs. 56.3 percent, $p<0.001$). In addition, the applicant stated that Burgess et al. (2024), Halbert et al. (2020), and Astor et al. (2026) had patient populations similar in a number of key characteristics that are generally thought to influence patency and compared them to values reported in the United States Renal Data System (age: 62.6 years, 61.0 years, 58.24 years, and 63.21 years respectively; sex (percent male/female): 39/61, 45/55, 42/58, and 58.6/41.4, respectively; and diabetes prevalence: 62 percent, 48 percent, 52 percent, and 45 percent, respectively). The applicant stated that the patient population characteristics, such as age, sex, and prevalence of diabetes, in Burgess et al. (2024) are more closely associated with worse

outcomes for cumulative patency, and insofar as these variables might affect cumulative patency, they would tend to depress rather than elevate the cumulative patency results relative to those in the other studies; however, the EndoForce™ System showed a clinically significant improvement.

In response to our concern that results in Halbert et al. (2020), Harms et al. (2016), and Woodside et al. (2021) may be inappropriate comparators to Burgess et al. (2024) as older studies may not reflect current operative techniques and perioperative care in the U.S., the applicant stated that basic procedures and technology related to AVGs have not materially changed in the last 20 years. The applicant added that further analysis of studies in Halbert et al. (2020) illustrate slightly higher (69.5 percent vs. 68.8 percent), but not statistically significant, 12-month cumulative patency results in the older cohort of studies (published pre-2014) compared to the more recent cohort (published between 2014 and 2019). The applicant also noted that, in Burgess et al. (2024) and Halbert et al. (2020), included studies' time periods overlap (2018 to 2021 compared to 2007 to 2019, respectively). The applicant stated that this suggests that no meaningful improvement in AVG vascular access outcomes occurred and that the studies in question are all comparable regardless of publication date. The applicant stated that the EndoForce™ System represents a meaningful technological advance in AVG, because it directly targets the longstanding failure point through a sutureless endovascular venous anastomosis. Another commenter stated that although the concern warrants consideration, the significance of a study's age should depend on whether the treatment being compared has materially changed. The commenter stated that although imaging, graft materials, perioperative management, surveillance, and techniques used to treat failing access have advanced, the basic surgical method for creating venous anastomosis in a conventional AVG has remained largely the same for decades. The commenter added that the EndoForce™ System's design avoids the conventional sutured graft-to-vein junction by creating an end-to-end endovascular venous anastomosis, reduces local vessel trauma and adverse flow conditions, and may lessen the drivers

of neointimal hyperplasia. The commenter concluded that older studies comparing ePTFE grafts with conventional surgical anastomosis are still relevant if that comparator and its underlying failure mechanism remain a cause of graft failure, even if the study predates Burgess et al. (2024). Lastly, the commenter stated that older evidence may warrant less weight than a contemporary controlled comparison, but this does not negate the older evidence's value when the conventional treatment remains materially similar and the failure mechanism under study remains clinically relevant.

In response to our concern that differences in vascular access location for the patients in the Burgess et al. (2024), Halbert et al. (2020), Harms et al. (2016), and Woodside et al. (2021) studies may be confounding factors that influence patency and adversely impact comparability of results, the applicant stated that the most important difference that might matter for the outcomes of interest is the size of the vessels: the major veins and arteries in the upper arm being larger than in those the lower arm. The applicant cited a study stating this difference is more pertinent for AVFs, which generally appear to work best when vessels have a larger diameter.[45] The applicant stated that for AVGs, vessels as small as two millimeters in diameter generally work well and such vessels are available in the lower arms of most individuals. In addition, the applicant cited another study that investigated AVGs' optimal location (upper arm versus forearm) and concluded that upper arm AVGs have similar graft patency and access-related complications compared with forearm AVGs despite the fact that [upper arm AVGs] are assumed to be constructed based on larger outflow veins.[46] Further, the applicant cited a study that reviewed records of over 52,000 accesses placed between 2021 and 2022 and found that only 9.7 percent of AVGs were placed in forearms and that this percentage had declined over

[45] Van Vliet, L.V, Zonnebeld, N., Tordoir, J. H., Huberts, W., Bouwman, L. H., Cuypers, P. W., Heinen, S. G., Huisman, L. C., Lemson, S., Mees, B. M., Schlösser, F. J., de, A., Toorop, R. J., Tammo Delhaas, & Snoeijs, M. G. (2023). Guideline recommendations on minimal blood vessel diameters and arteriovenous fistula outcomes. *The Journal of Vascular Access*, *25*(5), 1584–1592. *https://doi.org/10.1177/11297298231180627*.

[46] Farber, A., Tan, T.-W., Hu, B., Dember, L. M., Beck, G. J., Dixon, B. S., Kusek, J. W., & Feldman, H. I. (2015). The effect of location and configuration on forearm and upper arm hemodialysis arteriovenous grafts. *Journal of Vascular Surgery*, *62*(5), 1258–1265. *https://doi.org/10.1016/j.jvs.2015.06.132*.

time.[47] Based on these studies, the applicant stated that although the comparator studies may include lower-arm cases while Burgess et al. (2024) does not, any confounding effect on the outcomes of interest may be minimal.

In response to our concern regarding differences in vascular access locations in Burgess et al. (2024), which evaluated upper arm AVGs, compared to the background studies' (Halbert et al., 2020; Harms et al., 2016; and Woodside et al., 2021), which had various access locations, and our concern that comparator studies included in the Astor et al. (2026) excluded studies which only assessed lower extremity or chest AVGs, the applicant stated that lower extremity AVGs have generally been regarded as a last resort for patients who have exhausted their upper extremity access possibilities. The applicant added that, although good estimates of the extent of use in the dialysis population are unavailable, a few studies suggest the number may be less than two percent of patients. Additionally, the applicant cited a study that found recent case studies show cumulative patency rates at 6 months for leg (thigh) grafts and arm (upper extremity) AVGs are generally comparable, ranging between 75 and 85 percent. The applicant further stated that this study found that leg AVGs may exhibit slightly superior or equal cumulative patency compared to arm grafts due to femoral vessels' larger diameter.[48] Based on this information, the applicant stated that, if the comparator studies did include patients with lower extremity AVGs, the net effect would likely be a higher cumulative patency, which in turn would understate the EndoForce™ System's comparative advantage.

Finally, with regard to our concern about the potential inclusion of chest AVGs in the comparative data, the applicant stated that chest AVGs appear to only be used in an exceedingly small number of cases. The applicant also cited one medical center's case-series, which reported

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[47] Fitzgibbon, J. J., Heindel, P., Appah-Sampong, A., Holden-Wingate, C., Hentschel, D. M., Mamdani, M., Ozaki, C. K., & Hussain, M. A. (2024). Temporal trends in hemodialysis access creation during the fistula first era. *Journal of vascular surgery* (Vol. 79, Issue 6, pp. 1483–1492.e3).. *https://doi.org/10.1016/j.jvs.2024.02.020.*

[48] Han, S., Song, D., & Yun, S. (2016). Long Term Outcomes of Arteriovenous Grafts for Hemodialysis in Lower Extremities. *Vascular Specialist International*, *32*(4), 180–185. *https://doi.org/10.5758/vsi.2016.32.4.180*.

chest AVGs in only 0.56 percent of 1,192 patients between 2007 and 2012.[49] The applicant stated that the possibility of cases with AVGs in the legs or chest does not appear to be a major concern, and specific to chest AVGs, the possibility of the comparator studies' results being affected is remote enough to be negligible.

A commenter stated that, taken together, the Burgess et al. (2024), Kramer et al. (2026), and Astor et al. (2026) studies support substantial clinical improvement for the EndoForce™ System. The commenter also stated that, while the studies are not randomized, concurrent comparisons, and have identified limitations, they provide prospective, multicenter evidence in the specific upper-arm AVG population for which the EndoForce™ System is indicated. The commenter added that these limitations affect the precision of attributing outcomes solely to the EndoForce™ System, but they do not negate the clinical significance of the observed results or justify CMS disregarding the comparative evidence altogether.

In response to the totality of our concerns regarding Burgess et al. (2024), a commenter stated that experienced, specialized dialysis-access physicians prospectively designed Burgess et al. (2024) to support FDA review and understood the difference between a statistically attractive endpoint and an access that remains useful to a real patient, and therefore, the consistency of the patency findings across the pivotal study, systematic reviews, and the Astor et al. (2026) meta-analysis should be given meaningful weight.

In response to our concerns about Astor et al.'s (2026) comparison of primary patency results, a commenter agreed that the evidence does not suggest that the EndoForce™ System improves every AVG performance measure but stated that primary patency and cumulative patency measure different clinical outcomes. Per the commenter, primary patency measures how long an access remains functional before the first intervention, and cumulative or secondary patency concerns whether the access can ultimately be preserved rather than abandoned. The

[49] Liechty, J. M., Fisher, T., Davis, W., Oglesby, W. C., Bennett, M., Grimsley, B., & Shutze, W. (2015). Experience with chest wall arteriovenous grafts in hemodialysis patients. In *Annals of vascular surgery* (Vol. 29, Issue 4, pp. 690–697). *https://doi.org/10.1016/j.avsg.2014.11.014.*

commenter stated that, therefore, an AVG that requires an intervention but remains available for dialysis is not clinically equivalent to an AVG that is lost. The commenter added that it believes the available evidence suggests that the EndoForce™ System may be more beneficial for preserving AVG access than for preventing all subsequent interventions. Additionally, the commenter stated that this distinction is particularly important for patients whose permanent-access options are already limited, because AVG preservation is a clinically meaningful outcome and can prevent loss of a functioning AVG, use of additional vascular territory, interruptions in reliable dialysis access, and a patient returning to catheter dependence. The commenter concluded that substantial clinical improvement should be based on whether the EndoForce™ System improves the ability to maintain durable permanent access and avoid graft abandonment, not by measures of primary patency.

In response to our note that Astor et al. (2026) derived 6-month patency measurements from studies that did not specifically report 6-month patency outcomes, the applicant stated that 6-month patency outcomes in Burgess et al. (2024) were higher than both cohorts of studies. The applicant further stated that Astor et al. (2026) provided comparison information indicating little difference between studies that relied on survival curves versus other studies. The applicant also stated that relying on information in survival curves where such information is not reported in text or tables is methodologically appropriate. The applicant further stated that Astor et al. (2026) used commercial software specifically designed to extract numerical data from plots and that these studies, among many others, have found excellent accuracy and no differential bias in estimates abstracted using such tools. The applicant concluded that there is, therefore, no reason to suspect that this effect is considerable or would manifestly affect results' reliability to the extent that they should be excluded from the analysis. Lastly, the applicant noted that a peer-reviewed journal accepted the study which included this methodology after publication of the CY 2027 OPPS/ASC proposed rule.

In response to our concern about whether Halbert et al. (2020)'s 20 percent AVG

abandonment rate is an appropriate comparator to Astor et al. (2026)'s 8 percent AVG abandonment rate due to varied study locations and time periods, the applicant stated that the Astor et al. (2026) meta-analysis summarized 30 of the 32 studies published in the last 10 years and that studies conducted in the U.S. and outside the U.S. reflect no significant difference based on supplemental tables for Halbert et al. (2020).

In response to our interest in additional information clarifying the meaning of upper arm, the applicant stated that the term upper arm in the EndoForce™ System's FDA approval refers to the portion of the arm above the elbow.

In response to our concern that Kramer et al. (2026) lacked sufficient power to assess statistical significance, the applicant stated that the study authors do not claim the results are statistically significant. The applicant stated that Kramer et al.'s observed number of interventions per patient-year (1.32), while somewhat higher than the rate of 1.22 reported for the larger sample in Burgess et al. (2024), does compare favorably with the rates of 1.58 and 1.87 shown in Halbert et al. (2020) and Woodside et al. (2021), respectively. The applicant further stated that Kramer et al. (2026) is an extension of Burgess et al. (2024), capturing up to an additional 6 months of data for a subset of Burgess et al. (2024) patients who were high risk due to their experience of early interventions, were not lost to follow-up, and consented to additional evaluation. Additionally, the applicant noted that Kramer et al. (2026) is an intentional sub-group analysis with some additional observations on patients treated with the EndoForce™ System, and therefore, the sample size was ipso facto limited by the number of Burgess et al. (2024) patients that received at least 1 intervention in 6 months, were available for further study, and consented to extended follow up; however, the characteristics of the patient groups in both studies are very similar.

In response to our concerns regarding Kramer et al.'s (2026) insufficiently-sized patient population, inconclusive results, and differences from the available comparator populations, a commenter stated that although the study was not a randomized efficacy trial and had a small

sample, it should be viewed as an assessment of durability and procedural burden in a particularly challenging subgroup from the pivotal cohort, including patients who required early maintenance. The commenter also stated that Kramer et al.'s (2026) lower intervention rates are clinically meaningful because each potential avoided intervention reduces procedural risk, preserves veins, protects future options, and reduces the likelihood that a patient will experience access failure and return to catheter dependence.

In response to our concern about whether the strength of evidence of Kramer et al. (2026) may have been impacted by selection bias, as the patient cohort was selected and analyzed post-hoc, rather than identified as a variable of interest at the Burgess et al. (2024) initiation, the applicant explained that it selected and analyzed the Kramer et al. (2026) cohort post-hoc because, during the Burgess et al. (2024) study with input from FDA, it realized that durability results may be skewed if the patients in Burgess et al. (2024) received more maintenance services than normal. The applicant stated that it sponsored Kramer et al. (2026) to examine whether patients with an AVG and the EndoForce™ System received more maintenance procedures than normally expected and that the study determined the patients received fewer interventions than comparator studies.

In response to our concern about the appropriateness of comparing measures of cumulative patency in Burgess et al. (2024) and Kramer et al. (2026) that are not equally defined, the applicant stated the measure of cumulative patency for both studies was identical with respect to whether those who received an intervention before first cannulation were included, and how patency was measured did not differ between the studies, though obviously the measurement periods were different. The applicant stated the design of Kramer et al. (2026) was intended to capture 6 months of patient experience after either a first intervention (if the patient experienced 1 within the first 6 months) or after an implant (in the case of those who received no maintenance interventions during the 6 months). The applicant further stated a patient who received a first intervention on day 179 after implant would then be followed for an additional 6 months for a

total of 1 year less a day (in the absence of some other censoring event), and investigation of a patient with no interventions by day 180 would be censored on that day. Per the applicant, how patency was measured did not differ between the Burgess et al. (2024) and Kramer et al. (2026) studies, though obviously the measurement periods were different.

In response to our concern that it is clinically inappropriate to compare the EndoForce™ System to devices used for AVF creation to demonstrate substantial clinical improvement over existing technologies, the applicant stated AVFs and AVGs are indisputably different, but it objects to CMS's dismissal of the comparison. The applicant stated its claim that the improvement in AVG patency means that an AVG with the EndoForce™ System would exhibit patency comparable to mature AVFs is important because greater patency has been recognized as one advantage of AVFs over AVGs, and therefore, impacts clinical decision making relating to choice of vascular access for a particular patient at a particular time. The applicant additionally stated that comparison of AVGs with the EndoForce™ System to AVFs is entirely pertinent as reviewing a technology as it compares to other relevant clinical choices should be an important point of examining substantial clinical improvement. The applicant further stated that patients and their physicians are frequently able to choose between AVFs and AVGs where both would be anatomically and otherwise suitable, and speed to maturity for dialysis (on which AVGs dominate), cumulative patency (on which AVFs have dominated), extent of maintenance procedures required, and risk of infection are among the factors taken into consideration. Lastly, the applicant stated that achieving comparable cumulative patency to that reported for AVFs, including the two percutaneous AVF devices (WavelinQ™ and Ellipsys™), would thus improve AVGs' clinical attractiveness in comparison to an existing, widely used therapeutic option for the dialysis population and that this improvement could be particularly important for patients that may be marginal as candidates for an AVF (e.g., those with smaller vessels, such as many females).

In contrast to the applicant, a commenter stated that because the EndoForce™ System

creates an AVG in such patients, the relevant comparator for assessing substantial clinical improvement is the conventional surgically-created graft-to-vein anastomosis, not mature AVFs and devices used to create AVFs as these technologies involve fundamentally different mechanisms and clinical uses. The commenter also agreed with CMS that AVFs and AVGs differ in mechanism and use and noted that AVF creation may be unsuccessful or inappropriate for some patients, making an AVG the more appropriate permanent-access option.[50] The commenter further stated that for patients who are appropriate candidates for permanent AVG access, maintaining this access can help avoid prolonged catheter dependence, its greater infection risk, and other associated clinical risks.

Further, the commenter stated that CMS's prior application of the substantial clinical improvement standard supports granting the EndoForce™ System transitional pass-through payment status despite meaningful evidentiary limitations because overall the evidence supports the technology producing a clinically important benefit. The commenter cited three precedents it believes support evaluating the limitations in the provided evidence as factors affecting weight and certainty, rather than as categorical barriers to approval. The commenter cited CMS's approval of the Hemospray® Endoscopic Hemostat in the CY 2021 OPPS/ASC final rule (85 FR 85997 through 86003), in which CMS considered concerns including single-arm studies, selection bias, and differences in study populations but approved transitional pass-through payment status; the AUGMENT Bone Graft in the CY 2020 OPPS/ASC final rule (84 FR 61292 through 61294) after initially questioning the evidence's adequacy, the appropriate comparator, and the duration of follow-up; and the Tablo System in the CY 2022 ESRD PPS final rule (86 FR 61889 through 61906), in which CMS stated that randomized controlled trials are not required to demonstrate substantial clinical improvement.

Response: We appreciate the applicant's and commenters' input. We agree with the

[50] *CMS ESRD Measures Manual for the 2026 Performance Period*. (2026). *https://www.cms.gov/files/document/esrd-measures-manual-v11-2.pdf.*

applicant and commenters that the EndoForce™ System and the endovascular procedure should be assessed together for the purposes of evaluating substantial clinical improvement. However, we continue to have several of the concerns listed in the CY 2027 OPPS/ASC proposed rule. In particular, we are concerned about the lack of comparative evidence based on matched patient data. We note that imbalance in baseline patient characteristics could confound the association between EndoForce™ and patency. We acknowledge the comments from the applicant and a commenter regarding vascular access location and the time periods, or ages, of different studies, but remain concerned about the extent to which the findings of the Burgess et al. (2024), Astor et al. (2026), and Kramer et al. (2026) studies might have been biased by measured and unmeasured confounders. We expressed concern in the CY 2027 OPPS/ASC proposed rule that Burgess et al. (2024) lacked stratification by key clinical factors known to affect AVG outcomes, and therefore, there are insufficient data to rule out the possibility that factors other than EndoForce™ may also have impacted cumulative and primary unassisted patency. We acknowledge the comparison provided by the applicant, in its comments, of the average age and body mass index (kg/m2) of the patients in the Burgess et al.(2024) and Astor et al. (2026) studies, and the percentages of those who were male, white, diabetic, with hypertension, cardiovascular disease, or current tobacco use. However, we note that other risk factors, such as prior catheter use, low albumin, an elevated high-sensitivity C-reactive protein (hsCRP) level, low fetuin-A, low diastolic blood pressure, hemoglobin <10 g/dL, peripheral artery disease, and low initial intra-access blood flow (< 650 mL/min), have also been associated with decreased

patency.[51][52][53][54][55] Although the applicant noted that the sample size would have limited the value of stratified analyses within the Burgess et al. study (2024), this limitation does not resolve our concerns about differences across studies in patients' baseline characteristics, inclusion and exclusion criteria, and study designs. These differences could increase the uncertainty[56] around the estimates for the endpoints.[57][58]

While we agree with the commenter who stated that cumulative patency is a clinically relevant endpoint for evaluating the EndoForce™ System, we continue to have concerns about the high degree of variability, or heterogeneity, among the comparison studies in the two meta-analyses, Astor et al. (2026) and Halbert et al. (2020). Although commenters discussed several potential sources of heterogeneity, we did not receive sufficient information or analyses to determine the extent to which those factors account for the high degree of variability among the included studies. We note that the values of the I^2 statistic in Astor et al. (2026) (I^2=99.36 percent for cumulative patency at 6 months; I^2=99.44 percent for primary unassisted patency at 6 months) and Halbert et al. (2020) (I^2=91 percent for cumulative patency at 12 months) indicated considerable heterogeneity among included studies. We remain uncertain whether the pooled estimates of 83.23 percent and 60.35 percent in the Astor et al. study (2026) accurately

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[51] Monroy-Cuadros M, Yilmaz S, Salazar-Bauelos AS, et al. (2012). Independent prediction factors for primary patency loss in arteriovenous grafts within six months. *The Journal of Vascular Access*. Jan-Mar; 13(1):29-35. doi: 10.5301/JVA.2011.8425 https://pubmed.ncbi.nlm.nih.gov/21688243/.

[52] Ocak, G., Rotmans, J.I., Vossen, C.Y. et al. Type of arteriovenous vascular access and association with patency and mortality. *BMC Nephrol* **14**, 79(2013). https://doi.org/10.1186/1471-2369-14-79.

[53] Trivedi PS, Lind KE, Ray CE, et al. (2018). Race and sex disparities in outcomes of dialysis access maintenance interventions. *Journal of Vascular and Interventional Radiology* 2018 Apr;29(4):476-481.e1. doi: 10.1016/j.jvir.2017.10.018 https://pubmed.ncbi.nlm.nih.gov/29373244/.

[54] Park J, Kim J, Hwang S, et al. (2018). Arteriovenous graft patency outcomes and prognostic factors. *Vascular* DOI: 10.1177/1708538118807844 https://pubmed.ncbi.nlm.nih.gov/30360702/.

[55] Hamouda M, Rahgozar S, Rogers UH, et al. (2026). Progression of peripheral arterial disease predicts worse outcomes after dialysis access surgery. *Journal of Vascular Surgery*. 84(2): p. 510-518. DOI: 10.1016/j.jvs.2026.04.00 https://pubmed.ncbi.nlm.nih.gov/42268171/.

[56] International Council for Harmonization (ICH) (2000). ICH Harmonized Tripartite Guideline. E10 – Choice of Control Group and Related Issues in Clinical Trials. Step 4 version (*https://www.ich.org/page/efficacy-guidelines*, accessed September 15, 2026).

[57] Hatswell A, Freemantle N, Baio G, et al. (2020). Summarizing salient information on historical controls: A structured assessment of validity and comparability across studies. *Clinical Trials*. Vol. 17(6) 607-616 *https://doi.org/10.1177/1740774520944855*.

[58] Collignon O, Schritz A, Spezia R, et al. (2021). Implementing historical controls in oncology trials. *The Oncologist*. 26:e859-e862 *https://doi.org/10.1002/onco.13696*.

represented the 6-month cumulative and primary unassisted patency, respectively, of AVGs with a sutured venous anastomosis. Similarly, we remain concerned about the reliability and validity of the patency rates reported by Halbert et al. (2020) and whether these serve as an appropriate standard for comparison. While we acknowledge that heterogeneity can be difficult to avoid when comparing the results of different studies, we remain concerned that substantial variability may affect the extent to which generalizable conclusions can be formed about EndoForce™'s impact on patency relative to existing technologies.[59] As a result, we remain concerned that the comparisons between EndoForce™ and existing treatments for those endpoints may not be reliable indicators of EndoForce™'s substantive clinical improvements.

In addition, we note that the primary endpoint of Burgess et al. (2024), cumulative patency at 6 months, was compared to the pre-specified 6-month performance goal of 75 percent. Per Burgess et al. (2024), this performance goal was based on five published studies.[60] However, we note that these studies reported cumulative and primary unassisted patency at different time points, ranging from 6 to 22.5 months. We also note that while three of the studies reported patency at 12 months, only one[61] reported patency at 6 months. As a result, we are unable to determine whether the 75 percent performance goal was a valid indicator of the 6-month performance of existing technologies, or the extent to which comparing EndoForce™'s effects on cumulative patency against the 75 percent performance goal could reliably indicate whether EndoForce™ performs better than existing technologies in maintaining patency.

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[59] Higgins JPT, Thomas J, Chandler J, Cumpston M, Li T, Page MJ, et al, editor(s). *Cochrane Handbook for Systematic Reviews of Interventions* version 6.5 (updated August 2024). Cochrane, 2024. Available from www.cochrane.org/handbook. (*https://www.cochrane.org/authors/handbooks-and-manuals/handbook/current,* accessed September 15, 2026).

[60] Those 5 publications included Huber TS, Carter JW, Carter RL, et al. Patency of autogenous and polytetrafluoroethylene upper extremity arteriovenous hemodialysis accesses: A systematic review. *Journal of Vascular Surgery* 2003: 38:1005-1011; Glickman MH, Burgess J, Cull D, et al. Prospective multi-center study with a 1-year analysis of a new vascular graft used for early cannulation in patients undergoing hemodialysis. *Journal of Vascular Surgery.* 2015: 62:434-441; Dixon BS, Beck GJ, Vazquez MA, et al. Effect of dipyridamole plus aspirin on hemodialysis graft patency. *New England Journal of Medicine*. 2009: 360: 2191-2201; Miller PE, Carlton D, Deierhoi MH, et al. Natural history of arteriovenous grafts in hemodialysis patients. *American Journal of Kidney Disease* 2000; 36:68-74; and Cnat ME, Hopkins J and Wilson SE. A prospective evaluation of PTFE graft patency and surveillance techniques in hemodialysis access. *Annals of Vascular Surgery* 1999; 13: 191-198.

[61] Huber 2003, *op.cit.*

In addition, we remain concerned about the use of a digitization tool by Astor et al. (2026) and Halbert et al. (2020) to abstract data on 6-month patency measurements from Kaplan-Meier survival curves from studies that did not specifically report 6-month patency outcomes. We note that the 6-month patency rates from more than half of the studies in Astor et al.'s (2026) meta-analysis were abstracted using DigitizeIt software, a digitization tool.[62] We note that studies validating abstracted data have found DigitizeIt and similar software in general to be highly accurate.[63] However, we also note that the reliability and validity of the abstracted data have been found to be independent of the specific software program, but are dependent on the properties of the figure being digitized.[64] In particular, the reliability of the abstracted data depends on the quality of the initial input and the level of information provided by the publication.[65] Published figures, like low-quality or rasterized images, rather than the abstraction, were a major source of errors.[66] Halbert et al (2020) reported that some survival curves could not be digitized because of the poor quality of the original publication graphics.[67] A recent study found that digitization tools like DigitizeIt could be limited by operator precision and image resolution.[68] Even tools developed using automated image-based approaches remain constrained by figure quality and rasterization artifacts. Errors introduced during digitization can propagate and affect downstream analyses, such as treatment effect estimation and meta-analysis. Another recent study found that pixelation and color blending could degrade coordinate

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[62] Figure 2 of the Astor study (2026) showed that data were abstracted from 24 (53 percent) of the 45 studies in its meta-analysis of 6-month cumulative patency. Figure 3 of the same study showed that data were abstracted from 25 (N=54 percent) of the 46 studies in its meta-analysis of 6-month primary unassisted patency.

[63] Rakap S, Rakap S, Evran D, et al. (2016). Comparative evaluation of the reliability and validity of three data extraction programs: UnGraph, Graphclick, and DigitizeIt. *Computers in Human Behavior* 55:159-166.

[64] Moeyaert M, Maggin D, Verkulen J, et al. (2016). Reliability, validity, and usability of data extraction programs for single-case research designs. *Behavior Modification* Vol 40, Issue 6 *https://doi.org/10.1177/014544551664*.

[65] Guyot P, Ades AE, Ouwens MJNM, et al. (2012). Enhanced secondary analysis of survival data: reconstructing the data from published Kaplan-Meier survival curves. *BMC Medical Research Methodology*. 12:9 *https://doi.org/10.1186/1471-2288-12-9.*

[66] Wojtyniak JG, Britz H, Selzer D, et al. (2020). Data digitizing: Accurate and precise data extraction for quantitative systems pharmacology and physiologically-based pharmacokinetic modeling. *Pharmacometrics & Systems Pharmacology https://doi.org/10.1002/psp4.12511*.

[67] Halbert et al, 2020, *op.cit.*, p. 1439.

[68] Lang L, Gao Q, Zhao Y, et al. (2026). RESOLVE-IPD: High-Fidelity Individual Patient Data Reconstruction and Uncertainty--Aware Subgroup Meta-Analysis. arXiv:2511.01785v2 [stat.ME] *https://arxiv.org/html/2511.01785*.

accuracy, introducing noise during digitization.[69] The study also found visual representations of censoring to be another common source of errors. Specifically, when censoring ticks are missing or poorly resolved, algorithms may misplace event timings, leading to biased survival estimates. Dense clustering of early censoring marks can obscure later events or make digitization unreliable. Because a 6-month patency point sits exactly in this early, censoring-dense region, we are concerned that these limitations may have important implications for the Astor et al. (2026) and Halbert et al. (2020) meta-analyses. We remain concerned about the quality of these abstracted data and the potential impact on the pooled 6-month patency among currently available AVGs, and uncertain whether the results reported by Astor et al. (2026) and Halbert et al. (2020) indicate that EndoForce™ produced better clinical outcomes than the AVGs with a standard sutured venous anastomosis. Regarding Astor et al. (2026), it also remains unclear whether the difference between the 6-month cumulative patency rates of 92 percent in Burgess et al. (2024) and 86 percent in the 12 studies reporting numerical values was statistically significant.

We continue to have concerns about the appropriateness of comparing EndoForce™'s effects on patency with those of AVFs. We agree with the commenter who stated that AVF is not a viable permanent-access strategy for some patients, that current KDOQI guidance[70] emphasizes a patient-centered approach based on vessel characteristics, comorbidities, anticipated dialysis needs, and patient circumstances rather than an absolute 'fistula first' approach, and that the substantial clinical improvement inquiry should ask whether EndoForce™ improves treatment relative to the conventional, surgically created graft-to-vein anastomosis it replaces, not whether an AVG created with EndoForce™ is superior to an AVF in a patient for whom an AVF is otherwise appropriate. Accordingly, comparisons between EndoForce™ and

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[69] Tong G, and Li F (2026). Reconstructing Pseudo Individual Patient-Level Data From Published Survival Curves in Cardiovascular Trials. *Journal of American College of Cardiology* 87(5): 530-532. doi: *10.1016/j.jacc.2025.12.060*.

[70] Lok CE, Huber TS, Lee T, et al; KDOQI Vascular Access Guideline Work Group. KDOQI clinical practice guideline for vascular access: 2019 update. *American Journal for Kidney Disease*. 2020; 75(4) (suppl 2):S1-S164.

AVFs do not directly address whether EndoForce™ provides substantial clinical improvement over existing technologies.

In response to our concern that Kramer et al. (2026) was not sufficiently powered to assess patency at 180 days post-implantation among patients with ESRD who needed hemodialysis, the applicant stated that the study did not claim that its results were statistically significant and a commenter noted that CMS should nevertheless treat the results as clinically meaningful. However, we maintain our concern that a comparison of the results from Kramer et al. (2026) to other studies could be confounded by differences between the studies, and we remain uncertain whether any difference in intervention rates or patency can be attributed to the use of EndoForce™ alone.

A commenter noted that CMS's prior application of the substantial clinical improvement standard supports granting the EndoForce™ System transitional pass-through payment status despite meaningful evidentiary limitations, because the evidence supports the technology producing a clinically important benefit. We disagree that the prior approvals cited by the commenter establish that EndoForce™ System meets the substantial clinical improvement criterion. We note that we assess each application on its own merits based on the evidence submitted. Our concerns regarding the evidence supporting this application are discussed previously. We refer to the full details of our rationale regarding other applications in the respective final rules.

After consideration of the public comments we received and our review of the application, the EndoForce™ System does not meet the substantial clinical improvement criterion to be considered for device pass-through payment. Therefore, in this final rule with comment period, we will not address whether the technology meets the remaining criterion required for device pass-through payment. We are not approving the EndoForce™ System for device pass-through payment status for CY 2027 because the technology does not meet the substantial clinical improvement criterion at § 419.66(c)(2).

(b) LINK™ External Fixator

Metric Medical Devices, Inc. submitted an application for a new device category for transitional pass-through payment status for the LINK™ External Fixator for CY 2027. According to the applicant, the LINK™ External Fixator is a dynamic percutaneous bone external fixator that provides continuous compression during the healing of bony fractures, fusions, and osteotomies. The applicant stated that the LINK™ External Fixator is composed of the (1) LINK™, a stainless steel box-shaped spring that applies forces to wires or pins inserted in the bone to either actively pull together and compress or distract the bones; (2) LINK™ Cover, a silicone cap that covers the bone pins or wire; and (3) LINK™ Bone Pins, which are inserted in a patient's bones and to which the LINK™ attaches.

Table 55 provides an overview of the transitional pass-through payment status application for the LINK™ External Fixator and CMS's preliminary assessment. For additional details provided by the applicant, please refer to the online application posting available at *https://mearis.cms.gov/public/publications/device-ptp/DEP250902M814F*.

TABLE 55: LINK™ EXTERNAL FIXATOR APPLICATION OVERVIEW

Device Pass-through Criteria	Applicant Statements	Preliminary CMS Assessment
Newness Criterion	*FDA Marketing Authorization:* 510(k) clearance - May 29, 2024 *Application submitted to CMS*: September 2, 2025	No concerns.
FDA Indication	Indications for use: 1) hand and foot bone fragment and osteotomy fixation and joint arthrodesis, 2) fixation of proximal tibial metaphysis osteotomy and 3) adjunctive fixation of small bone fragments (i.e. small fragments of bone which are not comminuted to the extent to preclude LINK™ bone pin placement). These fragments may be located in long bones such as the femur, fibula and tibia in the lower extremities; the humerus, ulna or radius in the upper extremities; the clavicle and ribs; and in flat bones such as the pelvis, scapula and sternum.	No concerns.
§ 419.66(b)(3)	Device is integral to the service(s) furnished, used for one patient only, comes in contact with human tissue, and is surgically inserted/implanted/applied in or on a wound or other skin lesion.	See following discussion.
§ 419.66(b)(4)	Device is not equipment, an instrument, apparatus, implement, or item of this type for which depreciation and financing expenses are recovered as depreciable assets, and is not a material or supply furnished incident to a service.	See following discussion.
Device Category	Device category code C1713 (Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)) does not describe the device.	See following discussion.
Cost Criteria	The cost of the LINK™ External Fixator is $4,800. This cost includes the 4-pin LINK™ and the corresponding LINK™ Cover ($4,500) as well as two LINK™ Bone Pin packages (2 pins in each package)	No concerns.

	($300).[1] For cost significance requirements:[2] HCPCS code: 28899 APC code: 5111 CY 2025 device offset amount: $50.18 CY 2025 APC payment rate: $239.88 Requirement #1: ($4,800 / $239.88) x 100 = 2,001.00%. Requirement #2: ($4,800 / $50.18) x 100 = 9,565.56%. Requirement #3: (($4,800 - $50.18) / $239.88) x 100 = 1,980.08%.	
Substantial Clinical Improvement Criterion	Claim #1: The LINK™ External Fixator offers a treatment option for a patient population unresponsive to, or ineligible for, currently available treatments, such as those patients with infected sites, metal allergies, anesthesia sensitivity, skin pathology, or other co-morbidities such as diabetes, neuropathy or immunocompromised patients, due to the minimally invasive nature of the bone fixation the LINK™ External Fixator provides. Claim #2: The LINK™ External Fixator significantly improves clinical outcomes for a patient population as compared to currently available treatments because of its ability to percutaneously fixate fractures, osteotomies, or arthrodesis, thus protecting the soft tissue envelope, vascular, and neural structures, which historically result in a more robust healing response and a shorter time to function. Two documents describing the nominated technology and its fundamental principles were provided. No published or unpublished studies assessing the technology were provided.	See following discussion.

[1.] Per the applicant, the LINK™ is the shape changing force creating bridging element between bone pin implants with the fracture or site of fusion between the pins. The cost and components listed in the table are for a 4-pin LINK™ External Fixator. According to the applicant, a 2-pin LINK™ External Fixator is available and would cost $3,650 for the 2-pin LINK™ and LINK™ Cover ($3,500) as well as one LINK™ Bone Pin package (2 pins in each package) ($150). Each LINK™ package includes a cover to protect it from the environment. Additional LINK™ Covers can be purchased in a separate package if a replacement cover is needed ($300 for a 2-pin cover or $350 for a 4-pin cover). Per the applicant, all components (LINK™, LINK™ Bone Pins, and LINK™ Cover) are required, and there are no partial systems. The applicant stated that multiple LINK™ units may be used for higher level musculoskeletal procedures, such as five LINK™ units for a Lisfranc dislocation, complex fractures, or Charcot foot fixation.

[2.] In the CY 2027 OPPS/ASC proposed rule, we noted that the applicant selected the APC level device offset amount of $0.19 for APC 5111 found in CY 2025 NFRM APC Offset File. Beginning in CY 2017, we calculate the device offset amount at the HCPCS code level instead of the APC level (81 FR 79657). We noted the HCPCS code level device offset amounts for the HCPCS codes provided by the applicant are available in Addendum P to the CY 2025 OPPS/ASC final rule with comment period (89 FR 93912). For our calculation, we selected the HCPCS level device offset amount of $50.18 related to HCPCS 28899 in APC 5111 found in Addendum P. Based on our initial assessment for the CY 2027 OPPS/ASC proposed rule, we stated using the device offset amount of $50.18 would result in the LINK™ External Fixator meeting the cost significance requirements.

We invited public comment on whether the LINK™ External Fixator meets the newness criterion at § 419.66(b)(1).

Comment: With respect to the newness criterion at § 419.66(b)(1), the applicant reiterated that the LINK™ External Fixator meets the newness requirement for device pass-through payment.

Response: We appreciate the applicant's input. We received the application for device

pass-through payment status for the LINK™ External Fixator within 3 years of the date of FDA 510(k) clearance. After consideration of the public comments we received and our review of the application, we have determined that the LINK™ External Fixator meets the newness criterion at § 419.66(b)(1).

Regarding the eligibility criterion at § 419.66(b)(3), we stated in the CY 2027 OPPS/ASC proposed rule that we were concerned that the LINK™ External Fixator components may not be integral to the service furnished, come in contact with human tissue, or be surgically inserted or implanted.

With respect to whether the LINK™ Bone Pins and LINK™ Cover are integral to the service furnished, based on the information provided by the applicant, we questioned whether the components are necessary to furnish or deliver the primary procedure with which it is used. We noted that, in the CY 2014 OPPS/ASC final rule with comment period (78 FR 75005), we stated that we have interpreted the term "integral" to mean that the device is necessary to furnish or deliver the primary procedure with which it is used. We stated, for example, a pacemaker is integral to the procedure of implantation of a pacemaker. We noted that according to the applicant, the LINK™ uses a single- use external fixator consisting of a stainless-steel bridge spring formed into a box shape, with holes that are held in alignment by surgical needle drivers during pin placement. We stated that per the applicant, when released, the bridge shortens to apply forces and the side elements swing outward to create moments on bone fixation pins or wires embedded in bone, pulling together and compressing or distracting bony structures. We stated, while the LINK™ External Fixator may include LINK™ Bone Pins, per the applicant, other commercially available bone pins, k-wires, or Steinmann pins (hereinafter referred to collectively as "bone fixation pins or wires") may be compatible with the LINK™ External Fixator, and we therefore questioned whether the LINK™ Bone Pins are integral to the service furnished as they may be replaced with other commercially available bone fixation pins or wires. We further questioned whether the LINK™ Bone Pins are integral to the service furnished as it

is unclear, based on the information provided in the application, whether any LINK™ Bone Pins are included in the LINK™ External Fixator packaging, or if they are packaged and sold separately from the LINK™ External Fixator. With respect to the LINK™ Cover, because the applicant stated that the LINK™ Cover is a separate removable silicon elastomer cover that protects the LINK™ and the patient from the pin and wire ends and does not play a role in providing compression, as such, we also questioned if the LINK™ Cover is integral to the service furnished. We stated that we would be interested in additional information about these components of the LINK™ External Fixator, including whether the components are required to furnish or deliver the primary procedure with which it is used and if the components can be substituted with other commercially available products.

With respect to whether the LINK™ External Fixator comes in contact with human tissue and is surgically inserted or implanted, we noted that, per the applicant, the LINK™ Bone Pins (or other bone pins or wires) are the only components that come in contact with human tissue and are surgically implanted or inserted into the patient. We stated, per the applicant, the LINK™ component remains outside the body and acts like a spring on skin penetrating bone fixation pins to reduce and provide continuous compression at the bone healing interface. We further noted that, according to the applicant, the LINK™ Cover is a separate, removable cover that does not come in contact with and is not surgically implanted or inserted into the patient. Therefore, we stated our belief that the LINK™ and the LINK™ Cover components of the LINK™ External Fixator do not come into contact with human tissue and are not surgically inserted or implanted as required by § 419.66(b)(3).

We invited public comment on whether the LINK™ External Fixator meets the eligibility criterion at § 419.66(b)(3).

Comment: In response to our concerns that the LINK™ External Fixator is not integral to the services furnished because the LINK™ and the LINK™ Cover components do not come into contact with human tissue and are not surgically inserted or implanted, the applicant and a

few commenters stated that the LINK™ and the LINK™ Bone Pins and Cover are integral for performing bone fixation. The applicant reiterated that an assembled LINK™ External Fixator consists of the LINK™, LINK™ Bone Pins with locking mechanism (sharp or flat groove), and the LINK™ Cover that protects the LINK™, limits forces by limiting expansion of the LINK™, restricts shape change, and provides the first layer of wound coverage.

The applicant commented that the LINK™ Bone Pins have sharp or flat grooves that lock into the LINK™ bridge, so that they operate as a single unit when implanted or inserted or applied to the wound. The applicant further stated it offers the LINK™ External Fixator under one part number as a bundled product offering consisting of the LINK™, two LINK™ Bone Pins with locking mechanism, and the LINK™ Cover. The applicant added that it offers three types of LINK™ Bone Pins, all with sharp or flat grooves to lock into the LINK™, so that the physician has the option of choosing which LINK™ Bone Pin type is best for the condition being treated and for the style of LINK™ selected. The applicant concluded that the LINK™, the LINK™ Bone Pins, and the LINK™ Cover are consequently an integral part of the bone fixation service provided, and thus, the LINK™ External Fixator meets the requirements of § 419.66(b)(3).

The applicant stated it does not offer k-wires or Steinman pins for use with the LINK™ External Fixator, although these wires or pins are compatible as they are stainless steel and 2.0 mm in diameter. The applicant and a few other commenters stated that although physicians may choose another vendor's pins or k-wires to use with the LINK™, this is not recommended because these pins or wires have not been adequately tested with the LINK™ External Fixator and may be unable to withstand the forces created. The applicant and a commenter specifically noted that use of other bone pins would not have the advantage of locking to the LINK™ to prevent moving or shifting, which could potentially alter a surgeon's positioning of bones and the preferred force profile generated. The applicant added that k-wires and Steinman pins will not retain the LINK™ nor have the strength of the LINK™ Bone Pins.

A commenter stated that the pins are integral to the functioning of the LINK™ External Fixator as the nominated device's bone stabilization and compression improves outcomes versus other devices on the market. The commenter stated that due to the spring-like quality of the LINK™ External Fixator, the device locks onto the bone pins once compression is realized by releasing the needle drivers from the compressing tab. The commenter explained that this converts the separate components of the LINK™ and each LINK™ Bone Pin into a solid dynamic construct, where any force applied to the LINK™ Bone Pins is transferred to the LINK™ and vice versa. The commenter expressed its belief that the LINK™ Bone Pins and LINK™ are essential to one another to function as intended.

Another commenter explained that the applicant packages the LINK™ Bone Pins separately to allow physicians to choose which pin type to use during surgery. The commenter stated that combining both types of pins into the same box would force a physician to open multiple packages and increase waste in the case the physician needs larger pins than originally expected or a mix of sizes due to anatomical challenges.

In response to our concerns that the LINK™ External Fixator does not come in contact with human tissue and may not be surgically inserted or implanted or applied in or on a wound or other skin lesion, the applicant commented that, in patients with complex, open Grade III fractures, the LINK™, the LINK™ Bone Pins, and the LINK™ Cover are surgically implanted or inserted (either permanently or temporarily) or applied in or on a wound. The applicant stated that, while inserting, implanting, or applying the LINK™ and a LINK™ Bone Pin, the LINK™ is placed in contact with the bone, wound, or skin while guiding the LINK™ Bone Pins and steading the placement. According to the applicant, once stable, the LINK™ Bone Pin is advanced deeper into bone and additional bone pins are placed prior to lifting the LINK™ from the bone or wound to adjust the bone fixation forces. The applicant further stated and provided images to show that the LINK™ Cover is commonly in contact with the skin or wound to seal the site from contamination, and that after removal, the LINK™ Cover leaves a visible

impression in the skin from long-term contact. The applicant stated that this clinical use shows the placement of the LINK™ on the wound, skin closure around the LINK™ Bone Pins, and evidence of the LINK™ Cover in long-term contact with the skin. The applicant further explained that the LINK™ Bone Pins are always implanted in bone while the LINK™ and the LINK™ Cover can be placed in direct contact with the osseous and soft tissue structures in an open wound (such as a grade III fracture) to apply the greatest forces to bone, then adjusted upward to optimize bone applied forces.

The applicant stated that an example of implantation of the LINK™, the LINK™ Bone Pins, and the LINK™ Cover occur when an open, often infected bone fracture requires a multi-step surgical procedure to close it. According to the applicant, in these fractures, the LINK™ External Fixator is used differently than in the office. Specifically, the applicant stated that in an open wound, the physician can move the LINK™ on the LINK™ Bone Pins from bony cortex to above the skin. The applicant stated that the LINK™ can lie in an open wound and be covered with skin flaps or dressing to support immediate bony reconstruction while limiting bacterial colonization, as physicians commonly do not immediately close infected or heavily contaminated wounds because sealing bacteria inside causes severe complications like osteomyelitis. Per the applicant, treatment relies on thorough cleaning, antibiotics, and delayed closure. The applicant further explained that screw, plate, staple, or rod type internal fixation hardware is contraindicated because it will often harbor the infection. The applicant stated that an unsolved healthcare problem exists during this treatment period when internal fixation cannot be used, because dynamic compression's enhanced bone healing effects are unavailable in external fixators other than the LINK™ External Fixator. The applicant stated that in this population, the LINK™ External Fixator is the only available bone fixation option, because if it becomes colonized by bacteria, the LINK™ External Fixator can be easily removed and replaced with a new sterile LINK™ system. The applicant stated that this permits immediate bone fixation and supports an optimized bone-healing response while still allowing the physician to perform staged

wound closure. The applicant stated that together, this allows the treated bone to achieve fusion while managing the infection with repeated debridement, covering and uncovering, force adjustment, and closure.

In addition, the applicant stated that when a wound is not traumatically opened, a physician either sutures the LINK™ Bone Pin within an incision or inserts it percutaneously. Specifically, the applicant stated that, prior to incision closure, the LINK™ is brought into contact with bone then raised to its optimal force height. The applicant stated that this step optimizes the dynamic compression forces the LINK™ applies to fixate bone and promote healing. The applicant further noted that, in both open and closed fractures, the LINK™ External Fixator is in contact with skin or surgically implanted. According to the applicant, the LINK™ cannot operate independently of the bone pins as it is assembled by inserting a bone pin through it and then bringing both the bone pin and the LINK™ into the wound such that they contact bone, subcutaneous tissues, fascia, or skin. The applicant stated that the bone being fixated is effectively part of the LINK™ External Fixator system, because the device cannot be assembled and function without bone being the final member in the construct. The applicant concluded that in patients suffering from an open fracture or bone-communicating skin ulcer, the LINK™ and the LINK™ Cover components of the LINK™ External Fixator do come into contact with human tissue, and thus, are surgically inserted or implanted as required by § 419.66(b)(3).

Response: We appreciate the applicant and commenters' input. Although we remain uncertain for reasons described in our consideration of the § 419.66(b)(4) criterion, we believe that the LINK™ External Fixator, including the LINK™ Cover and the LINK™ Bone Pin components, may be an integral part of the service furnished, used for one patient only, come in contact with human tissue, and be surgically implanted or inserted or applied in or on a wound or other skin lesion. After consideration of the public comments we received and our review of the application, we believe that the LINK™ External Fixator may meet the eligibility criterion at §

419.66(b)(3), unless the LINK™ Bone Pins may be considered a supply, as discussed in greater detail later in this section.

In the CY 2027 OPPS/ASC proposed rule, regarding the eligibility criterion at § 419.66(b)(4), we questioned whether the LINK™ Bone Pins could be considered a supply furnished incident to a service, based on the applicant's description. First, we questioned the role of LINK™ Bone Pins in creating surgical openings for access to bone to accomplish the fixation provided by the LINK™. In the CY 2001 OPPS interim final rule (65 FR 67804 through 67805), we stated that we consider items used to create incisions, such as scalpels, electrocautery units, biopsy apparatuses, or other commonly used operating room instruments, to be supplies or capital equipment not eligible for transitional pass-through payments. Based on the information in the application, we stated we were unclear if the LINK™ Bone Pins (or other bone fixation pins or wires) are placed through a previously created surgical opening or if they are directly inserted through skin and soft tissue to access bone. We stated we would welcome information regarding whether, when, and how an incision is created during placement of the LINK™ External Fixator. Second, as discussed previously with respect to criteria at § 419.66(b)(3), we noted that it is unclear whether the LINK™ Bone Pins may be replaced with other commercially available bone fixation pins or wires. We stated that we would be interested in clarification about whether the LINK™ Bone Pins can be substituted with other commercially available products. We questioned whether LINK™ Bone Pins may be considered a supply or material furnished incident to a service and excluded from device pass-through payment eligibility under § 419.66(b)(4).

We invited public comment on whether the LINK™ External Fixator meets the eligibility criterion at § 419.66(b)(4).

Comment: The applicant submitted a public comment reiterating its belief that the LINK™ External Fixator is not equipment, an instrument, apparatus, implement, or item of this type for which depreciation and financing expenses are recovered as depreciable assets, or a

material or supply furnished incident to a service. As previously mentioned, the applicant stated that it would not recommend the use of k-wires or Steinman pins with the LINK™ because they would not lock into the LINK™. The applicant stated that the LINK™ Bone Pin's locking system is unique to the LINK™ External Fixator and novel, as described in U.S. patents 11,944,352 and 12,690,890. The applicant stated that LINK™ Bone Pins are incompatible with general use as a pin or wire, and thus, are not a general supply incidental to the bone fixation procedure. A commenter also stated that other bone pins could possibly be used, although they were not tested with the LINK™ during the 510(k) clearance process. The commenter added that using non- LINK™ bone pins may present concerns because it is unclear whether they would lock into the LINK™ without moving, sliding, or shifting, potentially altering the surgeon's positioning of bones and the preferred force profile set.

In response to whether the LINK™ Bone Pins are used to create surgical openings during placement of the LINK™ External Fixator, the applicant stated that the LINK™ Bone Pins could not be considered a supply furnished incident to a service due to their unique locking feature design, use in open fractures, and within an incision, and in these cases, the LINK™ Bone Pins are not used to create a surgical opening for access to fixate in bone. The applicant stated that the LINK™ Bone Pins are, consequently, outside the scope of CY 2001 OPPS interim final rule (65 FR 67804 through 67805).

Response: We appreciate the applicant and commenter's input. With respect to the eligibility criterion at § 419.66(b)(4), in the CY 2001 OPPS interim final rule (65 FR 67804 through 67805), we stated that we consider items used to create incisions, such as scalpels, electrocautery units, biopsy apparatuses, or other commonly used operating room instruments, to be supplies or capital equipment not eligible for transitional pass-through payments.

While the applicant stated that the LINK™ Bone Pins are not used to create a surgical opening when used in open fractures and within an incision, the applicant also stated that when the wound is not traumatically opened, the LINK™ Bone Pin may be inserted percutaneously.

In these cases, it is unclear if the LINK™ Bone Pins are being inserted directly through the skin. In addition, while the LINK™ Bone Pins' locking feature is specific to the LINK™ External Fixator and not interchangeable with commonly available fixation pins or wires, which distinguishes the LINK™ Bone Pins from certain generally available supplies, we do not believe it resolves our concern regarding whether the LINK™ Bone Pins may constitute a supply, particularly when inserted percutaneously. Therefore, after consideration of the public comments we received and our review of the application, it remains unclear whether the LINK™ Bone Pins may be considered a supply or material furnished incident to a service. In addition, if the LINK™ Bone Pins may sometimes be considered a supply and therefore potentially ineligible for pass-through under § 419.66(b)(4), then the LINK™ External Fixator, considered as a whole device, may be ineligible. Considering the components separately, we remain concerned that the LINK™ and the LINK™ Cover components of the LINK™ External Fixator do not appear to be surgically implanted or inserted as required by § 419.66(b)(3) in cases where the LINK™ Bone Pins may be considered a supply.

We stated in the CY 2027 OPPS/ASC proposed rule, regarding the device category eligibility criterion at § 419.66(c)(1), that the applicant stated that the existing pass-through code of C1713 (Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)) does not appropriately describe the LINK™ External Fixator because the category does not include fixators with the LINK™'s shape-changing, spring-like design that stores elastic mechanical energy allowing it to provide continuous dynamic compression, which pulls bones together and closes gaps formed by bone resorption or inadvertent mechanical loading and stimulates mesenchymal stem cells (MSC) to differentiate along an osteogenic pathway to form bone and cartilage. In contrast, the applicant stated that traditional external fixators included in C1713 are static, and therefore, do not readjust or impart compression or distraction forces to enhance bone healing as the LINK™ does.

We also stated in the CY 2027 OPPS/ASC proposed rule that, based on the description

the applicant provided, the LINK™ External Fixator is an external fixator that attaches to pins inserted into the bone principally with the intent to facilitate stabilization or oppose bone-to-bone contact, and therefore, could be appropriately described by C1713 (Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)). Further, we stated that C1713 does not describe the type of fixation or specify the type of compression created by the device. Specifically, we stated our belief that the pass-through payment category C1713 may appropriately describe the LINK™ External Fixator because C1713 describes implantable pins and/or screws inserted or drilled into bone, principally with the intent to facilitate stabilization or oppose bone-to-bone contact, which is consistent with the LINK™ External Fixator description. We noted that we do not establish pass-through device categories for the purpose of describing specific devices, rather, device categories are intended to encompass all devices that can be appropriately described by a given category. In this context, we stated our belief that the LINK™ External Fixator may be appropriately described by C1713. We also stated that, after reviewing the information provided by the applicant, we were unable to determine that the LINK™ External Fixator meets the device category eligibility criteria, and therefore, we proposed to deny transitional pass-through payment status for CY 2027.

We invited public comment on whether the LINK™ External Fixator meets the device category eligibility criterion at § 419.66(c)(1). We also invited public comments on our proposal to deny transitional pass-through payment status for the LINK™ External Fixator for CY 2027.

Comment: Several commenters expressed general support for the approval of device pass-through payment for the LINK™ External Fixator. Another commenter expressed its support for the denial of device pass-through payment for the LINK™ External Fixator because it does not meet the criteria for device pass-through payment.

Response: We appreciate the applicant and commenters' input. We have taken these comments into consideration in our final determination for pass-through payment status for the LINK™ External Fixator.

Comment: The applicant and a commenter commented that the LINK™ External Fixator is not appropriately described by C1713, because the C1713 category includes static devices such as implantable pins and/or screws to oppose bone-to-bone or soft tissue-to-bone whereas the LINK™ External Fixator uses elastic energy. Specifically, the applicant stated that the device category C1713 does not describe the LINK™ External Fixator because the LINK™ External Fixator applies elastic mechanical energy to bone creating electrical current flow to stimulate healing. The applicant stated this is dramatically different from those devices in the C1713 category which describes static devices such as implantable pins and/or screws to oppose bone-to-bone or soft tissue-to-bone. The applicant commented that in effect, the elastic nature of the LINK™ bridge acts as an energy source to deform the bone matrix causing it to create current flow that recruits MSC to the site and then deforms the MSC nucleus causing it to differentiate along an osteogenic pathway. The applicant stated the use of elastic energy to create current versus implanted electrodes or pulsed magnetic fields used in bone stimulators is a significantly different mode of operation than the static pins and screws in the C1713 category and that thus the LINK™ meets the device category eligibility criterion at § 419.66(c)(1).

A commenter stated the compressive force created by the LINK™ External Fixator is dynamic and continuously closes gap formation forcing the body into the primary bone healing state. According to the commenter, without this important feature of continuous dynamic compression, gaps can form due to bone resorption, micromovements and non-compliant patients, leading to higher chances of non-union.

Response: We appreciate the applicant and commenter's input. After consideration of the public comments we received and our review of the application, we continue to believe that C1713 appropriately describes the LINK™ External Fixator because the device category code does not differentiate between static external fixators and those that use elastic mechanical energy. We do not believe that the LINK™ External Fixator's dynamic compression mechanism, by itself, places the device outside C1713, because the category encompasses

devices used to facilitate stabilization or oppose bone-to-bone or soft tissue-to-bone. Therefore, we have determined that the LINK™ External Fixator does not meet the device category eligibility criterion at § 419.66(c)(1), because it is appropriately described by an existing category or a category previously in effect.

After consideration of the public comments we received and our review of the application, the LINK™ External Fixator does not meet the device category eligibility criterion to be considered for device pass-through payment. Therefore, in this final rule with comment period, we will not address whether the technology meets the remaining criteria required for device pass-through payment. We are not approving the LINK™ External Fixator for device pass-through payment status for CY 2027 because the technology does not meet the device category eligibility criterion at § 419.66(c)(1).

(c) Santreva™-ATK Endovascular Revascularization Catheter

AngioSafe®, Inc. submitted an application for a new device category for transitional pass-through payment status for the Santreva™-ATK Endovascular Revascularization Catheter (Santreva™-ATK Catheter) for CY 2027. According to the applicant, the Santreva™-ATK Catheter is an energy and wire-free platform for simultaneous intraplaque crossing and revascularization of complex occlusive peripheral artery disease, intended for facilitating intraluminal placement of guidewires beyond stenotic lesions.

Table 56 provides an overview of the device category for the transitional pass-through payment status application for the Santreva™-ATK Catheter and CMS's preliminary assessment. For additional details provided by the applicant, please refer to the online application posting available at *https://mearis.cms.gov/public/publications/device-ptp/DEP260302QH9AE*.

TABLE 56: SANTREVA™-ATK CATHETER APPLICATION OVERVIEW

Device Pass-through Criteria	Applicant Statements	Preliminary CMS Assessment
Newness Criterion	*FDA Marketing Authorization:* 510(k) clearance - September 22, 2025 *Application submitted to CMS*: March 2, 2026	No concerns.

FDA Indication	The Santreva™-ATK Endovascular Revascularization Catheter is intended to facilitate the intraluminal placement of guidewires beyond stenotic lesions, including Chronic Total Occlusions (CTOs), in the femoropopliteal (arterial) peripheral vasculature.	No concerns.
§ 419.66(b)(3)	Device is integral, used for one patient only, comes in contact with human tissue, and is percutaneously inserted.	No concerns.
§ 419.66(b)(4)	Device is not equipment, an instrument, apparatus, implement, or item of this type for which depreciation and financing expenses are recovered as depreciable assets, and is not a material or supply furnished incident to a service.	No concerns.
Device Category	Device category code C1887 (catheter, guiding (may include infusion/perfusion capability)) does not describe the device.	See following discussion.
Cost Criteria	The cost of the Santreva™-ATK Catheter is $3,000.00. For cost significance requirements: HCPCS code: 37263 APC code: 5192 CY 2026 device offset amount: $2,314.89 CY 2026 APC payment rate: $5,814.84 Requirement #1: ($3,000.00 / $5,814.84) x 100 = 51.59%. Requirement #2: ($3,000.00 / $2,314.89) x 100 = 129.60%. Requirement #3: (($3,000.00 - $2,314.89) / $5,814.84) x 100 = 11.78%.	No concerns.
Substantial Clinical Improvement Criterion	Claim #1: Substantially improved mechanism; simultaneous crossing and revascularization Claim #2: Substantially improved safety: no periprocedural injury and reduced need for adjunctive plaque modification interventions with known adverse events Claim #3: Substantially improved complex lesion crossing Claim #4: Substantially improved crossing success in severely calcified lesions Claim #5: Substantial lumen gain while crossing complex lesions, delivering positive outcomes of multiple currently reimbursed maneuvers Claim #6: Predominantly intraplaque crossing and recanalization, preserving vessel wall integrity Claim #7: Substantial improvement in clinical condition and quality of life of patients Claim #8: Substantial improvement for physicians in day-to-day clinical practice Provided 1 published study assessing the technology, 19 published studies and articles assessing comparator technologies, and 31 background documents.	See following discussion.

We invited public comment on whether the Santreva™-ATK Catheter meets the newness criterion at § 419.66(b)(1) and the eligibility criteria at § 419.66(b)(3) and (4).

Comment: An applicant and another commenter submitted public comments regarding the newness criterion at § 419.66(b)(1). They reiterated that the Santreva™-ATK Catheter meets the newness requirement for device pass-through payment, and is an integral part of the service

furnished, used for one patient only, comes in contact with human tissue, and is surgically implanted or inserted, or applied in or on a wound or other skin lesion. They also reiterated that the Santreva™-ATK Catheter is not equipment, an instrument, apparatus, implement, or item of this type for which depreciation and financing expenses are recovered as depreciable assets, or a material or supply furnished incident to a service.

Response: We appreciate the applicant's and commenters' input. We received the application for device pass-through payment status for the Santreva™-ATK Catheter within 3 years of the date of FDA 510(k) clearance. After consideration of the public comments we received and our review of the application, we have determined that the Santreva™-ATK Catheter meets the newness criterion at § 419.66(b)(1).

We agree with the applicant and commenter that the Santreva™-ATK Catheter is an integral part of the service furnished, used for one patient only, comes in contact with human tissue, and is surgically implanted or inserted or applied in or on a wound or other skin lesion. We also agree that the Santreva™-ATK Catheter is not equipment, an instrument, apparatus, implement, or item of this type for which depreciation and financing expenses are recovered as depreciable assets, or a material or supply furnished incident to a service. After consideration of the public comments we received and our review of the application, we have determined that the Santreva™-ATK Catheter meets the eligibility criterion at § 419.66(b)(3) and (4).

In the CY 2027 OPPS/ASC proposed rule, regarding the device category eligibility criterion at § 419.66(c)(1), we noted that per the applicant, the existing pass-through code C1887 (Catheter, guiding (may include infusion/perfusion capability)) does not appropriately describe the Santreva™-ATK Catheter, because C1887 does not reflect the full scope of the device's function or the significant clinical improvement associated with the Santreva™-ATK Catheter, which facilitates the placement of guidewires beyond stenotic lesions by laterally cutting and then compressing plaque, to form an intraluminal channel to restore blood flow.

We stated that, based on the description the applicant provided, the Santreva™-ATK

Catheter is intended to facilitate the intraluminal placement of guidewires beyond stenotic lesions, including chronic total occlusions (CTOs), in the femoropopliteal (arterial) peripheral vasculature, and therefore, may be appropriately described by C1887 (Catheter, guiding (may include infusion/perfusion capability)). Specifically, we stated our belief that the pass-through payment category C1887 may describe the Santreva™-ATK Catheter because the pass-through payment category includes guiding catheters and the Santreva™-ATK Catheter's primary function of crossing peripheral stenotic lesions to establish a revascularization pathway appears to be the same function performed by devices described in C1887. We stated, in addition, per the applicant, the Santreva™-ATK Catheter is introduced and removed prior to final treatment, which is also consistent with the use of the guiding catheters described in C1887. We noted that we do not establish pass-through device categories for the purpose of describing specific devices; rather, device categories are intended to encompass all devices that can be appropriately described by a given category. In this context, we stated our belief that the Santreva™-ATK Catheter may be appropriately described by C1887. We also stated that, after reviewing the information provided by the applicant, we were unable to determine that the Santreva™-ATK Catheter meets the device category eligibility criteria, and therefore, we proposed to deny transitional pass-through payment status for CY 2027.

We invited public comment on whether the Santreva™-ATK Catheter meets the device category eligibility criterion at § 419.66(c)(1). We also invited public comments on our proposal to deny transitional pass-through payment status for the Santreva™-ATK Catheter for CY 2027.

Comment: A commenter expressed its support for the denial of device pass-through payment for the Santreva™-ATK Catheter because it does not meet the criteria for device pass-through payment.

Response: We appreciate the commenter's input.

Comment: Several commenters, including the applicant, urged CMS to approve device pass-through payment for the Santreva™-ATK Catheter, stating that the Santreva™-ATK

provides an additional treatment option for patients with complex peripheral arterial disease, including CTOs, and that approval of transitional pass-through payment would support appropriate physician and hospital adoption as well as improve patient access to innovative care. The commenters further stated that device pass-through payment status would encourage continued use of the Santreva™-ATK Catheter to address important safety, efficacy, durability of outcomes, and economic needs in complex peripheral vascular disease.

In response to our concerns that the Santreva™-ATK Catheter may be appropriately described by C1887, the applicant and commenters stated that they believe there are no existing categories or categories previously in effect that appropriately describe the Santreva™-ATK Catheter. Specifically, the applicant and commenters stated that while the Santreva™-ATK Catheter does perform the function of a guiding catheter, C1887 does not describe the Santreva™-ATK Catheter's additional capabilities that specifically contribute to the substantial clinical improvement the device provides.

The applicant stated that, as described by CMS, C1887 is intended for the introduction of interventional/diagnostic devices into the coronary or peripheral vascular systems and can be used to inject contrast material, function as a conduit through which other devices pass, and/or provide a mechanism for measuring arterial pressure, and maintain a pathway created by the guidewire during the performance of a procedure. The applicant stated that the Santreva™-ATK Catheter functions as an endovascular interventional device for complex lesions (occlusions) after it is delivered through such conduits and, at the end of its intervention, acts as a convenient conduit for other devices. The applicant also noted that the Santreva™-ATK Catheter's conduit function is not the focus of the transitional pass-through payment application. According to the applicant, the Santreva™-ATK Catheter directly contributes to revascularization in a way that traditional guiding catheters do not and is not associated with the introduction of other devices. Specifically, the applicant and another commenter stated that 90 percent of the evaluable subjects in Banerjee et al. (2026) had predominantly intraplaque crossing of the CTO and that

intravascular ultrasound analysis of the intraplaque track found a mean luminal gain of roughly 59 percent without any other revascularization interventions.

Furthermore, the applicant stated that CMS has created additional device categories that include guidance capabilities along with other functions, such as C1725 which describes a catheter, transluminal angioplasty, non-laser (may include guidance, infusion/perfusion capability). The applicant also stated that CMS has created numerous device categories to describe catheters that address calcified plaque through different approaches, including C1885 (Catheter, transluminal angioplasty, laser), C1725 (Catheter, transluminal angioplasty, non-laser (may include guidance, infusion/perfusion capability)), C1714 (Catheter, transluminal atherectomy, directional), C1724 (Catheter, transluminal atherectomy, rotational), and C1761 (Catheter, transluminal intravascular lithotripsy, coronary).

The applicant and several commenters stated that the Santreva™-ATK Catheter addresses plaque with a new multi-modal mechanism of action, atheroplasty, which is a wire- and energy-free mechanism that combines axial plaque disruption with low-pressure lateral plaque compression to form an intraluminal channel without actively stretching the vessel wall, and thus, does not fall into any of the existing categories (C1885, C1725, C1714, C1724, or C1761). These commenters also stated that atheroplasty disrupts, modifies, and compresses plaque in place against native plaque to create a channel while preserving the native vessel architecture unlike atherectomy, which debulks or removes plaque (classified as intraluminal artery stripper in the Code of Federal Regulation), or angioplasty (classified as hydraulic pressurization of vessel walls), which dilates the vessel wall via balloon expansion. The applicant and these commenters stated that atheroplasty therefore removes the obstruction to blood flow without physically removing the plaque from the body and that any interaction with the vessel wall structure during the procedure is atraumatic, whether mechanically or hydraulically. In addition, the applicant stated that vessel wall safety, high efficacy in difficult occlusions, and absence of periprocedural adverse events that could reduce durability of long-

term outcomes are key substantial clinical improvements associated with the Santreva™-ATK Catheter's atheroplasty mechanism. The applicant concluded that it believes a new device category is needed to describe this approach and requested that CMS establish a new category of catheter, transluminal atheroplasty, wireless.

Response: We appreciate the applicant's and commenters' input. After consideration of the public comments received and our review of the application, we continue to believe that C1887 appropriately describes the Santreva™-ATK Catheter because the nominated device's primary function of crossing peripheral stenotic lesions to establish a revascularization pathway appears to be the same function performed by the guiding catheters described by C1887. Additionally, the Santreva™-ATK Catheter's introduction and removal prior to final treatment are also consistent with the use of guiding catheters described by C1887. While the applicant and commenters stated that C1887 does not describe the device's additional capabilities during CTO crossing, including plaque disruption, compression, and intraluminal channel formation, we disagree that these additional capabilities demonstrate that C1887 does not appropriately describe the Santreva™-ATK Catheter, because the evidence submitted does not establish that these capabilities constitute a distinct therapeutic function independent of crossing the lesion to establish a revascularization pathway. Furthermore, we note that we do not establish pass-through device categories for the purpose of describing specific devices; rather, device categories are intended to encompass all devices that can be appropriately described by a given category while ensuring that no medical device is described by more than one category in accordance with section 1833(t)(6)(B)(ii)(II) of the Act. While CMS has established separate categories for catheters that treat or modify vascular lesions through different mechanisms, the presence of additional capabilities or potential to simplify a procedure does not necessarily establish that the device performs a distinct function requiring a separate category. Therefore, we have determined that the Santreva™-ATK Catheter does not meet the device category eligibility criterion at §419.66(c)(1), because it is appropriately described by an existing category or a

category previously in effect.

After consideration of the public comments we received and our review of the application, the Santreva™-ATK Catheter does not meet the device category eligibility criterion to be considered for device pass-through payment. Therefore, in this final rule with comment period, we will not address whether the technology meets the remaining criteria required for device pass-through payment. We are not approving the Santreva™-ATK Catheter for device pass-through payment status for CY 2027 because the technology does not meet the device category eligibility criterion at § 419.66(c)(1).

3. Other Comments

Comment: Several commenters recommended that CMS define a transition pathway from pass-through status to permanent payment with clearer criteria, timeline, data requirements and advance notice. The commenters requested that CMS should ensure the public can comment on the impact of expiration of pass-through status and should evaluate the effect of expiration of transitional device pass-through payment on the total resources associated with the procedure before packaging the cost of devices into an existing payment rate. A commenter stated that, for products used by small patient populations or in specialized centers, CMS should take the resulting limitations in claims data into account when determining whether an APC has sufficient information to absorb the cost of the technology without creating access problems.

Response: We appreciate the commenters' input and ongoing support of the device pass-through payment program. As specified in section 1833(t)(6)(B) of the Social Security Act, under the OPPS, categories of devices are eligible for transitional pass-through payments for at least two, but not more than three years. After expiration, the device category HCPCS code remains active; however, its payment is included in the primary service. The complete list of current and historical device category codes created since August 1, 2000, which is the implementation date of the hospital OPPS, is available in the quarterly updated OPPS

transmittals[71] and the Medicare Claims Processing Manual (Pub.100-04), Chapter 4, Section 60.4.2. The expiration dates of pass-through payment status for each device category receiving pass-through payment are detailed in the annual OPPS proposed rule and final rule with comment period, subject to public comments. We note that because charges related to packaged services are used for outlier and future rate setting, hospitals are advised to report the device category HCPCS codes on the claim whenever furnished in the hospital outpatient department setting, consistent with all applicable coding and billing instructions. We acknowledge the commenters' concerns regarding the impact of expiration of pass-through status and the limitations in claims data when calculating packaged APC payment rates. We will continue to monitor the available data and consider any additional public comments related to these issues.

Comment: A commenter requested that CMS revisit the methodology of device pass-through cost significance criteria to compare the cost of a proposed device using only the cost of the device or devices the proposed device replaces, especially when the new device does not replace all devices included in the device-related portion (DRP) of the associated APC. The commenter further recommended that, when issuing a transitional pass-through category, CMS should specify which portion of the DRP it will subtract from the costs of the new category, rather than assuming the full DRP applies, and should only subtract costs associated with devices being replaced.

Response: We appreciate the commenter's recommendations related to the methodology for device pass-through cost significance criteria and the calculation for the device offset of a pass-through device category. We will continue to consider the issues and any additional public comments related to them.

Comment: Multiple commenters expressed their support for, or concerns regarding CMS's repeal of the alternative pathway for new technology add-on payment and OPPS device pass-through applications and requirement for all applicants for new technology add-on

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[71] *https://www.cms.gov/medicare/regulations-guidance/transmittals.*

payments and OPPS device pass-through payments to demonstrate that they meet the same eligibility requirements to receive add-on payments and/or pass-through payments.

Response: We appreciate commenters' feedback. As noted in section IV.A.2.a. of this final rule with comment period, in the FY 2027 IPPS/LTCH PPS final rule (91 FR 49767 through 49789; 91 FR 50346 through 50347), we finalized our policy, with modification, that, unless specifically exempted, all applications received for device pass-through payment status on or after October 1, 2026, including all applications received through the remainder of the CY 2028 application cycle ending on March 1, 2027, and applications received for subsequent calendar years will have to demonstrate that the technology met the requirements currently reflected at § 419.66(c)(2)(i). We also finalized our policy that device pass-through payment applications submitted to CMS as of September 30, 2026, for devices that are part of the FDA's Breakthrough Devices Program that received FDA marketing authorization for the indication covered by the Breakthrough Device designation will be evaluated and could be approved under the alternative pathway, provided that all other criteria have been met. In addition, we finalized a limited exception for a new device that had received FDA Breakthrough Device designation as of September 30, 2026, and has received marketing authorization for the indication covered by the Breakthrough Device designation. Such devices will remain eligible to apply for device pass-through payment under the alternative pathway, which will continue to accept applications for CYs 2028 and 2029. As such, to be considered for the limited exception, CMS must receive a complete application for eligible devices under the limited exception no later than March 1, 2028. We finalized revisions, with modifications, to paragraph § 419.66(c)(2)(ii) to reflect the finalized policy, effective October 1, 2026. We refer the readers to the FY 2027 IPPS/LTCH PPS final rule (91 FR 49767 through 49789) for a full discussion of the finalized policy, including comments received and our responses.

Comment: We received several public comments regarding applications or category codes not under review, or requesting changes to the device pass-through payment policies, such as eligibility of section 351 implantable biological products.

Response: These comments were outside the scope of the proposals included in the CY 2027 OPPS/ASC proposed rule and we are therefore not addressing them in this final rule with comment period.

B. Device-Intensive Procedures

1. Background

Under the OPPS, prior to CY 2017, device-intensive status for procedures was determined at the APC level for APCs with a device offset percentage greater than 40 percent (79 FR 66795). Beginning in CY 2017, CMS began determining device-intensive status at the HCPCS code level. In assigning device-intensive status to an APC prior to CY 2017, the device costs of all the procedures within the APC were calculated and the geometric mean device offset of all of the procedures had to exceed 40 percent. Almost all of the procedures assigned to device-intensive APCs utilized devices, and the device costs for the associated HCPCS codes exceeded the 40 percent threshold. The no cost/full credit and partial credit device policy (79 FR 66872 through 66873) applies to device-intensive procedures and is discussed in detail in section IV.B.4. of the CY 2026 OPPS/ASC proposed rule. A related device policy was the requirement that certain procedures assigned to device-intensive APCs require the reporting of a device code on the claim (80 FR 70422) and is discussed in detail in section IV.B.3. of the CY 2026 OPPS/ASC proposed rule. For further background information on the device-intensive APC policy, we refer readers to the CY 2016 OPPS/ASC final rule with comment period (80 FR 70421 through 70426).

a. HCPCS Code-Level Device-Intensive Determination

As stated earlier, prior to CY 2017, under the device-intensive methodology we assigned device-intensive status to all procedures requiring the implantation of a device that were assigned

to an APC with a device offset greater than 40 percent and, beginning in CY 2015, that met the three criteria as listed. Historically, the device-intensive designation was at the APC level and applied to the applicable procedures within that APC. In the CY 2017 OPPS/ASC final rule with comment period (81 FR 79658), we changed our methodology to assign device-intensive status at the individual HCPCS code level rather than at the APC level. Under this policy, a procedure could be assigned device-intensive status regardless of its APC assignment, and device-intensive APC designations were no longer applied under the OPPS or the ASC payment system.

We believe that a HCPCS code-level device offset is, in most cases, a better representation of a procedure's device cost than an APC-wide average device offset based on the average device offset of all of the procedures assigned to an APC. Unlike a device offset calculated at the APC level, which is a weighted average offset for all devices used in all of the procedures assigned to an APC, a HCPCS code-level device offset is calculated using only claims for a single HCPCS code. We believe that this methodological change results in a more accurate representation of the cost attributable to implantation of a high-cost device, which ensures consistent device-intensive designation of procedures with a significant device cost. Further, we believe a HCPCS code-level device offset removes inappropriate device-intensive status for procedures without a significant device cost that are granted such status because of their APC assignment.

Under our existing policy, procedures that meet the criteria listed in section IV.C.1.b. of this final rule with comment period are identified as device-intensive procedures and are subject to all the policies applicable to procedures assigned device-intensive status under our established methodology, including our policies on device edits and no cost/full credit and partial credit devices discussed in sections IV.C.3. and IV.C.4. of this final rule with comment period.

b. Use of the Three Criteria to Designate Device-Intensive Procedures

We clarified our established policy in the CY 2018 OPPS/ASC final rule with comment period (82 FR 52474), where we explained that device-intensive procedures require the implantation of a device and additionally are subject to the following criteria:

- All procedures must involve implantable devices that would be reported if device insertion procedures were performed.
- The required devices must be surgically inserted or implanted devices that remain in the patient's body after the conclusion of the procedure (at least temporarily); and
- The device offset amount must be significant, which is defined as exceeding 40 percent of the procedure's mean cost.

We changed our policy to apply these three criteria to determine whether procedures qualify as device-intensive in the CY 2015 OPPS/ASC final rule with comment period (79 FR 66926), where we stated that we would apply the no cost/full credit and partial credit device policy--which includes the three criteria listed previously--to all device-intensive procedures beginning in CY 2015. We reiterated this position in the CY 2016 OPPS/ASC final rule with comment period (80 FR 70424), where we explained that we were finalizing our proposal to continue using the three criteria established in the CY 2007 OPPS/ASC final rule with comment period for determining the APCs to which the CY 2016 device intensive policy will apply. Under the policies we adopted in CYs 2015, 2016, and 2017, all procedures that require the implantation of a device and meet the previously described criteria are assigned device-intensive status, regardless of their APC placement.

2. Device-Intensive Procedure Policy

As part of our effort to better capture costs for procedures with significant device costs, in the CY 2019 OPPS/ASC final rule with comment period (83 FR 58944 through 58948), for CY 2019, we modified our criteria for device-intensive procedures. We had heard from interested parties that the criteria excluded some procedures that interested parties believed should qualify as device-intensive procedures. Specifically, we were persuaded by interested

party arguments that procedures requiring expensive surgically inserted or implanted devices that are not capital equipment should qualify as device-intensive procedures, regardless of whether the device remains in the patient's body after the conclusion of the procedure. We agreed that a broader definition of device-intensive procedures was warranted and made two modifications to the criteria for CY 2019 (83 FR 58948). First, we allowed procedures that involve surgically inserted or implanted single-use devices that meet the device offset percentage threshold to qualify as device-intensive procedures, regardless of whether the device remains in the patient's body after the conclusion of the procedure. We established this policy because we no longer believe that whether a device remains in the patient's body should affect a procedure's designation as a device-intensive procedure, as such devices could, nonetheless, comprise a large portion of the cost of the applicable procedure. Second, we modified our criteria to lower the device offset percentage threshold from 40 percent to 30 percent, to allow a greater number of procedures to qualify as device intensive. We stated that we believed allowing these additional procedures to qualify for device-intensive status would help ensure these procedures receive more appropriate payment in the ASC setting, which would help encourage the provision of these services in the ASC setting. In addition, we stated that this change would help to ensure that more procedures containing relatively high-cost devices are subject to the device edits, which leads to more correctly coded claims and greater accuracy in our claims data. Specifically, for CY 2019 and subsequent years, we finalized that device-intensive procedures will be subject to the following criteria:

- All procedures must involve implantable devices assigned a CPT or HCPCS code;
- The required devices (including single-use devices) must be surgically inserted or implanted; and
- The device offset amount must be significant, which is defined as exceeding 30 percent of the procedure's mean cost (83 FR 58945).

In addition, to further align the device-intensive policy with the criteria used for device pass-through payment status, we finalized, for CY 2019 and subsequent years, that for purposes of satisfying the device-intensive criteria, a device-intensive procedure must involve a device that:

- Has received FDA marketing authorization, or has received an FDA IDE and has been classified as a Category B device by FDA in accordance with §§ 405.203 through 405.207 and 405.211 through 405.215, or meets another appropriate FDA exemption from premarket review;
- Is an integral part of the service furnished;
- Is used for one patient only;
- Comes in contact with human tissue;
- Is surgically implanted or inserted (either permanently or temporarily); and
- Is not either of the following:

++ Equipment, an instrument, apparatus, implement, or item of the type for which depreciation and financing expenses are recovered as depreciable assets as defined in Chapter 1 of the Medicare Provider Reimbursement Manual (CMS Pub. 15-1); or

++ A material or supply furnished incident to a service (for example, a suture, customized surgical kit, scalpel, or clip, other than a radiological site marker) (83 FR 58945).

In addition, for new HCPCS codes describing procedures requiring the implantation of devices that do not yet have associated claims data, in the CY 2017 OPPS/ASC final rule with comment period (81 FR 79658), we finalized a policy for CY 2017 to apply device-intensive status with a default device offset set at 41 percent for new HCPCS codes describing procedures requiring the implantation or insertion of a device that did not yet have associated claims data until claims data are available to establish the HCPCS code-level device offset for the procedures. This default device offset amount of 41 percent was not calculated from claims data; instead, it was applied as a default until claims data were available upon which to calculate an actual device offset for the new code. The purpose of applying the 41-percent default device

offset to new codes that describe procedures that implant or insert devices was to ensure ASC access for new procedures until claims data become available.

As discussed in the CY 2019 OPPS/ASC proposed rule and final rule with comment period (83 FR 37108 through 37109 and 83 FR 58945 through 58946, respectively), in accordance with our policy stated previously to lower the device offset percentage threshold for procedures to qualify as device-intensive from greater than 40 percent to greater than 30 percent, for CY 2019 and subsequent years, we modified this policy to apply a 31-percent default device offset to new HCPCS codes describing procedures requiring the implantation of a device that do not yet have associated claims data until claims data are available to establish the HCPCS code-level device offset for the procedures. In conjunction with the policy to lower the default device offset from 41 percent to 31 percent, we continued our current policy of, in certain rare instances (for example, in the case of a very expensive implantable device), temporarily assigning a higher offset percentage if warranted by additional information such as pricing data from a device manufacturer (81 FR 79658). Once claims data are available for a new procedure requiring the implantation or insertion of a device, device-intensive status is applied to the code if the HCPCS code-level device offset is greater than 30 percent, according to our policy of determining device-intensive status by calculating the HCPCS code-level device offset.

In addition, in the CY 2019 OPPS/ASC final rule with comment period, we clarified that since the adoption of our policy in effect as of CY 2018, the associated claims data used for purposes of determining whether or not to apply the default device offset are the associated claims data for either the new HCPCS code or any predecessor code, as described by CPT coding guidance, for the new HCPCS code. Additionally, for CY 2019 and subsequent years, in limited instances where a new HCPCS code does not have a predecessor code as defined by CPT, but describes a procedure that was previously described by an existing code, we use clinical discretion to identify HCPCS codes that are clinically related or similar to the new HCPCS code but are not officially recognized as a predecessor code by CPT, and to use the

claims data of the clinically related or similar code(s) for purposes of determining whether or not to apply the default device offset to the new HCPCS code (83 FR 58946).

Clinically related and similar procedures for purposes of this policy are procedures that have few or no clinical differences and use the same devices as the new HCPCS code. In addition, clinically related and similar codes for purposes of this policy are codes that either currently or previously describe the procedure described by the new HCPCS code. Under this policy, claims data from clinically related and similar codes are included as associated claims data for a new code, and where an existing HCPCS code is found to be clinically related or similar to a new HCPCS code, we apply the device offset percentage derived from the existing clinically related or similar HCPCS code's claims data to the new HCPCS code for determining the device offset percentage. We stated that we believe that claims data for HCPCS codes describing procedures that have minor differences from the procedures described by new HCPCS codes will provide an accurate depiction of the cost relationship between the procedure and the device(s) that are used, and will be appropriate to use to set a new code's device offset percentage, in the same way that predecessor codes are used.

If a new HCPCS code has multiple predecessor codes, the claims data for the predecessor code that has the highest individual HCPCS-level device offset percentage is used to determine whether the new HCPCS code qualifies for device-intensive status. Similarly, in the event that a new HCPCS code does not have a predecessor code but has multiple clinically related or similar codes, the claims data for the clinically related or similar code that has the highest individual HCPCS level device offset percentage is used to determine whether the new HCPCS code qualifies for device-intensive status.

In the CY 2025 OPPS/ASC final rule with comment period (89 FR 94214 through 92419), we finalized a change to our methodology for applying default device offset percentages for new device-intensive procedures. Under our previous policy, if a new CPT/HCPCS code did not have available claims data, either from the new HCPCS code or any predecessor code

or clinically-similar code that uses the same device, and the CPT/HCPCS code otherwise met our criteria for device-intensive status, we would apply a default device offset percentage of 31 percent. However, we were aware of certain situations where the default device offset amount might not adequately reflect the existing device portion of the procedure's costs when compared to the cost of similar devices. A potential large difference between the default device offset amount and the device portion of similar devices might impede our ability to accurately remove device offset amounts from new device-intensive procedures under the OPPS and to set payment rates for device-intensive procedures under the ASC payment system.

Therefore, for CY 2025 and subsequent CYs, we finalized our proposal to modify our default device offset percentage policy for new device-intensive procedures. Specifically, for new CPT/HCPCS codes that both describe a procedure that requires the surgical implantation or insertion of a single-use device that exceeds 30 percent of the procedure's cost and that meets our requirements of a device as described here and lack claims data (from either the new HCPCS code or any predecessor code or clinically-similar code that uses the same device), we would apply a default device offset percentage that is the greater of 31 percent or the device offset percentage of the APC to which the procedure has been assigned. We stated that we still believe that a HCPCS code-level device offset is, in most cases, a more accurate representation of a procedure's device cost than an APC-wide average device offset based on the average device offset of all the procedures assigned to an APC. However, because newer device-intensive procedures lack claims data, we believe the APC-wide average device offset percentage is, in many cases, a better reflection of the estimated device costs of the procedure than a default 31 percent offset. Additionally, there can be instances where the typical device costs of procedures in an APC can be significantly greater than the 31 percent default device offset. For these reasons, we finalized our modification to our default device offset percentage for new device-intensive procedures. This methodological change was finalized for both the OPPS and

ASC Payment System for CY 2025 and subsequent CYs and applies to new procedures assigned to clinical APCs, but not to new procedures assigned to New Technology APCs.

Additionally, in the CY 2025 OPPS/ASC final rule with comment period (89 FR 92414 through 92419), we stated that we were persuaded by commenters that the lack of a device edit for device-intensive procedures, particularly new technologies, might lead to an underreporting of device costs and total procedure costs and potentially impede beneficiary access to such new technologies over time. Therefore, in addition to finalizing a modification to our device edits policy for CY 2025, we finalized a modification to our device offset percentage calculation. For procedures subject to our modified device edits policy for CY 2025 that cannot report modifier "CG" to bypass this claims processing edit, the device offset percentages calculated (for the CPT/HCPCS code or its predecessor code) are based on hospital claims that reported a device code. We stated that we believed that hospital outpatient claims that report a device code with such procedures provide, in general, a more accurate representation of the procedures' total costs. We also finalized, for purposes of determining device offset percentages, that we will not use claims data from procedures that had a status indicator of ''E1'' during the calendar year we are using for ratesetting and determining device offset percentages. Lastly, we refined our process for applying device offset percentages to use available claims data from predecessor codes annually, rather than the first year of the successor code's activation date, until we have available claims data from the successor code. In the CY 2026 OPPS/ASC final rule with comment period (90 FR 53673 through 53679), we finalized our proposal to continue these policies for CY 2026.

2. Proposed Device-Intensive Procedure Policy

We proposed to continue the CY 2026 device-intensive procedure policies for CY 2027. Specifically, we proposed to continue use of HCPCS code-level device-intensive determination and three criteria to designate device-intensive procedures, in accordance with existing policies. We also proposed to continue our

device-intensive procedure policy, our proposed use of CY 2025 claims information for determining device offset percentages and assigning device-intensive status, and our proposed default device offset policy for determining device offset percentages in the absence of claims data for device-intensive procedures (91 FR 41848). As we indicated in the CY 2019 OPPS/ASC proposed rule and final rule with comment period, additional information for our consideration of an offset percentage higher than the default of 31 percent (or the APC-wide default offset percentage) for new HCPCS codes describing procedures requiring the implantation (or, in some cases, the insertion) of a device that do not yet have associated claims data, such as pricing data or invoices from a device manufacturer, should be directed to the Division of Outpatient

Care electronically at *outpatientpps@cms.hhs.gov*. Additional information can be submitted prior to issuance of an OPPS/ASC proposed rule or as a public comment in response to an issued OPPS/ASC proposed rule. Device offset percentages will be set in each year's final rule.

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: Several commenters requested that CMS designate CPT code 52282 (Cystourethroscopy, with insertion of permanent urethral stent) as device-intensive and establish its CY 2027 device offset using manufacturer invoice data. The commenters stated that the historical claims are not representative because no FDA-approved permanent prostatic urethral stent was commercially available in the United States for approximately a decade, making the proposed zero device offset unreliable.

Response: As discussed in section III. of this final rule with comment period, we agree with the commenters that no FDA-approved permanent prostatic urethral stent had been available on the U.S. market for approximately 9 years before FDA approved such a device through the premarket approval application process in late 2025. Therefore, we believe that the

CY 2025 claims data for CPT code 52282 do not accurately reflect the device and service costs associated with inserting a permanent prostatic urethral stent and are not an appropriate data source for calculating the device offset percentage for CPT code 52282. In the absence of representative CY 2025 claims data, we are accepting the commenters' recommendation to assign device-intensive status to CPT code 52282 for CY 2027. We are not accepting the commenters' recommendation to use manufacturer invoice data to calculate the device offset percentage. Instead, we will apply our default device offset methodology to CPT code 52282 for CY 2027.

Comment: Several commenters opposed removing device-intensive status from CPT code 55882 (Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation; with insertion of transurethral ultrasound transducer for delivery of thermal ultrasound, including suprapubic tube placement and placement of an endorectal cooling device, when performed) for CY 2027 under the ASC payment system. The commenters stated that the TULSA procedure requires proprietary, single-use transurethral ultrasound and endorectal cooling devices that are integral to the service, contact human tissue, and are temporarily inserted into the patient. They stated that the proposed offset is distorted by incomplete device reporting, noting that the average invoice cost of $8,089 represents approximately 49 percent of the proposed $16,366 geometric mean cost. The commenters also reported that claims identifying C1889 produced offsets above the 30-percent threshold, whereas many hospitals reported little or no device cost. They requested a 49-percent device offset based on documented acquisition costs.

Response: CPT code 55882 became effective January 1, 2025. In reviewing these comments, we discovered that we had correctly assigned device-intensive status to this procedure under the ASC payment system but had inadvertently not assigned device-intensive status to this procedure under the OPPS. In general, a new CPT code that meets our criteria for device-intensive status and is separately payable in both the OPPS and ASC payment system

should be designated as device-intensive under both the OPPS and the ASC payment system. (Once claims data is available, differences in the claims data available under the two systems' ratesetting methodologies may result in a procedure receiving device-intensive status under the ASC payment system but not under the OPPS.)

The incomplete reporting of devices associated with CPT code 55882 under the OPPS underscores the importance of our device edits policy for device-intensive procedures. In the absence of an applicable device edit, we do not believe it would be appropriate to selectively determine which claims to use to calculate the device offset percentage; instead, we believe it is appropriate to rely on a full year of claims data during which CPT code 55882 is subject to the device edits policy. Therefore, because usable CY 2025 claims data are unavailable for CPT code 55882, we are accepting the commenters' recommendation to maintain device-intensive status for the code for CY 2027 and will apply our device edits and device credits policies to the procedure beginning in CY 2027 by assigning the procedure device-intensive status for both the ASC and OPPS settings. We are not accepting the commenters' recommendation to calculate the device offset percentage using acquisition-cost data and will instead apply our default device offset methodology.

Comment: Several commenters requested that we designate CPT code 0786T (Insertion or replacement of percutaneous electrode array, sacral, with integrated neurostimulator, including imaging guidance, when performed) as device intensive for CY 2027. The commenters stated that the procedure requires implantation of a single-use integrated sacral neuromodulation system and that the manufacturer-reported device cost of $18,500 represents approximately 83.5 percent of the proposed APC payment. The commenters stated that the two claims apparently used to determine device-intensive status were invalid or unrepresentative because the code had status indicator "E1" until the device received FDA approval in June 2025 and commercial use did not begin until after November 2025.

They requested that we disregard those claims and apply the default offset for the APC, manufacturer invoice pricing, or another appropriate new technology methodology.

Response: We agree with the commenters that we should disregard CY 2025 claims for CPT code 0786T. As we stated previously, in the CY 2025 OPPS/ASC final rule with comment period (89 FR 94218), for purposes of determining device offset percentages, we will not use claims data from procedures that had a status indicator of ''E1''. Since CPT code 0786T was assigned a status indicator of "E1" for all of CY 2025, under our current policy, we will continue to assign CPT code 0786T device-intensive status for CY 2027 and will apply a device offset percentage based on our default device offset methodology.

Comment: Several commenters requested that we designate CPT code 0730T (Trabeculotomy by laser, including optical coherence tomography (OCT) guidance) as device intensive and apply a 65-percent device offset. The commenters explained that the procedure requires two proprietary, single-use optical interfaces that contact the cornea and are integral to OCT-guided imaging and laser treatment under a CMS-approved Category B IDE study. The commenters stated that the combined $3,750 acquisition cost represents approximately 65 percent of the proposed geometric mean cost for APC 5493 and therefore exceeds the 30-percent device-cost threshold.

Response: CPT code 0730T describes a minimally invasive glaucoma surgical procedure that reduces intraocular pressure by improving aqueous outflow. Specifically, CPT code 0730T describes a laser trabeculotomy procedure that noninvasively creates a channel through the trabecular meshwork, unlike other laser trabeculoplasty procedures that apply laser energy to stimulate biological changes that improve aqueous outflow. We are not accepting the commenter's recommendation to treat the patient interface system as a device for purposes of determining device-intensive status. Our criteria for device-intensive status require that a device be surgically inserted or implanted into the patient. In the CY 2006 OPPS/ASC final rule with comment period (70 FR 68629 through 68630), we explained that the surgical insertion or

implantation criterion encompasses devices inserted or implanted through a natural or surgically created orifice, as well as devices inserted or implanted through a surgically created incision. We do not consider placement beneath the eyelid and against the ocular surface to constitute insertion through a natural or surgically created orifice or incision. Therefore, we do not consider the patient interface system associated with CPT code 0730T to be an insertable medical device for purposes of device-intensive status.

Comment: Several commenters requested that we expand device-intensive policy to permit CPT codes 0686T (Histotripsy (i.e., non-thermal ablation via acoustic energy delivery) of malignant hepatocellular tissue, including image guidance) and 0888T (Histotripsy (i.e., non-thermal ablation via acoustic energy delivery) of malignant renal tissue, including imaging guidance), which describe histotripsy of liver and kidney tumors, respectively, to qualify based on the cost of a nonimplantable "single patient use device" applied to the patient's skin. The commenters stated that the device will cost $7,500 in CY 2027 and stated that both procedures satisfy the 30-percent device-cost threshold, notwithstanding that the device is neither surgically inserted nor implanted. The commenters stated that revising the policy and increasing payment would facilitate beneficiary access to noninvasive histotripsy in the lower-cost ASC setting.

Response: While we understand the commenters' concerns regarding payment adequacy for capital-intensive procedures furnished in the ASC setting and may consider these concerns in future rulemaking, we did not propose revising the eligibility criteria for device-intensive procedures. We believe that expanding the definition of device-intensive procedures to include high-cost items that contact a patient's skin, but are not surgically implanted/inserted, could have significant unintended consequences for both the OPPS and the ASC payment system. Therefore, we are not accepting the commenters' recommendations.

Comment: A commenter opposed the proposed device offset percentage for CPT code 0885T (Colonoscopy, flexible, with initial transendoscopic mechanical dilation (e.g., nondrug-coated balloon) followed by therapeutic drug delivery by drug-coated balloon catheter for

colonic stricture, including fluoroscopic guidance, when performed) and requested that we continue to assign device-intensive status. The commenter stated that the three claims used to calculate the proposed offsets were erroneous because the ProTractX3 drug-coated balloon was available only through company-funded IDE trials and the facilities submitting the claims were not trial participants. The commenter requested that in the absence of sufficient claims data, the procedure should be assigned the APC-level device offset percentage under the OPPS.

Response: We rely on hospitals to accurately report device costs associated with procedures. However, based on this comment and other public comments raising concern with determining device intensive status for services with very few claims, we believe that in instances where a procedure has very few claims upon which to determine device intensive status it would be appropriate to apply a low volume methodology for device intensive status which we are finalizing for this CY 2027 OPPS/ASC final rule with comment period and which is discussed further later in this section of the preamble.

Under this low volume policy for device-intensive procedures, for procedures assigned device-intensive status in the current year with fewer than 10 claims in the ratesetting year, we will use the greater of: (1) the device offset percentage calculated from the available claims; or (2) the device offset percentage calculated under our default methodology, which is the greater of 31 percent or the device offset percentage of the APC to which the procedure is assigned.

Given the limited number of claims – three claims for this final rule with comment period – the device offset percentage of CPT code 0885T would fall under this low volume policy for device-intensive procedures and would be assigned a default device offset of 34.95 percent based on the APC-wide device offset of APC 5331 (Complex GI Procedures).

Comment: Commenters supported our proposal to designate CPT code 27486 (Revision of total knee arthroplasty, with or without allograft; 1 component) as device intensive and to

continue the device-intensive designation for CPT code 31295 (Nasal/sinus endoscopy, surgical, with dilation (e.g., balloon dilation); maxillary sinus ostium, transnasal or via canine fossa), noting that the associated device costs exceed the 30-percent threshold. The commenters requested that we also designate CPT codes 31296 (Nasal/sinus endoscopy, surgical, with dilation (e.g., balloon dilation); frontal sinus ostium), 31297 (Nasal/sinus endoscopy, surgical, with dilation (e.g., balloon dilation); sphenoid sinus ostium), and 31298 (Nasal/sinus endoscopy, surgical, with dilation (e.g., balloon dilation); frontal and sphenoid sinus ostia) as device intensive because these clinically related sinus procedures use similar balloon dilation devices; they noted that the calculated offset for CPT code 31296 exceeds 30 percent and recommended a stabilization policy for procedures such as CPT codes 31297 and 31298 that fluctuate near the threshold.

Response: We appreciate the commenters' recommendation to establish a stabilization policy for procedures with device offset percentages that fluctuate around the 30-percent device-intensive threshold. We addressed a related concern under the OPPS in prior rulemaking. Specifically, in the CY 2025 OPPS/ASC final rule with comment period (89 FR 94219 through 94222), we modified our device edits policy to minimize disruptions resulting from procedures moving above and below the 30-percent threshold. Under that policy, once a procedure is designated as device-intensive for a calendar year, we continue to apply the device edits to the procedure in subsequent years, even if it no longer qualifies as device-intensive. Since the device offset percentage for each procedure is below our device-intensive threshold of 30 percent and there are 10 or greater singles for each procedure based on claims data available for this final rule with comment period, we are not assigning device-intensive status under the OPPS to CPT codes 31296, 31297, and 31298 for CY 2027.

Comment: A commenter supported our proposal to assign device-intensive status to CPT code 52284 (Cystourethroscopy, with mechanical urethral dilation and urethral therapeutic drug delivery by drug-coated balloon catheter for urethral stricture or stenosis, male, including

fluoroscopy, when performed) and recommended finalizing the associated device offsets. The commenter explained that the procedure requires the Optilume Stricture drug-coated balloon catheter and the proposed OPPS device offset appropriately reflects the device-intensive nature of the procedure.

Response: We appreciate the commenter's support and are assigning a device offset percentage to CPT code 52284 based on the CY 2025 claims data available for this final rule with comment period.

Comment: A commenter supported our proposal to assign device-intensive status to CPT code 64728 (Decompression; median nerve at the carpal tunnel, percutaneous, with intracarpal tunnel balloon dilation, including ultrasound guidance) but requested an increase from the proposed default device offset of 31 percent. The commenter recommended a device offset of 61.69 percent under the OPPS.

Response: We appreciate the commenter's support of our assignment of device-intensive status to CPT code 64728. In the absence of available claims data, we are relying on our default offset methodology which applies the greater of the default 31-percent device offset or the APC-wide device offset. We are finalizing our proposal to assign CPT code 64728 to APC 5431 (Level 1 Nerve Procedures) for CY 2027. The device offset percentage for APC 5431 is 1.4 percent; therefore, we are not accepting the commenter's recommendation and are assigning a default 31-percent device offset to CPT code 64728 for CY 2027.

Comment: A commenter requested that we designate CPT code 52649 (Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)) as device intensive, noting that the procedure requires single-use, insertable devices, including a morcellator reported with HCPCS code C1782 and a laser fiber reported with C1889. The commenter stated that the proposed device offset under the OPPS understate the costs of these

required devices. Based on its claims analysis, the commenter reported that only approximately 21 percent of claims identified the morcellator and approximately 37 percent reported any relevant device code or revenue code, indicating inconsistent device reporting. The commenter recommended that we establish a targeted supplemental evidentiary pathway allowing validated acquisition-cost information, invoices, or other objective evidence to inform the device offset and device-intensive determination when claims do not reliably capture required device costs.

Response: For this final rule with comment period, the CY 2025 claims data included more than 10,000 single claims for CPT code 52649. We rely on hospitals to accurately report device costs associated with procedures and the device offset percentage calculated from this volume of claims indicates that the device costs associated with the procedure are below the 30-percent device-intensive threshold. Therefore, we are not accepting the commenter's recommendation and are calculating the device offset percentage for CPT code 52649 using the CY 2025 claims data available for this final rule with comment period.

Comment: Several commenters requested that CMS designate CPT code 53854 (Transurethral destruction of prostate tissue; by radiofrequency generated water vapor thermotherapy) as device intensive and calculate its device offset using only claims that identify the required single-use delivery device through HCPCS code C1889 or revenue center code 0278. The commenters stated that the device is integral to the procedure, used for one patient, contacts human tissue, and is surgically inserted, thereby satisfying CMS' device criteria. They reported that only 30.84 percent of claims identified the required device, producing an all-claims offset of 17.39 percent, whereas claims identifying the device produced an offset of 45.07 percent, above the 30-percent threshold.

Response: For this final rule with comment period, the CY 2025 claims data included more than 1,000 single claims for CPT code 53854. We rely on hospitals to accurately report device costs associated with procedures and the device offset percentage calculated from this volume of claims indicates that the device costs associated with the procedure are below the 30-

percent device-intensive threshold. Therefore, we are not accepting the commenter's recommendation and are calculating the device offset percentage for CPT code 53854 using the CY 2025 claims data available for this final rule with comment period.

Comment: A commenter requested that CMS grant temporary device-intensive status to CPT code 66174 (Transluminal dilation of aqueous outflow canal (e.g., canaloplasty); without retention of device or stent), which requires an advanced microcatheter that is surgically inserted into the eye. The commenter stated that the procedure previously qualified as device intensive in the CY 2025 proposed rule but lost that status following changes in reported costs and cost-to-charge ratios, despite subsequent efforts to improve hospital device-cost reporting. The commenter requested that CMS calculate the device offset using only claims reporting HCPCS code C1889 or include revenue code 0272 in offset calculations.

Response: For this final rule with comment period, the CY 2025 claims data included more than 2,000 single claims for CPT code 66174. We rely on hospitals to accurately report device costs associated with procedures and the device offset percentage calculated from this volume of claims indicates that the device costs associated with the procedure are below the 30-percent device-intensive threshold. Additionally, revenue code 0272 is designated for sterile supplies associated with the operating room and would not be an applicable source of device costs under our device-intensive criteria. Therefore, we are not accepting the commenter's recommendation and are calculating the device offset percentage for CPT code 66174 using the CY 2025 claims data available for this final rule with comment period.

Comment: A commenter also requested that we increase the device offset for HCPCS code C9781 (Arthroscopy, shoulder, surgical; with implantation of subacromial spacer (e.g., balloon), includes debridement (e.g., limited or extensive), subacromial decompression, acromioplasty, and biceps tenodesis when performed) based on submitted invoice data demonstrating that the proposed offset understates the acquisition cost of the subacromial spacer.

Response: For this final rule with comment period, the CY 2025 claims data included more than 400 single claims for CPT code C9781. We rely on hospitals to accurately report device costs associated with procedures and the device offset percentage calculated from this volume of claims indicates that the device costs associated with the procedure are approximately 61 percent. Therefore, we are not accepting the commenter's recommendation and are calculating the device offset percentage for CPT code C9781 using the CY 2025 claims data available for this final rule with comment period.

Comment: A commenter opposed CMS's proposal to increase the device offset percentage for APC 5231 (Level 1 ICD and Similar Procedures) from 58 percent to 79 percent. The commenter stated that implantation of the WiSE CRT System, described by CPT code 0515T (Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; complete system (includes electrode and generator [transmitter and battery])), requires substantially greater non-device hospital resources than the conventional implantable cardioverter-defibrillator procedures assigned to the APC, including specialized personnel, laboratory time, anesthesia, imaging, device programming, and post-procedure monitoring. The commenter stated the higher offset would understate the non-device costs and reduce the transitional pass-through payment for the device.

Response: Based on the CY 2025 claims data available for this final rule with comment period, we calculated an APC-level device offset percentage of approximately 67 percent for APC 5231. The APC-level device offset reflects the weighted-average device costs associated with all procedures assigned to the APC. We do not believe it would be appropriate to reduce the device offset percentage below the amount supported by the claims data solely to increase the transitional pass-through payment for devices that currently have pass-through payment status under the OPPS. Therefore, we are not accepting the commenter's recommendation.

Comment: Several commenters recommended that CMS establish a specific process for determining device-intensive status for procedures removed from the inpatient-only list. The commenters stated that the limited outpatient claims generated while a procedure remained on the inpatient-only list may not reliably reflect typical outpatient resource or device costs. They recommended that CMS use inpatient claims and device revenue-code information to identify procedures involving high-cost implantable devices and estimate their device costs.

Response: We generally rely on outpatient claims data to determine device-intensive status and calculate device offset amounts. However, under the OPPS, we have adopted alternative methodologies when the available claims volume is insufficient to support reliable ratesetting. For example, under our universal low-volume APC policy, we use up to 4 years of claims data to determine the APC cost when an APC has fewer than 100 claims annually. We also generally exempt services assigned to New Technology APCs from reassignment under a policy when fewer than 10 claims are available during the 4-year lookback period.

We agree with the commenters that the limited outpatient claims generated for procedures while they remained on the inpatient-only list may not reliably reflect the device costs that hospitals will incur when furnishing those procedures in the outpatient setting. Therefore, we are accepting the commenters' recommendation and revising our device-intensive procedure methodology to address circumstances in which a low volume of claims may not accurately represent the underlying device costs associated with a procedure.

Specifically, for CY 2027 and subsequent years, when fewer than 10 claims are available in the ratesetting year, we will use the greater of: (1) the device offset percentage calculated from the available claims; or (2) the device offset percentage calculated under our default methodology, which is the greater of 31 percent or the device offset percentage of the APC to which the procedure is assigned. As discussed in section XIII.C.4. of this final rule with comment period, we are adopting this policy for the ASC payment system as well.

We believe this revision will reduce the likelihood that a small number of potentially unrepresentative claims will result in an inappropriately low device offset, while continuing to recognize the available claims data when those data indicate that the device portion of the procedure is significant. We also agree with the commenters that device revenue-code information from inpatient claims may provide relevant evidence when determining whether procedures removed from the inpatient-only list are device-intensive. Accordingly, we will consider such information, as appropriate, when making device-intensive designations for these procedures.

After consideration of public comments, we are finalizing our device-intensive procedures proposal with a modification for device-intensive procedures with fewer than ten claims in the ratesetting year, for which we will apply the greater of: (1) the device offset percentage calculated from the available claims; or (2) the device offset percentage calculated under our default methodology, which is the greater of 31 percent or the device offset percentage of the APC to which the procedure is assigned. We are also finalizing our proposed continued use of HCPCS code-level device-intensive determination and the three criteria to designate device-intensive procedures in accordance with existing policies as discussed in section IV.B.1.a. of the CY 2027 OPPS/ASC proposed rule (91 FR 41846). We are also finalizing our proposed continuation of our device-intensive procedure policy, proposed use of CY 2025 claims information for determining device offset percentages and assigning device-intensive status, and our proposed default device offset policy for determining device offset percentages in the absence of claims data for device-intensive procedures, in accordance with existing policies as discussed in section IV.B.1.b. of the CY 2027 OPPS/ASC proposed rule (91 FR 41846).

Comments and our responses related to device-intensive procedure policy and the procedures we proposed for device-intensive status under the ASC payment system for CY 2027 can be found in section XIII.C.4. of this final rule with comment period. Our responses

and final determinations related to device-intensive status for certain procedures under the ASC payment system are also applied to our final determinations of device-intensive status under the OPPS.

The full listing of the CY 2027 device-intensive procedures can be found in Addendum P to this final rule with comment period (which is available via the internet on the CMS website). Further, our claims accounting narrative contains a description of our device offset percentage calculation. Our claims accounting narrative for this final rule with comment period can be found under supporting documentation for the CY 2027 OPPS/ASC final rule with comment period on our website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient*.

3. Device Edit Policy

In the CY 2015 OPPS/ASC final rule with comment period (79 FR 66795), we finalized a policy and implemented claims processing edits that require any of the device codes used in the previous device-to-procedure edits to be present on the claim whenever a procedure code assigned to any of the APCs listed in Table 5 of the CY 2015 OPPS/ASC final rule with comment period (the CY 2015 device-dependent APCs) was reported on the claim. In addition, in the CY 2016 OPPS/ASC final rule with comment period (80 FR 70422), we modified our previously existing policy and applied the device coding requirements exclusively to procedures that require the implantation of a device assigned to a device-intensive APC. In the CY 2016 OPPS/ASC final rule with comment period, we also finalized our policy that the claims processing edits are such that any device code, when reported on a claim with a procedure assigned to a device-intensive APC (listed in Table 42 of the CY 2016 OPPS/ASC final rule with comment period (80 FR 70422)), will satisfy the edit.

In the CY 2017 OPPS/ASC final rule with comment period (81 FR 79658 through 79659), we changed our policy for CY 2017 and subsequent years to apply the CY 2016 device coding requirements to the newly defined device-intensive procedures. For CY 2017

and subsequent years, we also specified that any device code, when reported on a claim with a device-intensive procedure, will satisfy the edit. In addition, we created HCPCS code C1889 to recognize devices furnished during a device-intensive procedure that are not described by a specific Level II HCPCS Category C-code. Reporting HCPCS code C1889 with a device-intensive procedure will satisfy the edit requiring a device code to be reported on a claim with a device-intensive procedure. In the CY 2019 OPPS/ASC final rule with comment period, we revised the description of HCPCS code C1889 to remove the specific applicability to device-intensive procedures (83 FR 58950). For CY 2019 and subsequent- years, the description of HCPCS code C1889 is "Implantable/insertable device, not otherwise classified".

In the CY 2024 OPPS/ASC final rule with comment period (88 FR 81758 through 81759), we finalized our proposal to establish a procedure-to-device edit for the procedures assigned to APC 5496 (Level 6 Intraocular Procedures) and require hospitals to report the correct device HCPCS codes when reporting any of the four procedures – CPT codes 0308T and 0616T, 0617T, and 0618T. (We note that CPT codes 0617T and 0618T were deleted effective January 1, 2025 and CPT code 0616T was deleted effective January 1, 2025 and replaced with new CPT code 66683.) We have noted that interested parties have previously recommended in past rulemaking that we reestablish all our previous procedure-to-device edits, but we do not expect to extend this policy beyond the procedures assigned to APC 5496 (Level 6 Intraocular Procedures). This APC represents a unique situation – the APC (which was the Level 5 Intraocular APC in previous years) had been a Low Volume APC (fewer than 100 claims in a claims year) since we established our Low Volume APC policy, the procedures associated with this APC have significant procedure costs often greater than $15,000, and the procedures associated with this APC require the implantation of a high-cost intraocular device. In the CY 2025 OPPS/ASC final rule with comment period, we finalized to continue this policy for APC 5496 (Level 6 Intraocular Procedures) for CY 2025 and subsequent years.

In the CY 2025 OPPS/ASC final rule with comment period (89 FR 92419 through 92422), we finalized a modification to our device edits policy. While historically our device edits policy has only applied to procedures that are device-intensive based on the most recent claims data available, commenters had raised concerns about hospitals underreporting device costs in years when certain device-intensive procedures had lost device-intensive status because the device portion of a procedure can fluctuate above and below our device-intensive threshold of 30 percent. Commenters indicated to us that the presence of the device edit requirement can have a significant impact on the device portion and geometric mean cost of a procedure, particularly for newer technologies. Therefore, for CY 2025 and subsequent CYs, we finalized a policy to apply our device edits policy permanently once a procedure is designated as a device-intensive procedure in a given year. Additionally, we finalized a policy to reinstate our device edits policy for procedures that have been device-intensive since we began assigning device-intensive status at the HCPCS code level on January 1, 2017. We believed that by applying our device edit policy to procedures that were device-intensive on or after January 1, 2017, we might continue to receive device cost information for relatively new procedures with limited claims data, which may have been impacted by our policy to require that only existing device-intensive procedures be subject to our device edits policy.

We did not propose any changes to our device edit policy for CY 2027 (91 FR 41849). We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: Several commenters recommended that CMS reinstate device-to-procedure edits for certain device-intensive services, noting that inconsistent or omitted device-code reporting understates device costs and produces unreliable offsets and payment rates. The commenters recommended that CMS establish or assign appropriate C-codes for certain urethral stents, a bone-anchored implant, cervical fusion devices, or for device-intensive procedures that are removed from the inpatient-only list, and publish a crosswalk identifying

each procedure, its device-intensive status, and the applicable device code. A commenter also requested specific reporting instructions for C1776 on total joint arthroplasty claims and recommended using only claims containing C1776 for rate-setting. The commenter further recommended that hospitals report C1889 when a procedure-level C-code encompasses both the procedure and device but does not separately identify the device cost.

Response: We believe hospitals are experienced in coding and billing for joint replacement procedures and other device-intensive procedures which are subject to our device edits policy and do not believe it is necessary to reinstate specific procedure-to-device edits for device-intensive procedures. Additionally, while we may create new device category C-codes for device categories approved under transitional pass-through status to be paid at charges reduced to cost, we do not believe it is appropriate or necessary to create additional device category C-codes outside of the transitional pass-through approval process. We believe hospitals are experienced in coding and reporting significant device costs correctly on hospital claims using the existing device category HCPCS C-codes as well as revenue codes.

Comment: A commenter requested distinct outpatient coding for customized aprevo® cervical and lumbar interbody fusion devices, noting that expired HCPCS code C1831 does not adequately distinguish their different anatomy, indications, procedures, and resource costs. If a future pass-through category is available, the commenter requested separate cervical and lumbar customized-device C-codes with zero-dollar device offsets. The commenter stated that distinct coding would permit accurate cost collection and support temporary New Technology APC assignments until sufficient outpatient claims become available. Finally, the commenter requested that we evaluate a new technology APC application for aprevo® Cervical procedure and aprevo® Lumbar procedures using hospital inpatient invoice data and manufacturer validated cases.

Response: We are not accepting the commenter's recommendations. As we discussed in the CY 2026 OPPS/ASC final rule with comment period (90 FR 53637 through

53643), the aprevo® Cervical ACDF system was not approved for transitional pass-through payment status as the device did not meet the device category eligibility criterion at 419.66(c)(1) because it is appropriately described by an existing category or a category previously in effect. We do not believe additional product-specific coding is necessary to permit accurate cost collection as hospitals are experienced in device-reporting on outpatient claims across a wide variety of device products. Additionally, we note that the new technology APC application process is a subregulatory process. As a general note, interested parties can submit applications and reconsideration requests through MEARIS throughout the year.

After consideration of public comments, we are finalizing our proposal, without modification, to continue our device edits policy for CY 2027.

4. Adjustment to OPPS Payment for No Cost/Full Credit and Partial Credit Devices

a. Background

To ensure equitable OPPS payment when a hospital receives a device without cost or with full credit, in CY 2007, we implemented a policy to reduce the payment for specified device-dependent APCs by the estimated portion of the APC payment attributable to device costs (that is, the device offset) when the hospital receives a specified device at no cost or with full credit (71 FR 68071 through 68077). Hospitals were instructed to report no cost/full credit device cases on the claim using the "FB" modifier on the line with the procedure code in which the no cost/full credit device is used. In cases in which the device is furnished without cost or with full credit, hospitals were instructed to report a token device charge of less than $1.01. In cases in which the device being inserted is an upgrade (either of the same type of device or to a different type of device) with a full credit for the device being replaced, hospitals were instructed to report as the device charge the difference between the hospital's usual charge for the device being implanted and the hospital's usual charge for the device for which it received full credit. In CY 2008, we expanded this payment adjustment policy to include cases in which hospitals receive partial credit of 50 percent or more of the cost of a specified device. Hospitals

were instructed to append the "FC" modifier to the procedure code that reports the service provided to furnish the device when they receive a partial credit of 50 percent or more of the cost of the new device. We refer readers to the CY 2008 OPPS/ASC final rule with comment period for more background information on the "FB" and "FC" modifiers payment adjustment policies (72 FR 66743 through 66749).

In the CY 2014 OPPS/ASC final rule with comment period (78 FR 75005 through 75007), beginning in CY 2014, we modified our policy of reducing OPPS payment for specified APCs when a hospital furnishes a specified device without cost or with a full or partial credit. For CY 2013 and prior years, our policy had been to reduce OPPS payment by 100 percent of the device offset amount when a hospital furnishes a specified device without cost or with a full credit and by 50 percent of the device offset amount when the hospital receives partial credit in the amount of 50 percent or more of the cost for the specified device. For CY 2014, we reduced OPPS payment, for the applicable APCs, by the full or partial credit a hospital receives for a replaced device. Specifically, under this modified policy, hospitals are required to report on the claim the amount of the credit in the amount portion for value code "FD" (Credit Received from the Manufacturer for a Replaced Device) when the hospital receives a credit for a replaced device that is 50 percent or greater than the cost of the device. For CY 2014, we also limited the OPPS payment deduction for the applicable APCs to the total amount of the device offset when the "FD" value code appears on a claim. For CY 2015, we continued our policy of reducing OPPS payment for specified APCs when a hospital furnishes a specified device without cost or with a full or partial credit and to use the three criteria established in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68072 through 68077) for determining the APCs to which our CY 2015 policy will apply (79 FR 66872 through 66873). In the CY 2016 OPPS/ASC final rule with comment period (80 FR 70424), we finalized our policy to no longer specify a list of devices to which the OPPS payment adjustment for no cost/full credit and partial credit devices would apply and instead apply this APC payment adjustment to all replaced

devices furnished in conjunction with a procedure assigned to a device-intensive APC when the hospital receives a credit for a replaced specified device that is 50 percent or greater than the cost of the device.

b. Policy for No Cost/Full Credit and Partial Credit Devices

In the CY 2017 OPPS/ASC final rule with comment period (81 FR 79659 through 79660), for CY 2017 and subsequent years, we finalized a policy to reduce OPPS payment for device-intensive procedures, by the full or partial credit a provider receives for a replaced device, when a hospital furnishes a specified device without cost or with a full or partial credit. Under our current policy, hospitals continue to be required to report on the claim the amount of the credit in the amount portion for value code "FD" when the hospital receives a credit for a replaced device that is 50 percent or greater than the cost of the device.

In the CY 2014 OPPS/ASC final rule with comment period (78 FR 75005 through 75007), we adopted a policy of reducing OPPS payment for specified APCs when a hospital furnishes a specified device without cost or with a full or partial credit by the lesser of the device offset amount for the APC or the amount of the credit. We adopted this change in policy in the preamble of the CY 2014 OPPS/ASC final rule with comment period and discussed it in subregulatory guidance, including chapter 4, section 61.3.6 of the Medicare Claims Processing Manual. Further, in the CY 2021 OPPS/ASC final rule with comment period (85 FR 86017 through 86018, 86302), we made conforming changes to our regulations at § 419.45(b)(1) and (2) that codified this policy.

We did propose any changes to our policies regarding payment for no cost/full credit and partial credit devices for CY 2027 in the CY 2027 OPPS/ASC proposed rule, and we did not receive public comments (91 FR 41850). We are finalizing our proposal to maintain our current policy for CY 2027.

V. OPPS Payment for Drugs, Biologicals, and Radiopharmaceuticals

A. OPPS Transitional Pass-Through Payment for Additional Costs of Drugs, Biologicals, and Radiopharmaceuticals

1. Background

Section 1833(t)(6) of the Act (42 U.S.C. 1395*l*(t)(6)) provides for temporary additional payments or "transitional pass-through payments" for certain drugs and biologicals. A biological" as used in this final rule with comment period, and as codified at 42 CFR 414.802 and 414.902 includes a "product licensed under section 351 of the PHS [Public Health Service] Act". As enacted by the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106-113), this pass-through payment provision requires the Secretary to make additional payments to hospitals for: current orphan drugs for rare diseases and conditions, as designated under section 526 of the Federal Food, Drug, and Cosmetic Act; current drugs and biologicals and brachytherapy sources used in cancer therapy; and current radiopharmaceutical drugs and biologicals. "Current" refers to those types of drugs or biologicals mentioned previously that are hospital outpatient services under Medicare Part B for which transitional pass-through payment was made on the first date the hospital OPPS was implemented.

Transitional pass-through payments also are provided for certain "new" drugs and biologicals that were not being paid for as a Hospital Outpatient Department (HOPD) service as of December 31, 1996, and whose cost is "not insignificant" in relation to the OPPS payments for the procedures or services associated with the new drug or biological. For pass-through payment purposes, radiopharmaceuticals are included as "drugs." As required by statute, transitional pass-through payments for a drug or biological described in section 1833(t)(6)(C)(i)(II) of the Act can be made for a period of at least 2 years, but not more than 3 years, after the payment was first made for the drug as a hospital outpatient service under Medicare Part B. Drugs and biologicals pass-through applications are accepted and approved on a quarterly basis in which pass-through payments for approved applications could begin on the

next available OPPS quarterly update. Furthermore, our current policy, which was finalized in the CY 2017 OPPS/ASC final rule with comment period (81 FR 79662), is to allow for quarterly expiration of pass-through payment status for drugs, biologicals, and radiopharmaceuticals to afford a pass-through payment period that is as close to a full 3 years as possible to allow, on a prospective basis, for the maximum pass-through payment period without exceeding the statutory limit of 3 years. Notice of drugs for which pass-through payment status is ending during the calendar year is included in the quarterly OPPS Change Request transmittals. Final CY 2027 pass-through drugs and biologicals and their designated APCs are assigned status indicator "G" in Addenda A and B to this final rule with comment period (which are available on the CMS website).[72]

Section 1833(t)(6)(D)(i) of the Act specifies that the pass-through payment amount, in the case of a drug or biological, is the amount by which the amount determined under section 1842(o) of the Act (42 U.S.C. 1395u(o)) for the drug or biological exceeds the portion of the otherwise applicable Medicare Outpatient Department (OPD) fee schedule that the Secretary determines is associated with the drug or biological. The regulations at 42 CFR 419.64(d) specify that the pass-through payment equals the amount determined under section 1842(o) of the Act minus the portion of the Ambulatory Payment Classification (APC) payment that CMS determines is associated with the drug or biological.

Section 1847A of the Act (42 U.S.C. 1395w-3a) establishes the average sales price (ASP) methodology, which is used for payment for drugs and biologicals described in section 1842(o)(1)(C) of the Act furnished on or after January 1, 2005. The ASP methodology, as applied under the OPPS, uses several sources of data as a basis for payment, including the ASP, the wholesale acquisition cost (WAC), and the average wholesale price (AWP). In this final rule with comment period, the term "ASP methodology" and "ASP-based" are inclusive of all data sources and methodologies described therein. Additional information on the ASP methodology

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[72] *https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient.*

can be found on our website at *https://www.cms.gov/medicare/payment/fee-for-service-providers/part-b-drugs/average-drug-sales-price.*

The pass-through application[73] and review process for drugs and biologicals is described on our website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/pass-through-payment-status-new-technology-ambulatory-payment-classification-apc.*

2. Drugs and Biologicals with Expiring Pass-Through Payment Status in CY 2026

There are 49 drugs and biologicals for which pass-through payment status expires by December 31, 2026, as listed in Table 57. These drugs and biologicals will have received OPPS pass-through payment for 3 years during the period of April 1, 2023 through December 31, 2026. In accordance with the policy finalized in the CY 2017 OPPS/ASC final rule with comment period (81 FR 79662) and described earlier, pass-through payment status for drugs and biologicals approved in CY 2017 and subsequent years will expire on a quarterly basis, with a pass-through payment period as close to 3 years as possible.

With the exception of those groups of drugs and biologicals that are always packaged when they do not have pass-through payment status (specifically, anesthesia drugs; drugs, biologicals, and radiopharmaceuticals that function as supplies when used[74] in a diagnostic test or procedure; and drugs and biologicals that function as supplies when used in a surgical procedure), our standard methodology for providing payment for drugs and biologicals with expiring pass-through payment status in an upcoming calendar year is to determine the product's estimated per-day cost and compare it with the OPPS drug packaging threshold for that calendar year, which was proposed to be $140 for CY 2027 for all drugs, biologicals, and therapeutic

[73] To apply for OPPS transitional Pass-Through Payment Status and New Technology Ambulatory Payment Classification (APC), applicants complete an application that is subject to the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501 *et seq*.). This information collection (CMS-10008) is currently approved under OMB control number of 0938-0802 and has an expiration date of July 31, 2027.

[74] In the CY 2025 OPPS/ASC final rule with comment period (89 FR 93948), we finalized the diagnostic radiopharmaceuticals policy to separately pay those products when the per-day costs are greater than a threshold. Please refer to section II.A.3.c. of the CY 2025 OPPS/ASC final rule with comment period for more information regarding this policy.

radiopharmaceuticals (for high-cost diagnostic radiopharmaceuticals, we would provide separate payment when their per-day cost is greater than the threshold we proposed to adopt of $665). These policies are discussed further in section V.B.1. of this final rule with comment period. If the estimated per-day cost for the drug or biological is less than or equal to the applicable OPPS drug packaging threshold, we package payment for the drug or biological into the payment for the associated procedure in the upcoming calendar year. If the estimated per-day cost of the drug or biological is greater than the OPPS drug packaging threshold, we provide separate payment at the applicable ASP methodology-based payment amount (which is generally ASP plus 6 percent), as discussed further in section V.B.2. of this final rule with comment period.

We welcomed public comments on the status indicator for expiring pass-through drugs and biologicals, in accordance with our existing policies on packaged drugs, biologicals, and radiopharmaceuticals, including the threshold packaging policy.

TABLE 57: DRUGS AND BIOLOGICALS FOR WHICH PASS-THROUGH PAYMENT STATUS WILL END BY DECEMBER 31, 2026

CY 2026 HCPCS Code	Long Descriptor	CY 2026 Status Indicator	CY 2026 APC	Pass-Through Payment Effective Date	Pass-Through Payment End Date
C9145	Injection, aprepitant, (aponvie), 1 mg	G	9107	04/01/2023	03/31/2026
J9063	Injection, mirvetuximab soravtansine-gynx, 1 mg	G	9109	04/01/2023	03/31/2026
J9347	Injection, tremelimumab-actl, 1 mg	G	9110	04/01/2023	03/31/2026
J9380	Injection, teclistamab-cqyv, 0.5 mg	G	9111	04/01/2023	03/31/2026
J9381	Injection, teplizumab-mzwv, 4 mcg	G	9112	04/01/2023	03/31/2026
J0218	Injection, olipudase alfa-rpcp, 1 mg	G	9113	04/01/2023	03/31/2026
J1411	Injection, etranacogene dezaparvovec-drlb, per therapeutic dose	G	9138	04/01/2023	03/31/2026
J1449	Injection, eflapegrastim-xnst, 0.1 mg	G	9114	04/01/2023	03/31/2026

J1747	Injection, spesolimab-sbzo, 1 mg	G	9115	04/01/2023	03/31/2026
J1954	Injection, leuprolide acetate for depot suspension (lutrate depot), 7.5 mg	G	9136	04/01/2023	03/31/2026
J2403	Chloroprocaine hcl ophthalmic, 3% gel, 1 mg	G	9116	04/01/2023	03/31/2026
Q5128	Injection, ranibizumab-eqrn (cimerli), biosimilar, 0.1 mg	G	9117	04/01/2023	03/31/2026
Q5130	Injection, pegfilgrastim-pbbk (fylnetra), biosimilar, 0.5 mg	G	9118	04/01/2023	03/31/2026
J2329	Injection, ublituximab-xiiy, 1 mg	G	9149	07/01/2023	6/30/2026
J1440	Fecal microbiota, live - jslm, 1 ml	G	9142	07/01/2023	6/30/2026
Q5129	Injection, bevacizumab-adcd (vegzelma), biosimilar, 10 mg	G	9159	07/01/2023	6/30/2026
J9056	Injection, bendamustine hydrochloride (vivimusta), 1 mg	G	9154	07/01/2023	6/30/2026
J0208	Injection, sodium thiosulfate,100 mg	G	9119	07/01/2023	6/30/2026
J2781	Injection, pegcetacoplan, 1 mg	G	9158	07/01/2023	6/30/2026
J1961	Injection, lenacapavir, 1 mg	G	9155	07/01/2023	6/30/2026
J9350	Injection, mosunetuzumab-axgb, 1 mg	G	9150	07/01/2023	6/30/2026
J0402	Injection, aripiprazole, (abilify asimtufii), 1 mg	G	9246	10/01/2023	9/30/2026
J7214	Injection, factor viii/von willebrand factor complex, recombinant (altuviiio), per factor viii i.u.	G	9277	10/01/2023	9/30/2026
J0184	Injection, amisulpride, 1 mg	G	9247	10/01/2023	9/30/2026
J0577	Injection, buprenorphine extended-release (brixadi), less than or equal to 7 days of therapy	G	0732	10/01/2023	9/30/2026

J0578	Injection, buprenorphine extended release (brixadi), greater than 7 days and up to 28 days of therapy	G	0733	10/01/2023	9/30/2026
J9321	Injection, epcoritamab-bysp, 0.1 mg	G	9250	10/01/2023	9/30/2026
A9608	Flotufolastat F 18, diagnostic, 1 millicurie	G	9254	10/01/2023	9/30/2026
J1304	Injection, tofersen, 1 mg	G	9262	10/01/2023	9/30/2026
J2799	Injection, risperidone, (uzedy), 1 mg	G	9266	10/01/2023	9/30/2026
J7353	Anacaulase-bcdb, 8.8% gel, 1 gram	G	0742	01/01/2024	12/31/2026
J3401	Beremagene geperpavec-svdt for topical administration, containing nominal 5 x 10^9 pfu/mL vector genomes, per 0.1 mL	G	0716	01/01/2024	12/31/2026
J7354	Cantharidin for topical administration, 0.7%, single unit dose applicator (3.2 mg)	G	0707	01/01/2024	12/31/2026
A9601	Flortaucipir f 18 injection, diagnostic, 1 millicurie	G	0709	01/01/2024	12/31/2026
J0177	Injection, aflibercept hd, 1 mg	G	0704	01/01/2024	12/31/2026
J2782	Injection, avacincaptad pegol, 0.1 mg	G	0705	01/01/2024	12/31/2026
J0589	Injection, daxibotulinumtoxina-lanm, 1 unit	G	0703	01/01/2024	12/31/2026
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	G	0714	01/01/2024	12/31/2026
J1323	Injection, elranatamab-bcmm, 1 mg	G	0708	01/01/2024	12/31/2026
J9286	Injection, glofitamab-gxbm, 2.5 mg	G	0720	01/01/2024	12/31/2026
J0174	Injection, lecanemab-irmb, 1 mg	G	9157	01/01/2024	12/31/2026
J2508	Injection, pegunigalsidase alfa-iwxj, 1 mg	G	0715	01/01/2024	12/31/2026
J7165	Injection, prothrombin complex concentrate, human-lans, per i.u. of factor ix activity	G	0702	01/01/2024	12/31/2026
J0349	Injection, rezafungin, 1 mg	G	9267	01/01/2024	12/31/2026

J9333	Injection, rozanolixizumab-noli, 1 mg	G	0721	01/01/2024	12/31/2026
J3055	Injection, talquetamab-tgvs, 0.25 mg	G	0706	01/01/2024	12/31/2026
J1412	Injection, valoctocogene roxaparvovec-rvox, per mL, containing nominal 2 × 10^13 vector genomes	G	0713	01/01/2024	12/31/2026
J0217	Injection, velmanase alfa-tycv, 1 mg	G	0710	01/01/2024	12/31/2026
J9029	Intravesical instillation, nadofaragene firadenovec-vncg, per therapeutic dose	G	0717	01/01/2024	12/31/2026

We did not receive public comments on this provision, and therefore, we are finalizing as proposed.

3. Drugs, Biologicals, and Radiopharmaceuticals with Pass-Through Payment Status Expiring in or Continuing Through CY 2027

We proposed to end pass-through payment status in CY 2027 for 28 drugs and biologicals. These products, listed in Table 58, were initially approved for pass-through payment status between April 1, 2024 and January 1, 2025. We also proposed to continue pass-through payment status through CY 2027 for 45 drugs and biologicals, listed in Table 59, which were initially approved for pass-through payment status between April 1, 2025 and April 1, 2026. The APCs and Healthcare Common Procedure Coding System (HCPCS) codes for pass-through drugs and biologicals are assigned status indicator "G" (Pass-Through Drugs and Biologicals) in Addenda A and B to this final rule with comment period (which are available on the CMS website).[75] The APCs and HCPCS codes for these drugs and biologicals are assigned status indicator "G" only for the duration of their pass-through status.

Section 1833(t)(6)(D)(i) of the Act sets the amount of pass-through payment for pass-through drugs and biologicals (the pass-through payment amount) as the difference between the amount authorized under section 1842(o) of the Act and the portion of the otherwise applicable

[75] *https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient.*

OPD fee schedule that the Secretary determines is associated with the drug or biological. For CY 2027, we are continuing our policy to pay for pass-through drugs and biologicals using the ASP methodology, meaning a payment rate based on ASP, WAC, or AWP, as applicable. This payment rate is generally ASP plus 6 percent, equivalent to the payment rate these drugs and biologicals would receive in the physician's office setting in CY 2027. We note that, under the OPD fee schedule, separately payable drugs assigned to an APC are generally payable at ASP plus 6 percent. Therefore, a $0 pass-through payment amount will continue to be paid for pass-through drugs and biologicals under the CY 2027 OPPS because the difference between the amount authorized under section 1842(o) of the Act, which is generally ASP plus 6 percent, and the portion of the otherwise applicable OPD fee schedule that the Secretary determines is appropriate, which is generally ASP plus 6 percent, is $0.

In the case of policy-packaged drugs (which include the following: anesthesia drugs; drugs, biologicals, and radiopharmaceuticals[76] below the applicable cost threshold that function as supplies when used in a diagnostic test or procedure; and drugs and biologicals that function as supplies when used in a surgical procedure), their pass-through payment amount will continue to be equal to a payment rate calculated using the ASP methodology, meaning a payment rate based on ASP, WAC, or AWP. This payment rate will generally continue to be ASP plus 6 percent for CY 2027, minus a payment offset for the portion of the otherwise applicable OPPS payment that the Secretary determines is associated with the drug or biological. We note that if not for the pass-through payment status of these policy-packaged products, payment for these products would be packaged into the associated procedure and therefore, there are associated OPPS payment amounts for them.

[76] In the CY 2025 OPPS/ASC final rule with comment period (89 FR 93948), we finalized the diagnostic radiopharmaceuticals policy to separately pay those products when the per-day costs are greater than a threshold. Please refer to section II.A.3.c. of the CY 2025 OPPS/ASC final rule with comment period for more information regarding this policy.

We note that in the CY 2025 OPPS/ASC final rule with comment period (89 FR 93948 through 93963), we modified the regulation text at 42 CFR 419.2(b)(15) to specify that only those diagnostic radiopharmaceuticals with per-day costs at or below the per-day diagnostic radiopharmaceutical packaging threshold for the applicable year are policy-packaged. Meaning, for those diagnostic radiopharmaceuticals that are below the diagnostic radiopharmaceutical packaging threshold, for purposes of pass-through co-insurance calculations, they are treated like policy-packaged drugs. For those diagnostic radiopharmaceuticals above the diagnostic radiopharmaceutical packaging threshold, they are not packaged, and are not considered policy-packaged; therefore, for purposes of pass-through co-insurance calculations, they are treated like separately payable drugs assigned to an APC. Accordingly, a $0 pass-through payment amount is assigned consistent with our policy described previously in this section for separately payable drugs assigned to an APC.

We will continue our policy to update pass-through payment rates on a quarterly basis on the CMS website during CY 2027 if later quarter ASP submissions (or more recent WAC or AWP information, as applicable) indicate that adjustments to the payment rates for these pass-through payment drugs or biologicals are necessary. For a full description of this policy, we refer readers to the CY 2006 OPPS/ASC final rule with comment period (70 FR 68632 through 68635).

For CY 2027, consistent with our CY 2026 policy for diagnostic and therapeutic radiopharmaceuticals, we will continue to provide payment for both diagnostic and therapeutic radiopharmaceuticals that are granted pass-through payment status based on the ASP methodology. As stated earlier, for purposes of pass-through payment, we consider radiopharmaceuticals to be drugs under the OPPS. Therefore, if a diagnostic or therapeutic radiopharmaceutical receives pass-through payment status during CY 2027, we will continue to follow the standard ASP methodology to determine the pass-through payment rate that drugs receive under section 1842(o) of the Act, which is generally ASP plus 6 percent. If ASP data are

not available for a radiopharmaceutical, we will continue to provide pass-through payment at WAC plus 3 or 6 percent, the equivalent payment provided for pass-through drugs and biologicals without ASP information. Additional detail on the WAC plus 3 or 6 percent payment policy can be found in section V.B.2.a. of this final rule with comment period. If WAC information also is not available, we will continue to provide payment for the pass-through radiopharmaceutical at 95 percent of its most recent AWP.

We refer readers to Table 58 for the list of drugs and biologicals with pass-through payment status expiring during CY 2027 and Table 59 for the list of drugs and biologicals with pass-through payment status continuing through CY 2027. We note that there are 15 additional drugs and biologicals in Table 59 in this final rule with comment period to include the drugs and biologicals approved for pass-through status since the proposed rule with effective dates between July 1, 2026 and October 1, 2026.

TABLE 58: DRUGS AND BIOLOGICALS WITH PASS-THROUGH PAYMENT STATUS EXPIRING IN CY 2027

CY 2026 HCPCS Code	CY 2027 HCPCS Code	Long Descriptor	CY 2026 Status Indicator	CY 2026 APC	Pass-Through Payment Effective Date	Pass-Through Payment End Date
J7171	J7171	Injection, adamts13, recombinant-krhn, 10 iu	G	0727	04/01/2024	03/31/2027
J9248	J9248	Injection, melphalan (hepzato), 1 mg	G	0730	04/01/2024	03/31/2027
J2267	J2267	Injection, mirikizumab-mrkz, 1 mg	G	0728	04/01/2024	03/31/2027
J2277	J2277	Injection, motixafortide, 0.25 mg	G	0729	04/01/2024	03/31/2027
J3247	J3247	Injection, secukinumab, intravenous, 1 mg	G	0725	04/01/2024	03/31/2027
J3394	J3394	Injection, lovotibeglogene autotemcel, per treatment	G	0748	07/01/2024	06/30/2027
J3393	J3393	Injection, betibeglogene autotemcel, per treatment	G	0746	07/01/2024	06/30/2027
J3263	J3263	Injection, toripalimab-tpzi, 1 mg	G	0745	07/01/2024	06/30/2027
J0911	J0911	Instillation, taurolidine 1.35 mg and heparin	G	0744	07/01/2024	06/30/2027

		sodium 100 units (central venous catheter lock for adult patients receiving chronic hemodialysis)				
J7355	J7355	Injection, travoprost, intracameral implant, 1 microgram	G	0749	07/01/2024	06/30/2027
A9506	A9506	Graphite crucible for preparation of technetium Tc 99m-labeled carbon aerosol, each	G	0760	07/01/2024	06/30/2027
J9028	J9028	Injection, nogapendekin alfa inbakicept-pmln, for intravesical use, 1 microgram	G	0767	10/01/2024	09/30/2027
J9345	J9345	Injection, retifanlimab-dlwr, 1 mg	G	9280	10/01/2024	09/30/2027
Q5133	Q5133	Injection, tocilizumab-bavi (tofidence), biosimilar, 1 mg	G	0786	10/01/2024	09/30/2027
Q5135	Q5135	Injection, tocilizumab-aazg (tyenne), biosimilar, 1 mg	G	0784	10/01/2024	09/30/2027
J9026	J9026	Injection, tarlatamab-dlle, 1 mg	G	0768	10/01/2024	09/30/2027
J9172	J9172	Injection, docetaxel (docivyx), 1 mg	G	0757	10/01/2024	09/30/2027
J9324	J9324	Injection, pemetrexed (pemrydi rtu), 10 mg	G	0782	10/01/2024	09/30/2027
J1434	J1434	Injection, fosaprepitant (focinvez), 1 mg	G	0761	10/01/2024	09/30/2027
J1203	J1203	Injection, cipaglucosidase alfa-atga, 5 mg	G	0737	10/01/2024	09/30/2027
A9615	A9615	Injection, pegulicianine, 1 mg	G	0772	10/01/2024	09/30/2027
J2601	J2601	Injection, vasopressin (baxter), 1 unit	G	0778	01/01/2025	12/31/2027
A9697	A9697	Injection, carboxydextran-coated superparamagnetic iron oxide, per study dose	G	0814	01/01/2025	12/31/2027
J0175	J0175	Injection, donanemab-azbt, 2 mg	G	0765	01/01/2025	12/31/2027
Q5148	Q5148	Injection, filgrastim-txid (nypozi), biosimilar, 1 microgram	G	0811	01/01/2025	12/31/2027
J2468	J2468	Injection, palonosetron hydrochloride (posfrea), 25 micrograms	G	0815	01/01/2025	12/31/2027

J0870	J0870	Injection, imetelstat, 1 mg	G	0813	01/01/2025	12/31/2027
J9329	J9329	Injection, tislelizumab-jsgr, 1mg	G	0816	01/01/2025	12/31/2027

TABLE 59: DRUGS AND BIOLOGICALS WITH PASS-THROUGH PAYMENT STATUS CONTINUING THROUGH CY 2027

CY 2026 HCPCS Code	CY 2027 HCPCS Code	Long Descriptor	CY 2026 Status Indicator	CY 2026 APC	Pass-Through Payment Effective Date	Pass-Through Payment End Date
J0138	J0138	Injection, acetaminophen 10 mg and ibuprofen 3 mg	G	2075	04/01/2025	03/31/2028
J3300	J3300	Injection, triamcinolone acetonide, preservative-free, 1 mg	G	1253	04/01/2025	03/31/2028
A9611	A9611	Flurpiridaz f 18, diagnostic, 1 millicurie	G	2065	04/01/2025	03/31/2028
Q5147	Q5147	Injection, aflibercept-ayyh (pavblu), biosimilar, 1 mg	G	2068	04/01/2025	03/31/2028
J9072	J9072	Injection, cyclophosphamide (avyxa), 5 mg	G	0719	04/01/2025	03/31/2028
J9292	J9292	Injection, pemetrexed (avyxa), not therapeutically equivalent to j9305, 10 mg	G	2076	04/01/2025	03/31/2028
J9054	J9054	Injection, bortezomib (boruzu), 0.1 mg	G	2066	04/01/2025	03/31/2028
Q2058	Q2058	Obecabtagene autoleucel, up to 400 million cd19 car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	G	2061	04/01/2025	03/31/2028
Q2057	Q2057	Afamitresgene autoleucel up to 10 billion mage-a4 tcr positive t-cells, including leukapheresis and dose preparation procedures, per therapeutic dose	G	2067	04/01/2025	03/31/2028
J9276	J9276	Injection, zanidatamab-hrii, 2 mg	G	2062	04/01/2025	03/31/2028
J1326	J1326	Injection, zolbetuximab-clzb, 1 mg	G	2063	04/01/2025	03/31/2028
J7172	J7172	Injection, marstacimab-hncq, subcutaneous, 0.5 mg	G	2064	04/01/2025	03/31/2028

J9174	J9174	Injection, docetaxel (beizray), 1 mg	G	0841	07/01/2025	06/30/2028
J9382	J9382	Injection, zenocutuzumab-zbco, 1 mg	G	0853	07/01/2025	06/30/2028
Q5152	Q5152	Injection, eculizumab-aeeb (bkemv), biosimilar, 2 mg	G	0846	07/01/2025	06/30/2028
J9011	J9011	Injection, datopotamab deruxtecan-dlnk, 1 mg	G	0835	07/01/2025	06/30/2028
J0614	J0614	Injection, treosulfan, 50 mg	G	0837	07/01/2025	06/30/2028
J9249	J9249	Injection, melphalan (apotex), 1 mg	G	0842	07/01/2025	06/30/2028
J9038	J9038	Injection, axatilimab-csfr, 0.1 mg	G	0839	07/01/2025	06/30/2028
J9289	J9289	Injection, nivolumab, 2 mg and hyaluronidase-nvhy	G	0848	07/01/2025	06/30/2028
Q5100	Q5100	Injection, ustekinumab-kfce (yesintek), biosimilar, 1 mg	G	0857	07/01/2025	06/30/2028
J9220	J9220	Injection, indigotindisulfonate sodium, 1 mg	G	0821	07/01/2025	06/30/2028
J0458	J0458	Injection, aztreonam/avibactam, 7.5 mg/2.5 mg (10 mg)	G	0878	10/01/2025	09/30/2028
J9256	J9256	Injection, nipocalimab-aahu, 3 mg	G	0893	10/01/2025	09/30/2028
J9326	J9326	Injection, telisotuzumab vedotin-tllv, 1 mg	G	0894	10/01/2025	09/30/2028
J3403	J3403	Revakinagene taroretcel-lwey, per implant	G	0897	10/01/2025	09/30/2028
Q5151	Q5151	Injection, eculizumab-aagh (epysqli), biosimilar, 2 mg	G	0852	10/01/2025	09/30/2028
A9616	A9616	Gallium ga-68 gozetotide (gozellix), diagnostic, 1 millicurie	G	0876	10/01/2025	09/30/2028
J7174	J7174	Injection, fitusiran, 0.04 mg	G	0889	10/01/2025	09/30/2028
Q9998	Q9998	Injection, ustekinumab-aekn (selarsdi), biosimilar, 1 mg	G	0859	10/01/2025	09/30/2028

Q9999	Q9999	Injection, ustekinumab-aauz (otulfi), biosimilar, 1 mg	G	0895	10/01/2025	09/30/2028
J0681	J0681	Injection, ceftobiprole medocaril sodium, 3 mg	G	0879	10/01/2025	09/30/2028
C9307	J9601	Injection, linvoseltamab-gcpt, 1 mg	G	0916	01/01/2026	12/31/2028
C9308	J9278	Injection, carboplatin (avyxa), 1 mg	G	0917	01/01/2026	12/31/2028
J1737	J1737	Injection, meloxicam (azurity), 1 mg	G	0898	01/01/2026	12/31/2028
J9184	J9184	Injection, gemcitabine hydrochloride (avyxa), 200 mg	G	0909	01/01/2026	12/31/2028
J9275	J9275	Injection, cosibelimab-ipdl, 2 mg	G	0915	01/01/2026	12/31/2028
J9282	J9282	Mitomycin, intravesical instillation, 1 mg	G	0913	01/01/2026	12/31/2028
Q5158	Q5158	Injection, denosumab-bnht (bomyntra/conexxence), biosimilar, 1 mg	G	0892	01/01/2026	12/31/2028
Q5160	Q5160	Injection, bevacizumab-nwgd (jobevne), biosimilar, 10 mg	G	0918	01/01/2026	12/31/2028
C9309	J3405	Injection, onasemnogene abeparvovec-brve, per treatment	G	0922	04/01/2026	03/31/2029
J3404	J3404	Injection, zopapogene imadenovec-drba suspension, per therapeutic dose	G	0924	04/01/2026	03/31/2029
J9183	J9183	Gemcitabine intravesical system, 225 mg	G	0926	04/01/2026	03/31/2029
J9277	J9277	Injection, pembrolizumab, 1 mg and berahyaluronidase alfa-pmph	G	0930	04/01/2026	03/31/2029
Q5162	Q5162	Injection, denosumab-nxxp (bildyos/bilprevda), biosimilar, 1 mg	G	0934	04/01/2026	03/31/2029
Q5161	Q5161	Injection, denosumab-kyqq (aukelso/bosaya), biosimilar, 1 mg	G	0951	07/01/2026	06/30/2029
J2789	J2789	Riboflavin 5'-phosphate, ophthalmic solution (epioxahd/epioxa), up to 2 mL	G	0941	07/01/2026	06/30/2029
J2361	J2361	Injection, depemokimab-ulaa, 1 mg	G	0940	07/01/2026	06/30/2029

A9574	A9574	Injection, ferumoxytol, 1 mg	G	0935	07/01/2026	06/30/2029
Q5146	Q5146	Injection, trastuzumab-strf (hercessi), biosimilar, 10 mg	G	0865	07/01/2026	06/30/2029
Q5098	Q5098	Injection, ustekinumab-srlf (imuldosa), biosimilar, 1 mg	G	0952	07/01/2026	06/30/2029
J9062	J9062	Injection, amivantamab 5 mg and hyaluronidase-lpuj	G	0942	07/01/2026	06/30/2029
C9310	J0644	Injection, leucovorin calcium (avyxa), 1 mg	G	0936	07/01/2026	06/30/2029
J1289	J1289	Injection, narsoplimab-wuug, 1 mg	G	0938	07/01/2026	06/30/2029
C9311	C9311	Injection, eplontersen, 1 mg (code may be used for medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered)	G	0958	10/01/2026	09/30/2029
C9312	C9312	Injection, trabectedin (apotex), not therapeutically equivalent to J9362, 0.01 mg	G	0959	10/01/2026	09/30/2029
J9186	J9186	Injection, etoposide (avyxa), 1 mg	G	0970	10/01/2026	09/30/2029
C9313	C9313	Injection, pivekimab sunirine-pvzy, 0.01 mg	G	0960	10/01/2026	09/30/2029
J9191	J9191	Injection, fluorouracil (avyxa), 10 mg	G	0971	10/01/2026	09/30/2029
A9613	A9613	Piflufolastat F-18 (pylarify truvu), diagnostic, 1 millicurie	G	0962	10/01/2026	09/30/2029

We welcomed public comments on the status indicator for expiring pass-through drugs and biologicals, in accordance with our existing policies on packaged drugs, biologicals, and radiopharmaceuticals, including the threshold packaging policy.

We received a public comment on these proposals.

Comment: One commenter supported maintaining pass-through status for HCPCS code J7355 through June 30, 2027. In addition, the commenter believed that J7355 should be assigned a K status indicator upon pass-through status expiration effective July 1, 2027 since, per the commenter, the drug does not function as a supply in a surgical procedure and the per- day cost of the drug is significantly above the proposed OPPS drug packaging threshold of $140. The commenter further stated that the drug is provided to the patient through an administration procedure that puts the drug into the body and the current cost is $196.746 per microgram and beneficiaries typically receive a 75-microgram dose.

Response: We thank the commenter for their comment. We appreciate the support regarding proposed continuation of pass-through status for J7355 through June 30, 2027 and will consider the comment when assessing the appropriate status indicator for J7355 after pass-through status expires.

After consideration of public comments, we are finalizing as proposed with the modification of the additional 15 drugs and biologicals in Table 59 approved for pass-through status since the proposed rule.

B. OPPS Payment for Drugs, Biologicals, and Radiopharmaceuticals Without Pass-Through Payment Status

1. Criteria for Packaging Payment for Drugs, Biologicals, and Radiopharmaceuticals

a. Packaging Threshold

In accordance with section 1833(t)(16)(B) of the Act, the threshold for establishing separate APCs for payment of drugs and biologicals was set to $50 per administration during CYs 2005 and 2006. In CY 2007, we used the four-quarter moving average Producer Price Index (PPI) levels for Pharmaceutical Preparations (Prescription) to trend the $50 threshold forward from the third quarter of CY 2005 (when the Pub. L. 108-173 mandated threshold became effective) to the third quarter of CY 2007. We then rounded the resulting dollar amount to the nearest $5 increment to determine the CY 2007 threshold amount of $55. Using the same

methodology as that used in CY 2007 (which is discussed in more detail in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68085 through 68086)), we set the packaging threshold for establishing separate APCs for drugs and biologicals at $140 for CY 2026 (90 FR 53698).

Following the CY 2007 methodology, for the CY 2027 OPPS/ASC proposed rule, we proposed to use the most recently available four-quarter moving average PPI levels to trend the $50 threshold forward from the third quarter of CY 2005 to the third quarter of CY 2027 and round the resulting dollar amount ($142.40) to the nearest $5 increment, which yields a figure of $140. In performing this calculation, we used the most recent forecast of the quarterly index levels for the PPI for Pharmaceuticals for Human Use (Prescription) (Bureau of Labor Statistics series code WPUSI07003) from IHS Global, Inc. (IGI). IGI is a nationally recognized economic and financial forecasting firm with which CMS contracts to forecast various price indexes including the PPI Pharmaceuticals for Human Use (Prescription). Based on these calculations, we proposed a packaging threshold for CY 2027 of $140 for drugs, biologicals, and therapeutic radiopharmaceuticals. We also proposed that if more recent data subsequently becomes available after the publication of the CY 2027 OPPS/ASC proposed rule, we would use such updated data, if appropriate, to determine the final CY 2027 OPPS drug packaging threshold amount in the CY 2027 OPPS/ASC final rule with comment period.

We finalized in section II.A.3.c. of the CY 2025 OPPS/ASC final rule with comment period (89 FR 94238 through 94241) to pay separately for diagnostic radiopharmaceuticals with a per-day cost above the packaging threshold for CY 2025 of $630. We also finalized that starting in CY 2026 and subsequent years, we would update this threshold by the PPI for Pharmaceuticals for Human Use (Prescription) (Bureau of Labor Statistics series code WPUSI07003) from IGI. For the diagnostic radiopharmaceutical packaging threshold, we finalized using the same methodology as that used in CY 2007 (which is discussed in more detail in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68085 and 68086)) to

calculate the update to the OPPS drug packaging threshold. Specifically, we finalized that, starting with the CY 2026 rulemaking cycle, we would use the most recently available four-quarter moving average PPI levels to trend the CY 2025 threshold amount forward from the third quarter of the data year (CY 2024) to the third quarter of the payment year (CY 2025) and round the resulting dollar amount to the nearest $5 increment. In the CY 2026 OPPS/ASC final rule, we finalized a technical refinement to this policy to use the most recently available four-quarter moving average PPI levels to trend the CY 2025 threshold amount of $630 forward from the third quarter of CY 2025 to the third quarter of the payment year (CY 2026) and round the resulting dollar amount to the nearest $5 increment. We believed using the most recently available forecast of the four-quarter moving average PPI levels more appropriately updates the packaging threshold amount from CY 2025 to the current payment year moving forward. For this final rule with comment period, we proposed to use the most recently available four-quarter moving average PPI levels to trend the final CY 2025 $630 diagnostic radiopharmaceutical packaging threshold forward from the third quarter of CY 2025 to the third quarter of CY 2027 and round the resulting dollar amount ($667.44) to the nearest $5 increment, which yielded a proposed radiopharmaceutical packaging threshold amount of $665 for CY 2027. We also proposed that if more recent data subsequently become available after the publication of the CY 2027 OPPS/ASC proposed rule, we would use such updated data, if appropriate, to determine the final CY 2027 diagnostic radiopharmaceutical packaging threshold amount in the CY 2027 OPPS/ASC final rule with comment period.

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: Several commenters supported continued use of the PPI methodology for updating the drug and diagnostic radiopharmaceutical packaging threshold. They also noted that the threshold for diagnostic radiopharmaceuticals has moved in a trajectory that appropriately reflects inflation in medical costs and should be maintained. Other commenters supported

holding the drug packaging threshold at $140, a level that preserves separate payment for therapeutic radiopharmaceuticals and other high-cost products.

Response: We thank the commenters for their support. We believe using the four-quarter moving average PPI levels for Pharmaceuticals for Human Use, Prescription to adjust the OPPS drug and diagnostic radiopharmaceutical packaging threshold through notice-and-comment rulemaking is a transparent and predictable methodology that has been in use under the OPPS for many years.

Comment: Some commenters did not support continued increases to the drug packaging threshold and recommended maintaining the threshold at $140. These commenters expressed concerns that increases in the threshold may result in additional high-cost drugs being packaged, creating financial concerns. Commenters also recommended that CMS continue to evaluate whether packaging appropriately accounts for high-cost, low-utilization drugs and radiopharmaceuticals. Some commenters recommended establishing separate payment for certain high-cost, low-utilization cancer drugs, similar to the separate payment policy for certain diagnostic radiopharmaceuticals.

Response: We appreciate these perspectives; however, we believe that the PPI update factor provides aggregate changes in the selling prices of pharmaceuticals, which makes it an appropriate factor with which to update the OPPS drug packaging threshold to ensure that as costs change over time, the threshold continues to identify products appropriate for payment packaging, a fundamental principle of a prospective payment system. We also continue to believe that using the four-quarter moving average PPI levels for Pharmaceuticals for Human Use, Prescription to adjust the OPPS drug packaging threshold through notice and comment rulemaking is a transparent and predictable methodology that has been in use under the OPPS for many years. We acknowledge the concern that the threshold may result in additional high-cost drugs being packaged, which could create financial implications for providers. However, for CY 2027, the update to the inflation factor results in a lower final OPPS drug packaging threshold

compared to CY 2026. We also appreciate commenters' recommendation to establish separate payment for certain high-cost, low-utilization cancer drugs similar to the policy for certain diagnostic radiopharmaceuticals. We do not believe it is appropriate to extend that policy to other drugs at this time, as the diagnostic radiopharmaceutical policy addresses circumstances specific to those products. We will continue to monitor and evaluate whether current packaging policies appropriately account for high-cost, low-utilization drugs and radiopharmaceuticals. We will take these commenters into consideration for future policy development.

After consideration of public comments, we are finalizing our proposal to use the most recently available four-quarter moving average PPI levels to trend the $50 threshold forward from the third quarter of CY 2005 to the third quarter of CY 2027 and round the resulting dollar amount to the nearest $5 increment for the OPPS drug packaging threshold. We proposed that if more recent data subsequently become available after the publication of the CY 2027 OPPS/ASC proposed rule, we would use such updated data, if appropriate, to determine the final CY 2027 OPPS drug packaging threshold amount in the CY 2027 OPPS/ASC final rule with comment period. Using the most recent forecast of the quarterly index levels for the PPI for Pharmaceuticals for Human Use (Prescription) (Bureau of Labor Statistics series code WPUSI07003) from IGI, we trended the $50 threshold forward from the third quarter of CY 2005 to the third quarter of CY 2027 and round the resulting dollar amount ($135.43) to the nearest $5 increment, which yields a figure of $135.

We refer readers to section II.A.3.c.(2). of this final rule with comment period for additional details regarding the diagnostic radiopharmaceutical packaging threshold comment and response discussion. We are finalizing our proposal to update the CY 2026 $655 threshold amount by the four-quarter moving average PPI levels for Pharmaceuticals for Human Use, Prescription to trend the $655 threshold forward. Specifically, we are using the most recently available forecast of the four-quarter moving average PPI levels for Pharmaceutical for Human Use, Prescription from the third quarter of 2025 to the third quarter of 2027, and to round the

resulting dollar amount to the nearest $5 increment. We also proposed, and are subsequently finalizing, that if more recent data are subsequently available (for example, a more recent estimate of the PPI for Pharmaceuticals for Human Use, Prescription), we would use such data, if appropriate, to determine the CY 2027 diagnostic radiopharmaceutical packaging threshold in the final rule. Based on this methodology, using the most recent data available for this final rule, we trended the $630 threshold forward and rounded the resulting dollar amount ($634.80) to the nearest $5 increment, which yields a final diagnostic radiopharmaceutical packaging threshold figure of $635 per day for CY 2027.

b. Packaging of Payment for HCPCS Codes that Describe Certain Drugs, Certain Biologicals, and Certain Radiopharmaceuticals Under the Cost Thresholds

To determine the proposed CY 2027 packaging status for all nonpass-through drugs, biologicals, diagnostic and therapeutic radiopharmaceuticals that are not policy packaged, we calculated, on a HCPCS code-specific basis, the per-day cost of all drugs, biologicals, and therapeutic radiopharmaceuticals that had a HCPCS code in CY 2025 and were paid (via packaged or separate payment) under the OPPS. We used data from CY 2025 claims processed through December 31, 2025, for this calculation. However, we did not perform this calculation for those drugs and biologicals with multiple HCPCS codes that include different dosages, as described in section V.B.1.d. of this final rule with comment period, or for the following policy-packaged items that we proposed to continue to package in CY 2027: anesthesia drugs; drugs, biologicals, and contrast agents and other drugs that function as supplies when used in a diagnostic test or procedure; and drugs and biologicals that function as supplies when used in a surgical procedure. Consistent with our policy described in section V.B.5. of this final rule with comment period, in situations where we have no claims data and must determine if these products exceed the per-day cost threshold, we estimated the average number of units of each product that would typically be furnished to a patient during one day in the hospital outpatient

setting and utilized the ASP methodology to determine whether their payment will be packaged as well as their payment status indicators.

To calculate the per-day costs for drugs, biologicals, diagnostic radiopharmaceuticals, and therapeutic radiopharmaceuticals to determine their proposed packaging status for CY 2027, we used the methodology that was described in detail in the CY 2006 OPPS proposed rule (70 FR 42723 through 42724) and finalized in the CY 2006 OPPS final rule with comment period (70 FR 68636 through 68638). For each drug and biological HCPCS code, we estimated payment rates for CY 2027 using the ASP methodology (ASP plus 6 percent, which is the payment rate we proposed for separately payable drugs and biologicals), as discussed in more detail in section V.A.1. and V.B.2. of the proposed rule and this final rule with comment period to calculate the proposed CY 2027 per-day costs. We used the manufacturer-submitted ASP data from the fourth quarter of CY 2025 (data that were used for payment purposes in the physician's office setting, effective April 1, 2026) to determine the proposed CY 2027 OPPS/ASC per-day costs.

As is our standard methodology, for CY 2027, we proposed to use payment rates based on the ASP data from the fourth quarter of CY 2025 for budget neutrality estimates, packaging determinations, impact analyses, and completion of Addenda A and B to the proposed rule (which are available via the internet on the CMS website) because these were the most recent data available for use at the time of development of the CY 2027 OPPS/ASC proposed rule. These data also are the basis for drug payments in the physician's office setting, effective April 1, 2026. Exceptions to our standard methodology include:

- For therapeutic radiopharmaceuticals that do not have pass-through status as of April 1, 2026, and do not have an ASP-based payment rate, we did not use a payment rate based on WAC or AWP for those items, consistent with our policy described in section V.B.3.a. of this final rule with comment period. Instead, we used their arithmetic mean unit cost derived from the CY 2025 hospital claims data to determine their per-day cost.

- For diagnostic radiopharmaceuticals that do not have pass-through status as of April 1, 2026, we used their arithmetic mean unit cost derived from the CY 2025 hospital claims data to determine their per-day cost. We did not use an ASP-based, WAC-based, or AWP-based payment rate for those items unless there was no arithmetic mean unit cost reported for the product, consistent with our proposed policy described in section V.B.3. of this final rule with comment period.

- For items other than diagnostic or therapeutic radiopharmaceuticals that did not have either an ASP-based payment rate, a payment rate based on WAC, or a payment rate based on AWP, we used the arithmetic mean unit cost of the items derived from the CY 2025 hospital claims data to determine their per-day cost.

We proposed to package drugs, biologicals, and therapeutic radiopharmaceuticals with a per-day cost less than or equal to $140 and identify items with a per-day cost greater than $140 as separately payable unless they are policy packaged. For diagnostic radiopharmaceuticals, we proposed to package those items with a per-day cost less than or equal to $665 and identify items with a per-day cost greater than $665 as separately payable. Consistent with our past practice (72 FR 667580), we cross-walked historical OPPS claims data from the CY 2025 HCPCS codes that were reported to the CY 2025 HCPCS codes that we displayed in Addendum B to this proposed rule (which is available on the CMS website)[77] for proposed payment in CY 2027.

Our policy during previous cycles of OPPS rulemaking has been to use updated ASP and claims data to make final determinations of the packaging status of HCPCS codes for drugs, biologicals, and therapeutic radiopharmaceuticals for the OPPS/ASC final rule with comment period (71 FR 68086; 78 FR75022; 89 FR 94238). We note that it is also our policy to make an annual packaging determination for a HCPCS code only when we develop the OPPS/ASC final rule with comment period for the update year (71 FR 68086). Only HCPCS codes that are identified as separately payable in the final rule with comment period are subject to quarterly

[77] *https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient.*

updates. For our calculation of per-day costs of HCPCS codes for drugs, biologicals, and radiopharmaceuticals in the proposed rule, we proposed to use ASP data from the fourth quarter of CY 2025, which is the basis for calculating payment rates for drugs and biologicals in the physician's office setting using the ASP methodology, effective April 1, 2026, along with updated hospital claims data from CY 2025. We note that we also propose to use these data for budget neutrality estimates and impact analyses for the proposed rule.

We proposed that payment rates for HCPCS codes for separately payable drugs and biologicals included in Addenda A and B of the CY 2027 OPPS/ASC final rule with comment period would be based on ASP data from the second quarter of CY 2026. These data are the basis for calculating payment rates for drugs and biologicals in the physician's office setting using the ASP methodology, effective October 1, 2026. These payment rates would then be updated in the January 2027 OPPS update, based on the most recent ASP data to be used for physicians' office and OPPS payment as of January 1, 2027. For drugs and biologicals that do not currently have a payment rate based on ASP, WAC, or AWP, for therapeutic radiopharmaceuticals that do not currently have an ASP payment rate, and for all diagnostic radiopharmaceuticals, we will calculate their arithmetic mean unit cost from all of the CY 2025 claims data and updated cost report information available for the CY 2027 final rule with comment period to determine their final per-day cost.

Consequently, the packaging status of some HCPCS codes for drugs, biologicals, and radiopharmaceuticals in the proposed rule may be different from the same drugs' HCPCS codes' packaging status determined based on the data used for the CY 2027 OPPS/ASC final rule with comment period. Under such circumstances, we proposed to continue to follow the established policies initially adopted for the CY 2005 OPPS final rule with comment period (69 FR 65780) in order to more equitably pay for those drugs whose costs fluctuate relative to the proposed CY 2027 OPPS drug packaging threshold and the drug's payment status (packaged or separately payable) in CY 2027. These established policies have not changed for many years and are the

same as described in the CY 2016 OPPS/ASC final rule with comment period (80 FR 70434). Specifically, for CY 2027 and subsequent years, consistent with our historical practice, we proposed to apply the following policies to those HCPCS codes for drugs, biologicals, and therapeutic radiopharmaceuticals whose relationship to the drug packaging threshold changes based on the updated drug packaging threshold and on the final updated data:

- HCPCS codes for drugs, biologicals, and radiopharmaceuticals that were paid separately in CY 2026 and that are proposed for separate payment in CY 2027, and that then have per-day costs equal to or less than the CY 2027 final rule drug packaging threshold or diagnostic radiopharmaceutical packaging threshold, based on the updated ASPs and hospital claims data used for the CY 2027 final rule, would continue to receive separate payment in CY 2027.

- HCPCS codes for drugs, biologicals, and radiopharmaceuticals that were packaged in CY 2026 and that are proposed for separate payment in CY 2027, and that then have per-day costs equal to or less than the CY 2027 final rule drug packaging threshold or diagnostic radiopharmaceutical packaging threshold, based on the updated ASPs and hospital claims data used for the CY 2027 final rule with comment period, would remain packaged in CY 2027.

- HCPCS codes for drugs, biologicals, and radiopharmaceuticals for which we proposed packaged payment in CY 2027 but that then have per-day costs greater than the CY 2027 final rule drug packaging threshold or diagnostic radiopharmaceutical packaging threshold, based on the updated ASPs and hospital claims data used for the CY 2027 final rule, would receive separate payment in CY 2027.

We did not receive public comments on this provision, and therefore, we are finalizing as proposed.

c. Policy-Packaged Drugs, Biologicals, and Radiopharmaceuticals

As mentioned earlier in this section, under the OPPS, we package several categories of nonpass-through drugs, biologicals, and radiopharmaceuticals, regardless of the cost of the

products. Because the products are packaged according to the policies in 42 CFR 419.2(b), we refer to these packaged drugs, biologicals, and radiopharmaceuticals as "policy-packaged" drugs, biologicals, and radiopharmaceuticals. These policies are either longstanding or based on longstanding principles and inherent to the OPPS and are currently as follows:

- Anesthesia, certain drugs, biologicals, and other pharmaceuticals; medical and surgical supplies and equipment; surgical dressings; and devices used for external reduction of fractures and dislocations (§ 419.2(b)(4));
- Intraoperative items and services (§ 419.2(b)(14));
- Drugs, biologicals, and radiopharmaceuticals that function as supplies when used in a diagnostic test or procedure (including, but not limited to, diagnostic radiopharmaceuticals with per-day costs at or below the per-day diagnostic radiopharmaceutical packaging threshold for the applicable year, contrast agents, and pharmacologic stress agents) (§ 419.2(b)(15)); and
- Drugs and biologicals that function as supplies when used in a surgical procedure including, but not limited to, products, excluding skin substitutes, that aid wound healing (§ 419.2(b)(16)).

The policy at § 419.2(b)(16) is broader than the policy at § 419.2(b)(14). As we stated in the CY 2015 OPPS/ASC final rule with comment period: "We consider all items related to the surgical outcome and provided during the hospital stay in which the surgery is performed, including postsurgical pain management drugs, to be part of the surgery for purposes of our drug and biological surgical supply packaging policy" (79 FR 66875). The category described by § 419.2(b)(15) is large and includes diagnostic radiopharmaceuticals that have a per-day cost below the finalized diagnostic radiopharmaceutical packaging threshold that we discuss in section II.A.3. of this final rule with comment period, contrast agents, stress agents, and some other products. The category described by § 419.2(b)(16) currently includes skin substitutes and some other products. We believe it is important to reiterate that cost consideration is not a factor when determining whether an item is a surgical supply (79 FR 66875).

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: One commenter suggested CMS should develop a payment policy for drugs that are administered at the time of ophthalmic surgery, that are direct substitutes for postoperative medications, or that have an FDA-approved indication to treat/prevent post-operative issues, such as pain, inflammation, or infection, separately under Medicare Part B.

Response: We thank the commenter for their suggestion. However, we do not believe it is appropriate to establish separate payment for these drugs. Under 42 CFR 419.2, in which drugs and biologicals that function as supplies when used in a surgical procedure (including, but not limited to, skin substitutes and similar products that aid wound healing and implantable biologicals) are appropriately packaged into the payment for the procedure in which they are used, and thus receive packaged payment. We believe drugs administered at the time of ophthalmic surgery that function as supplies to, and are supportive of, the procedure are consistent with this existing packaging framework, which reflects the fundamental OPPS principle of encouraging efficiency in the furnishing of covered services.

After consideration of public comments, we are finalizing this policy without modification in CY 2027.

d. Packaging Determination for HCPCS Codes That Describe the Same Drug or Biological but Different Dosages

In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60490 through 60491), we finalized a policy to make a single packaging determination for a drug, rather than an individual HCPCS code, when a drug has multiple HCPCS codes describing different dosages because we believe that adopting the standard HCPCS code-specific packaging determinations for these codes could lead to inappropriate payment incentives for hospitals to report certain HCPCS codes instead of others. We continue to believe that making packaging determinations on a drug-specific basis eliminates payment incentives for hospitals to report

certain HCPCS codes for drugs and allows hospitals flexibility in choosing to report all HCPCS codes for different dosages of the same drug or only the lowest dosage HCPCS code. Therefore, we proposed to continue our policy to make packaging determinations on a drug-specific basis, rather than a HCPCS code-specific basis, for those HCPCS codes that describe the same drug or biological but different dosages in CY 2027.

To propose a packaging determination that is consistent across all HCPCS codes that describe different dosages of the same drug or biological, we aggregated both our CY 2025 claims data and our pricing information, which is based on the ASP methodology, generally ASP plus 6 percent, across all of the HCPCS codes that describe each distinct drug or biological in order to determine the mean units per day of the drug or biological in terms of the HCPCS code with the lowest dosage descriptor. The following drugs did not have pricing information available for the ASP methodology for the proposed rule; and, as is our current policy for determining the packaging status of other drugs, we used the arithmetic mean unit cost available from the CY 2025 claims data to make the proposed packaging determinations for them: HCPCS 3471 (injection, hyaluronidase, ovine, preservative free, per 1 usp unit (up to 999 usp units)); HCPCS code J3472 (Injection, hyaluronidase, ovine, preservative free, per 1000 usp units); HCPCS code J7100 (Infusion, dextran 40,500 ml); and HCPCS code J7110 (Infusion, dextran 75,500 ml).

For all other drugs and biologicals that have HCPCS codes describing different doses, we then multiplied the proposed weighted average ASP methodology based payment rate, which is generally ASP plus 6 percent, per-unit payment amount across all dosage levels of a specific drug or biological by the estimated units per day for all HCPCS codes that describe each drug or biological from our claims data to determine if the estimated per-day cost of each drug or biological is less than or equal to the proposed CY 2027 drug packaging threshold of $140 (in which case all HCPCS codes for the same drug or biological would be packaged) or greater than the proposed CY 2027 drug packaging threshold of $140 (in which case all HCPCS codes for the

same drug or biological would be separately payable). The proposed and final packaging status of each drug and biological HCPCS code to which this methodology would apply in CY 2027 is displayed in Table 60.

TABLE 60: HCPCS CODES TO WHICH THE CY 2027 DRUG-SPECIFIC PACKAGING DETERMINATION METHODOLOGY APPLIES

CY 2027 HCPCS Code	CY 2027 Long Descriptor	Proposed CY 2027 Status Indicator (SI)	Final CY 2027 Status Indicator (SI)
C9257	Injection, bevacizumab, 0.25 mg	K	K
J9035	Injection, bevacizumab, 10 mg	K	K
J1460	Injection, gamma globulin, intramuscular, 1 cc	K	K
J1560	Injection, gamma globulin, intramuscular over 10 cc	K	K
J1642	Injection, heparin sodium, (heparin lock flush), per 10 units	N	N
J1644	Injection, heparin sodium, per 1000 units	N	N
J2788	Injection, rho d immune globulin, human, minidose, 50 micrograms (250 i.u.)	N	N
J2790	Injection, rho d immune globulin, human, full dose, 300 micrograms (1500 i.u.)	N	N
J3471	Injection, hyaluronidase, ovine, preservative free, per 1 usp unit (up to 999 usp units)	N	N
J3472	Injection, hyaluronidase, ovine, preservative free, per 1000 usp units	E2	E2
J7030	Infusion, normal saline solution, 1000 cc	N	N
J7040	Infusion, normal saline solution, sterile (500 ml=1 unit)	N	N
J7050	Infusion, normal saline solution, 250 cc	N	N
J7100	Infusion, dextran 40, 500 ml	N	N
J7110	Infusion, dextran 75, 500 ml	E2	E2
J7515	Cyclosporine, oral, 25 mg	N	N
J7502	Cyclosporine, oral, 100 mg	N	N

We proposed that our policy to make packaging determinations on a drug-specific basis, rather than a HCPCS code-specific basis, for those HCPCS codes that describe the same drug or biological but different dosages in CY 2027 would also apply to diagnostic radiopharmaceuticals. This is because, as with drugs and biologicals, we believe that adopting standard HCPCS code-specific packaging determinations for radiopharmaceutical codes could lead to inappropriate payment incentives for hospitals to report certain HCPCS codes instead of others. To propose a packaging determination that is consistent across all HCPCS codes that describe different dosages of the same diagnostic radiopharmaceutical, we would aggregate our CY 2025 claims data across all the HCPCS codes that describe each distinct diagnostic

radiopharmaceutical to determine the mean units per day of the diagnostic radiopharmaceutical in terms of the HCPCS code with the lowest dosage descriptor. We would then analyze the aggregate per-day cost of the diagnostic radiopharmaceutical to determine if the per-day cost is less than or equal to the proposed, and now final, CY 2027 diagnostic radiopharmaceutical packaging threshold of $665 (in which case all HCPCS codes for the same diagnostic radiopharmaceutical would be packaged) or greater than the proposed, and now final, CY 2027 diagnostic radiopharmaceutical packaging threshold of $665 (in which case all HCPCS codes for the same diagnostic radiopharmaceutical would be separately payable). We did not receive any public comments on our proposal, and we are finalizing our proposal without modification, and confirm that the final CY 2027 drug packaging threshold will be $135 per day as described in section V.B.1.a. of this final rule with comment period. All parts of the proposal are finalized without modification.

2. Payment for Drugs and Biologicals Without Pass-Through Status That Are Not Packaged

a. Payment for Specified Covered Outpatient Drugs (SCODs) and Other Separately Payable Drugs and Biologicals

Section 1833(t)(14) of the Act defines certain separately payable radiopharmaceuticals, drugs, and biologicals and mandates specific payments for these items. Under section 1833(t)(14)(B)(i) of the Act, a "specified covered outpatient drug" (known as a SCOD) is defined as a covered outpatient drug, as defined in section 1927(k)(2) of the Act, for which a separate APC has been established and that either is a radiopharmaceutical agent or a drug or biological for which payment was made on a pass-through basis on or before December 31, 2002.

Under section 1833(t)(14)(B)(ii) of the Act, certain drugs and biologicals are designated as exceptions and are not included in the definition of SCODs. These exceptions are—

- A drug or biological for which payment is first made on or after January 1, 2003, under the transitional pass-through payment provision in section 1833(t)(6) of the Act.

- A drug or biological for which a temporary HCPCS code has not been assigned.
- During CYs 2004 and 2005, an orphan drug (as designated by the Secretary).

Section 1833(t)(14)(A)(iii) of the Act requires that payment for SCODs in CY 2006 and subsequent years be equal to the average acquisition cost for the drug for that year as determined by the Secretary, subject to any adjustment for overhead costs and considering the hospital acquisition cost survey data collected by the Government Accountability Office (GAO) in CYs 2004 and 2005, and later periodic surveys conducted by the Secretary as set forth in the statute. If hospital acquisition cost data are not available, the law requires that payment be equal to payment rates established under the methodology described in section 1842(o), section 1847A, or section 1847B of the Act, as calculated and adjusted by the Secretary as necessary for purposes of paragraph (14) of the Act. We refer to this alternative methodology as the "statutory default." Most physician Part B drugs are paid at ASP plus 6 percent in accordance with section 1842(o) and section 1847A of the Act.

Section 1833(t)(14)(E)(ii) of the Act provides for an adjustment in OPPS payment rates for SCODs to consider overhead and related expenses, such as pharmacy services and handling costs. Section 1833(t)(14)(E)(i) of the Act required MedPAC to study pharmacy overhead and related expenses and to make recommendations to the Secretary regarding whether, and if so how, a payment adjustment should be made to compensate hospitals for overhead and related expenses. Section 1833(t)(14)(E)(ii) of the Act authorizes the Secretary to adjust the weights for ambulatory procedure classifications for SCODs to consider the findings of the MedPAC study.[78]

It has been our policy since CY 2006 to apply the same treatment to all separately payable drugs and biologicals, which include SCODs, and drugs and biologicals that are not SCODs. Therefore, we apply the payment methodology in section 1833(t)(14)(A)(iii) of the Act to SCODs, as required by statute, but we also apply it to separately payable drugs and biologicals

[78] Medicare Payment Advisory Committee. June 2005 Report to the Congress. Chapter 6: Payment for pharmacy handling costs in hospital outpatient departments. Available at *https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/June05_ch6.pdf.*

that are not SCODs, which is a policy determination rather than a statutory requirement. For CY 2023 and subsequent years, we finalized a policy to apply section 1833(t)(14)(A)(iii)(II) of the Act to all separately payable drugs and biologicals, including SCODs. Although we do not distinguish SCODs in this discussion, we note that we are required to apply section 1833(t)(14)(A)(iii)(II) of the Act to SCODs; but we also are applying this provision to other separately payable drugs and biologicals, consistent with our history of using the same payment methodology for all separately payable drugs and biologicals.

For a detailed discussion of our OPPS drug payment policies from CY 2006 to CY 2012, we refer readers to the CY 2013 OPPS/ASC final rule with comment period (77 FR 68383 through 68385). In the CY 2013 OPPS/ASC final rule with comment period (77 FR 68386 through 68389), we first adopted the statutory default policy to pay for separately payable drugs and biologicals at ASP plus 6 percent based on section 1833(t)(14)(A)(iii)(II) of the Act. We have continued this policy of paying for separately payable drugs and biologicals at the statutory default for CYs 2014 through 2025.

In the case of a drug or biological during an initial sales period in which data on the prices for sales of the drug or biological are not sufficiently available from the manufacturer, section 1847A(c)(4) of the Act permits the Secretary to make payments that are based on WAC. Under section 1833(t)(14)(A)(iii)(II) of the Act, the amount of payment for a separately payable drug equals the average price for the drug for the year established under, among other authorities, section 1847A of the Act. As explained in greater detail in the CY 2019 PFS final rule, under section 1847A(c)(4) of the Act, although payments may be based on WAC, unlike section 1847A(b) of the Act (which specifies that payments using ASP or WAC must be made with a 6 percent add-on), section 1847A(c)(4) of the Act does not require that a particular add-on amount be applied to WAC-based pricing for this initial period when ASP data are not available. Consistent with section 1847A(c)(4) of the Act, in the CY 2019 PFS final rule (83 FR 59661 to 59666), we finalized a policy that, effective January 1, 2019, WAC-based payments for Part B

drugs made under section 1847A(c)(4) of the Act will utilize a 3 percent add-on in place of the 6 percent add-on that was being used according to our policy in effect as of CY 2018. For the CY 2019 OPPS, we followed the same policy finalized in the CY 2019 PFS final rule (83 FR 59661 to 59666). Since CY 2020, we have continued to utilize a 3 percent add-on instead of a 6 percent add-on for drugs that are paid based on WAC pursuant to our authority under section 1833(t)(14)(A)(iii)(II) of the Act (84 FR 61318 and 85 FR 86039), which provides, in part, that the amount of payment for a SCOD is the average price of the drug in the year established under section 1847A of the Act. We also apply this provision to non-SCOD separately payable drugs, biologicals, and certain radiopharmaceuticals. Because we establish the average price for a drug paid based on WAC under section 1847A of the Act as WAC plus 3 percent instead of WAC plus 6 percent, we believe it is appropriate to price separately payable drugs paid based on WAC at the same amount under the OPPS. Our policy to pay for drugs and biologicals at WAC plus 3 percent, rather than WAC plus 6 percent, applies whenever WAC-based pricing is used for a drug, biological, or radiopharmaceutical under section 1847A(c)(4) of the Act. When WAC-based pricing is used for a drug, biological, or radiopharmaceutical, but not under section 1847A(c)(4) of the Act, the payment of WAC plus 6 percent would apply. We refer readers to the CY 2019 PFS final rule (83 FR 59661 to 59666) for additional background on this policy.

Consistent with our current policy, payments for separately payable drugs, biologicals, and radiopharmaceuticals are included in the budget neutrality adjustments, under the requirements in section 1833(t)(9)(B) of the Act. Also, the budget neutral weight scalar is not applied in determining payments for these separately payable drugs and biologicals.

Separately payable drug, biological, and radiopharmaceutical payment rates were listed in Addenda A and B to the proposed rule (available on the CMS website).[79] These addenda provide the proposed CY 2027 payment rates based on the ASP methodology for separately payable

[79] *https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient.*

nonpass-through drugs, biologicals, and radiopharmaceuticals, with exceptions for certain radiopharmaceuticals previously discussed, and the ASP methodology for pass-through drugs, biologicals, and radiopharmaceuticals. Except for proposed payment rates for certain radiopharmaceuticals, these rates were based either on ASP information that is the basis for calculating payment rates for drugs and biologicals in the physician's office setting effective April 1, 2026, or WAC, AWP, or the arithmetic mean unit cost from CY 2025 claims data and updated cost report information available for the proposed rule. For nonpass-through therapeutic radiopharmaceuticals, payment rates were based on ASP data or the arithmetic mean unit cost. We proposed to pay separately at the arithmetic mean unit cost for diagnostic radiopharmaceuticals with per-day costs above the proposed threshold; the payment rates proposed for qualifying diagnostic radiopharmaceuticals are entirely the arithmetic mean unit cost if available (see section II.A.3.c.(3) of this final rule with comment period, regarding payment policy of qualifying diagnostic radiopharmaceuticals). In general, these published proposed payment rates will not be the same as the actual January 2027 payment rates. This is because payment rates for drugs, biologicals, and therapeutic radiopharmaceuticals with ASP information for January 2027 will be determined through the standard quarterly process where ASP data submitted by manufacturers for the third quarter of CY 2026 (July 1, 2026, through September 30, 2026) will be used to set the payment rates that are released for the quarter beginning in January 2027 in December 2026. In addition, in Addenda A and B to the proposed rule, payment rates for drugs, biologicals, and therapeutic radiopharmaceuticals for which there was no ASP, WAC, or AWP information available for April 2026, as well as all separately payable diagnostic radiopharmaceuticals, were based on the arithmetic mean unit cost in the available CY 2025 claims data.

As stated in the proposed rule, if new pricing information becomes available for payment for the quarter beginning in January 2026, we will price payment for these drugs, biologicals, therapeutic radiopharmaceuticals, and diagnostic radiopharmaceuticals based on their newly

available information. Finally, there may be drugs, biologicals and therapeutic radiopharmaceuticals that had ASP, WAC, or AWP information available for the proposed rule (reflecting April 2026 ASP data) that do not have ASP, WAC, or AWP information available for the quarter beginning in January 2027. These drugs, biologicals and therapeutic radiopharmaceuticals would then be paid based on the arithmetic mean unit cost data derived from CY 2025 hospital claims. Therefore, the proposed payment rates listed in Addenda A and B to the final rule were not for January 2027 payment purposes and were only illustrative of the CY 2027 OPPS payment methodology using the most recently available information at the time of issuance of the CY 2027 OPPS/ASC proposed rule.

We note that payment amounts for most drugs separately payable under Medicare Part B are determined using the methodology in section 1847A of the Act, and in many cases, payment is based on the ASP plus a statutorily mandated 6 percent add-on.

In CY 2025, we clarified that only ASP data or, if ASP data are not available, the arithmetic mean unit cost data, would be used to set payment rates for separately payable nonpass-through therapeutic radiopharmaceuticals under the OPPS. For CY 2027, we did not propose any changes to our policies for payment for separately payable therapeutic or diagnostic radiopharmaceuticals.

For CY 2027, we did not propose any additional changes to our policies for payment for separately payable drugs, biologicals, and radiopharmaceuticals. We proposed to continue our payment policy that has been in effect since CY 2013 to pay for separately payable drugs and biologicals in accordance with section 1833(t)(14)(A)(iii)(II) of the Act (the statutory default). However, please see additional details in section V.C. of this final rule with comment period.

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: Several commenters supported our proposals related to the separate payment for separately payable nonpass-through drugs and biologicals under the OPPS. Commenters

supported our proposal to continue using mean unit cost (MUC) derived from hospital claims data to determine payment for diagnostic radiopharmaceuticals with per-day costs above the CY 2027 packaging threshold. Commenters supported continuing to use MUC while CMS develops the infrastructure for ASP-based payment. One commenter recommended continuing to use MUC for certain multi-dose and generator-based products for which the commenter stated that an accurate per-dose ASP may be difficult to determine. Another commenter recommended retaining MUC as a supplemental payment reference if CMS transitions to ASP-based payment in the future.

Response: We thank the commenters for their support. We will consider commenters' recommendations regarding the continued use of MUC for certain products as we further develop our ASP reporting framework.

Comment: Several commenters opposed continuing to use MUC and recommended that CMS use ASP to determine payment for separately payable diagnostic radiopharmaceuticals when sufficient ASP data are available. Commenters expressed concerns that MUC relies on historical hospital claims data and may not reflect current acquisition costs. Several commenters recommended a product-specific approach under which CMS would use ASP when sufficient data are available and MUC when ASP data are unavailable or insufficient. Commenters also recommended payment at ASP plus 6 percent, consistent with the payment methodology for certain other Part B drugs and biologicals and therapeutic radiopharmaceuticals.

Some commenters opposed packaging payment for high-cost, low-utilization cancer drugs once their pass-through status expires stating that it would reimburse hospitals at less than such drugs' actual cost, pushing patients toward older, less effective treatment options.

Response: We thank the commenters for their feedback. We will consider commenters' recommendations regarding the continued use of MUC for certain products as we further develop our ASP reporting framework. We will take these comments into consideration for

future rulemaking, future issuance of sub-regulatory guidance, and future internal process improvements.

After consideration of public comments, we are finalizing, without modification, our proposals to continue our payment policy for separately payable drugs and biologicals subject to the policy finalized in section V.C. of this final rule with comment period.

b. Biosimilar Biological Products

In the CY 2024 OPPS/ASC final rule with comment period, we finalized the exception of biosimilars from the OPPS threshold packaging policy when their reference products are separately paid (88 FR 81783 through 81785). This policy allows for separate payment for biosimilars even if the biosimilar's per-day cost is below the packaging threshold if the biosimilar's reference product is separately paid. This policy removes the financial incentive to use a more expensive separately payable biological and promotes biosimilar use as a lower cost alternative to higher cost reference products.

Payment rates for drugs and biologicals (including biosimilars) under Medicare Part B are determined using the methodology in section 1847A of the Act, and in many cases, payment is based on the ASP plus a statutorily mandated 6 percent add-on. Additionally, section 11403 of the IRA requires that a qualifying biosimilar be paid at ASP plus 8 percent of the reference product's ASP rather than 6 percent during the applicable 5-year period. Section 1847A(b)(8)(B)(ii) of the Act defines the applicable 5-year period for a qualifying biosimilar for which payment has been made using ASP (that is, payment under section 1847A(b)(8) of the Act) as of September 30, 2022, as the 5-year period beginning on October 1, 2022. For a qualifying biosimilar for which payment is first made using ASP during the period beginning October 1, 2022, and ending December 31, 2027, the statute defines the applicable 5-year period as the 5-year period beginning on the first day of such calendar quarter of such payment (88 FR 81783). These payment rates are published in the quarterly release of Addendum B or ASP pricing files.

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: Commenters supported continuing the biosimilar packaging exception when the reference product is separately payable, stating that the policy supports biosimilar competition and avoids incentives to use higher-cost products. A commenter recommended expanding the exemption to cover any biosimilar so long as either its reference product or any other biosimilar in the class remains separately paid, stating a narrower exemption could still leave an incentive to shift utilization toward higher-priced products.

Response: We thank the commenters for their support of continuing the biosimilar packaging exception. We continue to believe this policy supports the use of biosimilars as lower-cost alternatives while preserving the incentives for efficiency inherent in the OPPS packaging policy. We continue to believe packaging is an essential component of a prospective payment system and do not support categorically excepting all biosimilars from the threshold packaging policy.

After consideration of public comments, we are finalizing our proposal without modification to continue the exception of biosimilars from the OPPS threshold packaging policy when their reference products are separately paid. For CY 2027, we will pay separately for these biosimilars even if their per-day cost is below the threshold packaging policy when their reference products are separately paid. We also refer readers to our policy finalized in section V.C. of this final rule with comment period for additional information regarding the payment of biosimilars.

c. Invoice Drug Pricing for CY 2027

In the CY 2025 OPPS/ASC final rule with comment period (89 FR 94243 to 94244), we finalized that, for separately payable drugs or biologicals for which CMS does not provide a payment rate in Addendum B, which would indicate to MACs that CMS does not have pricing information (specifically, that ASP, WAC, AWP, and arithmetic mean unit cost information is

not available to determine a payment rate), MACs would calculate the payment based on provider invoices. The drug or biological invoice cost would be the net acquisition cost minus any rebates, chargebacks, or post-sale concessions. Before calculating an invoice-based payment amount, MACs would use the provider invoice to determine that: (a) the drug is not policy packaged; and (b) the per-day cost of the drug, biological, therapeutic radiopharmaceutical or diagnostic radiopharmaceutical is above the threshold packaging amount, as applicable. If both conditions are met, the MACs would use the provider invoice amount to set a payment rate for the separately payable drug, biological, or radiopharmaceutical until its payment amount becomes available to CMS. We generally expect invoice pricing to be temporary, lasting two to three quarters, for qualified drugs required to report ASP under section 1847A of the Act. For drug products that are not required to report ASP under section 1847A of the Act (for example, radiopharmaceuticals), invoice pricing may be used on a longer-term basis until an arithmetic mean unit cost (MUC) can be calculated. We finalized the invoice pricing policy for drugs to be effective January 1, 2026, with the intent to make technical updates to outpatient hospital claims and to allow providers time to prepare for any operational changes. We noted that the National Uniform Billing Committee (NUBC) created a value code that would allow for the reporting of invoice prices of drugs, biologicals, and radiopharmaceuticals, effective January 2026 for the purpose of this policy. The NUBC value code created is 92 (Drug/Biologic Invoice Cost), with the definition of: "Invoice Cost of drug/biologic. For use with Revenue Category 0636 when required by federal regulation." In the CY 2026 OPPS/ASC final rule with comment period, we finalized a technical clarification to this policy and clarified that CMS will determine whether the drug is not policy packaged; however, the MAC will continue to determine whether the per-day cost of the drug, biological, therapeutic radiopharmaceutical or diagnostic radiopharmaceutical is above the threshold packaging amount, as applicable (90 FR 53704). We reiterate that the drug or biological invoice cost would be the net acquisition cost minus any rebates, chargebacks, or post-sale concessions. We acknowledge any rebates, chargebacks, or post-sale concessions may

not be immediately available after administration of the drug but hospital providers have 12 months from date of service to submit claims for payment and allowing providers to adjust submitted claims when the price concession becomes available.

For CY 2027, we did not propose any additional changes to our invoice pricing policy for payment for separately payable drugs, biologicals, and radiopharmaceuticals. We proposed to continue our payment policy if CMS does not have pricing information (specifically, that ASP, WAC, AWP, and arithmetic mean unit cost information is not available to determine a payment rate), MACs would calculate the payment based on provider invoices.

We received a public comment on these proposals. The following is a summary of the comment we received and our response.

Comment: A commenter supported the use of invoice pricing when ASP, WAC, or AWP data are unavailable, stating that invoice pricing is preferable to assigning nonpayable status to new drugs. The commenter recommended allowing MACs greater flexibility to determine payment using WAC, AWP, or invoice pricing, similar to the physician office setting. The commenter also recommended more frequent updates to Addendum B and requested that CMS make payable status retroactive to a product's launch date once pricing information becomes available.

Response: We thank the commenter for its support of using invoice pricing when ASP, WAC, or AWP data are unavailable. The invoice pricing policy aims to enhance transparency and accuracy in the determination of payment rates for drugs and biologicals when CMS lacks pricing information. Invoice pricing is a sequential fallback, used when ASP, WAC, AWP, and MUC information are unavailable. This is intended to ensure a consistent, predictable basis for invoice-based payment. Furthermore, invoice pricing eliminates the need for retroactive payable-status changes because the product can be payable from the outset, consistent with the policy's purpose of providing a payment rate while CMS awaits sufficient pricing data. We will continue to evaluate our payment processes for new drugs and biologicals as additional pricing

information becomes available. Additionally, we appreciate the commenter's recommendations regarding the frequency of payment updates, and this will be taken into consideration as we continue to work to improve our payment operations.

After consideration of the public comments, we are implementing this policy without modification in CY 2027. We refer readers to the previous discussion when we finalized the policy in the CY 2025 OPPS/ASC final rule with comment period (89 FR 94243 to 94244).

3. Payment Policy for Radiopharmaceuticals

For a complete history of the OPPS payment policy for radiopharmaceuticals, we refer readers to the CY 2005 OPPS final rule with comment period (69 FR 65811), the CY 2006 OPPS final rule with comment period (70 FR 68655), and the CY 2010 OPPS/ASC final rule with comment period (74 FR 60524).

a. Payment Policy for Therapeutic Radiopharmaceuticals

In the CY 2023 OPPS/ASC final rule with comment period, we adopted as final our proposal to continue our longstanding payment policy for therapeutic radiopharmaceuticals for CY 2023 and subsequent years. Accordingly, this payment policy for therapeutic radiopharmaceuticals will continue to apply in CY 2027.

Specifically, our policy of paying for separately payable pass-through therapeutic radiopharmaceuticals under the ASP methodology adopted for separately payable drugs and biologicals described in section V.A.1. of this final rule with comment period will continue to apply for CY 2027. We will pay for separately payable nonpass-through therapeutic radiopharmaceuticals through a modified ASP methodology where we pay at ASP plus 6 percent if ASP data are available. However, if ASP information is unavailable for a separately payable nonpass-through therapeutic radiopharmaceutical, we will continue to base the payment rate on arithmetic mean unit cost data derived from hospital claims. Our policy not to use WAC or AWP to establish payment for separately payable nonpass-through therapeutic radiopharmaceuticals if ASP is not available will continue for CY 2027. We explained our

rationale in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60524 through 60525) when we first adopted our policy to apply the principles of separately payable drug pricing to therapeutic radiopharmaceuticals.

For a full discussion of ASP-based payment for therapeutic radiopharmaceuticals, we refer readers to the CY 2010 OPPS/ASC final rule with comment period (74 FR 60520 through 60521). We will rely on CY 2025 arithmetic mean unit cost data derived from hospital claims data for payment rates for separately payable nonpass-through therapeutic radiopharmaceuticals for which ASP data are unavailable and update the payment rates for these products according to our usual process for updating the payment rates for separately payable drugs and biologicals on a quarterly basis if updated ASP information becomes available.

The CY 2027 payment rates for separately payable nonpass-through therapeutic radiopharmaceuticals are included in Addenda A and B of this final rule with comment period (which are available on the CMS website).[80]

Though we made no proposal regarding payment for therapeutic radiopharmaceuticals, we received public comments that were generally in support of these policies. We thank the commenters for their support. We are continuing our policies unchanged for CY 2027 subject to the policy finalized in section V.C. of this final rule with comment period.

b. Payment Policy for Diagnostic Radiopharmaceuticals Without Claims Data

For CY 2025, we finalized, as described in the CY 2025 OPPS/ASC final rule with comment period (89 FR 93948 through 93963), to pay separately at arithmetic mean unit cost for diagnostic radiopharmaceuticals with a per-day cost above our diagnostic radiopharmaceutical packaging threshold (proposed at $665 for CY 2027). We also finalized our policy to pay for pass-through diagnostic radiopharmaceuticals based on ASP, WAC, and AWP.

We continue to believe that paying for nonpass-through diagnostic radiopharmaceuticals using the arithmetic mean unit cost would appropriately pay for the average price of a nonpass-

[80] *https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient.*

through separately payable diagnostic radiopharmaceutical, as discussed in section II.A.3.c. of this final rule with comment period. In our view, the arithmetic MUC is an appropriate proxy for the average price for a diagnostic radiopharmaceutical for a given year, as it is calculated based on the average costs for a particular year and is directly reflective of the actual cost data that hospitals submit to CMS. As we stated in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60523), we believe that WAC or AWP is not an appropriate proxy to provide OPPS payment for radiopharmaceuticals because these pricing methodologies do not include discounts. Specifically, the absence of appropriate ASP reporting could result in payment for a separately payable diagnostic radiopharmaceutical based on WAC or AWP indefinitely, a result which we believe would be inappropriate, as these pricing metrics do not capture all of the pricing discounts that may be reflected in the ASP.

Additionally, in the CY 2025 OPPS/ASC final rule with comment period (89 FR 93948 through 93963), we finalized a proposal to base the initial payment for new diagnostic radiopharmaceuticals with HCPCS codes that do not have pass-through status or claims data on ASP, and on the WAC for these products if ASP data for these diagnostic radiopharmaceuticals are not available. To further clarify, these products will be paid based on ASP plus 6 percent, and at WAC plus 3 or 6 percent according to the policy in section V.B.2.a. of this final rule with comment period if ASP data are not available.

If the WAC also is unavailable, we proposed to make payment for new diagnostic radiopharmaceuticals at 95 percent of the products' most recent AWP. We believe the volume of products in this category will typically be very low; however, in these rare situations, we believe it would be appropriate to use ASP, WAC, or AWP until an arithmetic MUC is established for new diagnostic radiopharmaceuticals with HCPCS codes that do not have pass-through status or claims data.

Please refer to section II.A.3.c. of this final rule with comment period for information regarding our broader payment policies for diagnostic radiopharmaceuticals, including our policy

to pay for separately payable diagnostic radiopharmaceuticals with claims data based on the arithmetic mean unit cost data derived from hospital claims, and a list of the qualifying diagnostic radiopharmaceuticals for CY 2027 in Tables 6 and 7 of this final rule with comment period. The proposed CY 2027 payment rates for separately payable nonpass-through diagnostic radiopharmaceuticals are included in Addenda A and B of the proposed rule. The CY 2027 final rule payment rates are included in Addenda A and B of this final rule with comment period (which are available on the CMS website).[81]

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: Commenters generally supported our proposed payment methodology for separately payable diagnostic radiopharmaceuticals without sufficient claims data. Commenters stated that the proposed methodology provides a market-based payment approach when hospital claims data are not available.

Response: We thank the commenters for their support.

Based on the comments received, we are continuing our policies unchanged for CY 2027 subject to the policy finalized in section V.C. of this final rule with comment period.

4. Payment for Blood Clotting Factors

For CY 2027, we proposed to continue our established policy to provide payment for blood clotting factors using the same methodology as other separately payable drugs and biologicals under the OPPS and to continue to pay a furnishing fee, authorized under section 1842(o)(5) of the Act. For a full discussion of our established payment policy for blood clotting factors, please refer to the CY 2023 OPPS/ASC final rule with comment period (87 FR 71969 through 71970). In accordance with our policy as finalized in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66765), we will announce the actual figure of the percent change in the CPI for medical care for the 12-month period ending with June of the previous year. The

[81] *https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices.*

updated CY 2027 furnishing fee calculation based on that figure through the applicable program instructions will be posted on the CMS website at *https://www.cms.gov/medicare/payment/part-b-drugs/asp-billing-resources.*

We received a public comment on these proposals. The following is a summary of the comment we received and our response.

Comment: The commenter supported our proposal to continue to provide payment for the for blood clotting factors using the same methodology as other separately payable drugs and biologicals under the OPPS and to continue to pay a furnishing fee.

Response: We thank the commenter for their support of our policy.

After consideration of public comments, we are finalizing our proposal without modification to pay for clotting factors using the same methodology as other separately payable drugs and biologicals under the OPPS, subject to the policy finalized in section V.C. of this final rule with comment period, and to provide a clotting factor furnishing fee. For CY 2027, the blood clotting factor furnishing fee is $0.270. The actual percentage change in the applicable CPI and the updated furnishing fee calculation based on that figure through the applicable program instructions are posted on the CMS website.[82]

5. Payment for Nonpass-Through Drugs, Biologicals, and Radiopharmaceuticals with HCPCS Codes but Without OPPS Hospital Claims Data

In the CY 2023 OPPS/ASC final rule with comment period, we adopted as final our proposal to continue our longstanding payment policy for nonpass-through drugs, biologicals, and radiopharmaceuticals with HCPCS codes but without OPPS hospital claims data for CY 2023 and subsequent years. Therefore, for CY 2027, this policy will continue to apply. For a detailed discussion of the payment policy and methodology, we refer readers to the CY 2016 OPPS/ASC final rule with comment period (80 FR 70442 through 70443). Consistent with our

[82] *https://www.cms.gov/medicare/payment/fee-for-service-providers/part-b-drugs/average-drug-sales-price.*

policy, because we have no claims data and must determine if these products, drugs, biologicals, therapeutic radiopharmaceuticals, and diagnostic radiopharmaceuticals, exceed the per-day cost threshold, we estimated the average number of units of each product that would typically be furnished to a patient during one day in the hospital outpatient setting and utilized the payment rate for the product, typically the ASP methodology, to determine whether their payment will be packaged as well as their payment status indicators.

We did not receive public comments on this provision, and therefore, we are finalizing as proposed.

6. CY 2027 Prospective Adjustment to Payments for Non-Drug Items and Services to Offset the Increased Payments for Non-Drug Items and Services Made in CY 2018 Through CY 2022 as a Result of the 340B Payment Policy

a. Overview

Under the OPPS, we generally set payment rates for separately payable drugs and biologicals (hereinafter referred to collectively as "drugs" in this section) under section 1833(t)(14)(A) of the Act. Section 1833(t)(14)(A)(iii)(II) of the Act provides that, if hospital acquisition cost data are not available, the payment amount is the average price for the drug in a year established under sections 1842(o), 1847A, or 1847B of the Act, as the case may be. Payment rates for drugs have usually been established under section 1847A of the Act, which generally sets a default rate of the average sales price (ASP) plus 6 percent. Section 1833(t)(14)(A)(iii)(II) of the Act also provides that the average price for the drug in the year as established under section 1847A of the Act, is calculated and adjusted by the Secretary as necessary for purposes of paragraph (14).

In the CY 2018 OPPS/ASC final rule with comment period (82 FR 59353 through 59371), CMS reexamined the appropriateness of paying the ASP plus 6 percent for drugs acquired through the 340B Drug Pricing Program (hereinafter referred to as the "340B Program"), a Health Resources and Services Administration (HRSA)-administered program that

allows covered entities to purchase certain covered outpatient drugs at discounted prices from drug manufacturers. Based on findings of the Government Accountability Office (GAO),[83] the HHS Office of the Inspector General (OIG),[84] and the Medicare Payment Advisory Commission (MedPAC)[85] that 340B hospitals were acquiring drugs at a significant discount under the 340B Program, CMS adopted a policy beginning in 2018 generally to pay an adjusted amount of ASP minus 22.5 percent for certain separately payable drugs or biologicals acquired through the 340B Program. This adjustment amount was based on our concurrence at the time with an analysis by MedPAC that concluded that the estimated average minimum discount of 22.5 percent of ASP adequately represented the average minimum discount that a 340B participating hospital received for separately payable drugs under the OPPS (82 FR 59354 through 59371). Our intent in implementing this payment adjustment was to reflect more accurately the actual costs incurred by participating hospitals in acquiring 340B drugs. We stated our belief that such changes would allow Medicare beneficiaries and the Medicare program to pay a more appropriate amount when hospitals participating in the 340B Program furnished drugs to Medicare beneficiaries that were purchased under the 340B Program (82 FR 59353 through 59371).

b. Payment for 340B Drugs and Biologicals in CYs 2018 Through 2022

From January 1, 2018 through September 27, 2022, under the OPPS we generally paid for certain separately payable drugs acquired through the 340B Program at ASP minus 22.5 percent. In the CY 2018 OPPS/ASC final rule with comment period (82 FR 59369 through 59370), we finalized our proposal to adjust the payment rate for separately payable drugs (other than drugs with pass-through payment status and vaccines) acquired under the 340B Program

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[83] Government Accountability Office. "Medicare Part B Drugs: "Action Needed to Reduce Financial Incentives to Prescribe 340B Drugs at Participating Hospitals." June 2015. Available at *https://www.gao.gov/assets/gao-15-442.pdf.*

[84] Office of Inspector General. "Part B Payment for 340B Purchased Drugs. OEI-12-14-00030". November 2015. Available at *https://oig.hhs.gov/oei/reports/oei-12-14-00030.pdf.*

[85] Medicare Payment Advisory Commission. March 2016 Report to the Congress: Medicare Payment Policy. March 2016. Available at Medicare Payment Advisory Commission. March 2016 Report to the Congress: Medicare Payment Policy. March 2016. Available at *https://www.medpac.gov/document/http-www-medpac-gov-docs-default-source-reports-may-2015-report-to-the-congress-overview-of-the-340b-drug-pricing-program-pdf/.*

from ASP plus 6 percent to ASP minus 22.5 percent. For ease of reference, the OPPS 340B drug payment adjustment policy is hereinafter referred to as the "340B Payment Policy" and refers both to the adjustments made to payment rates for 340B-acquired drugs described here and the corresponding rate adjustment for non-drug services and items described later in section V.B.6.c. of this final rule with comment period. We note that rural sole community hospitals, children's hospitals, and PPS-exempt cancer hospitals were exempted from the adjustments made to payment rates for 340B-acquired drugs primarily due to these hospitals receiving special payment adjustments under the OPPS. In addition, as stated in the CY 2018 OPPS/ASC final rule with comment period, this policy change did not apply to drugs with pass-through payment status, which are required to be paid based on the ASP methodology, or vaccines, which were excluded from the 340B Program. We also noted that critical access hospitals are not paid under the OPPS and therefore were not subject to the 340B Payment Policy. Finally, in CY 2018, we did not initially apply the 340B Payment Policy to 340B-acquired drugs furnished in non-excepted off-campus provider-based departments (PBDs).

In the CY 2019 OPPS/ASC final rule with comment period (83 FR 58981), we continued the Medicare 340B payment policies that were implemented in CY 2018 and made a series of refinements to the 340B Payment Policy, including a policy to pay for nonpass-through 340B-acquired biosimilars at ASP minus 22.5 percent of the biosimilar's ASP, rather than minus 22.5 percent of the reference biological product's ASP. Additionally, in the CY 2019 OPPS/ASC final rule with comment period (83 FR 59015 through 59022), we finalized a policy to pay ASP minus 22.5 percent for 340B-acquired drugs furnished in non-excepted off-campus PBDs paid under the PFS. We adopted this payment policy for CY 2019 and subsequent years.

During the CY 2019 OPPS/ASC rulemaking cycle, we also clarified that the 340B payment adjustment applied to drugs priced using either wholesale acquisition cost (WAC) or average wholesale price (AWP), and since the policy was first adopted, we applied the 340B payment adjustment to 340B-acquired drugs priced using these pricing methodologies. We

made this clarification because inquiries from interested parties following the finalization of the 340B Payment Policy in 2018 demonstrated that there was confusion as to whether drugs receiving WAC or AWP pricing were subject to the 340B payment adjustment (83 FR 33632). WAC is the drug manufacturer's list price for wholesalers or direct purchasers in the U.S., not including prompt payment or other discounts, rebates, or reductions in price, for the most recent month for which information is available, as reported in wholesale price guides or other publications of drug pricing data. AWP is set using industry-recognized AWP reference sources.[86] The 340B payment adjustment for WAC-priced drugs was WAC minus 22.5 percent. 340B-acquired drugs that were priced using AWP were paid an adjusted amount of 69.46 percent of AWP (83 FR 37125).[87]

As discussed further in section V.B.6.f. of this final rule with comment period, the results of this policy meant that hospitals received an estimated $10.6 billion less in 340B drug payments (including money that would have been paid by Medicare and money that would have come from beneficiaries as copayments) than they would have for drugs provided in CY 2018 through September 27th of 2022 had the 340B Payment Policy not been implemented (88 FR 77162). These reduced payments are detailed in Table 61 and are derived from Addendum AAA[88] published with the Final Remedy for the 340B-Acquired Drug Payment Policy for Calendar Years 2018-2022 final rule with comment period (hereinafter referred to as the "Final Remedy rule") (88 FR 77150).

TABLE 61: APPROXIMATE IMPACT IN REDUCED OPPS PAYMENT FOR 340B-ACQUIRED DRUGS 2018 THROUGH 2022

	2018	2019	2020	2021	2022
Approximate Reduced OPPS Drug Payment	$1.9	$2.2	$2.3	$2.4	$1.8*

[86] *www.cms.gov/files/document/part-b-drug-payment-limits-overview.pdf.*
[87] The 69.46 percent of AWP was calculated by first dividing the original 95 percent of AWP price by 6 percent to generate a value that is similar to ASP or WAC with no percentage markup. Then we applied the 22.5 percent reduction to ASP/WAC-similar AWP value to obtain the 69.46 percent of AWP, which was similar to either ASP minus 22.5 percent or WAC minus 22.5 percent.
[88] *https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1793-f.*

	2018	2019	2020	2021	2022
(including beneficiary cost sharing) (billions)					
*Amount January 1 to September 27, 2022. Reduced payments under the 340B Payment Policy were not in effect after September 27, 2022.					

For more detailed descriptions of our OPPS payment policy for drugs acquired under the 340B Program during this timeframe, we refer readers to the CY 2018 OPPS/ASC final rule with comment period (82 FR 59353 through 59371); the CY 2019 OPPS/ASC final rule with comment period (83 FR 59015 through 59022); the CY 2020 OPPS/ASC final rule with comment period (84 FR 61321 through 61327); the CY 2021 OPPS/ASC final rule with comment period (85 FR 86042 through 86055); the CY 2022 OPPS/ASC final rule with comment period (86 FR 63640 through 63649); the CY 2023 OPPS/ASC final rule with comment period (87 FR 71972 through 71973); the CY 2024 OPPS/ASC final rule with comment period (88 FR 81789 through 81792); and the CY 2026 OPPS/ASC final rule with comment period (90 FR 53707 through 53722).

c. Payment for Non-Drug Items and Services in CY 2018 Through CY 2022

In the CY 2018 OPPS/ASC final rule with comment period (82 FR 59216, 59258), to comply with the statutory budget neutrality requirements under sections 1833(t)(9)(B) and (t)(14)(H) of the Act, we finalized our proposal to redistribute our original, estimated reduction in payments for separately payable drugs as a result of the 340B Payment Policy by increasing the conversion factor used to determine the payment amounts for non-drug items and services. As further described in the CY 2018 OPPS/ASC final rule with comment period, we used updated CY 2016 claims data and a list of 340B-eligible providers to calculate an estimated impact of $1.6 billion based on the final CY 2018 policy to pay for OPPS 340B-acquired drugs at a payment rate of generally ASP minus 22.5 percent. To effectuate the budget neutrality provisions of the OPPS for CY 2018, we redistributed an estimated $1.6 billion in reduced drug payments from adoption of the final 340B payment methodology to all hospitals paid under the

OPPS by increasing the payment rates by 3.19 percent for nondrug items and services furnished by all hospitals paid under the OPPS for CY 2018. We carried through this conversion factor adjustment from CYs 2019 through 2022, increasing payments for non-drug items and services in these CYs. This resulted in approximately $7.769 billion, which for ease of reference in this final rule with comment period we hereafter refer to as $7.8 billion, in additional spending on non-drug items and services from CYs 2018 through 2022.

d. Litigation History of the 340B Payment Policy

The 340B Payment Policy was the subject of significant litigation. See the Proposed Remedy for the 340B-Acquired Drug Payment Policy for Calendar Years 2018-2022 (hereinafter referred to as the "proposed remedy rule") for a more comprehensive summary of the litigation history (88 FR 44079 through 44080).

On June 15, 2022, the Supreme Court held that because HHS had not previously conducted a survey of hospitals' acquisition costs, we could not vary the payment rates for outpatient prescription drugs by hospital group. *See Am. Hosp. Ass'n v. Becerra*, 596 U.S. 724, 739 (2022). The Supreme Court declined to opine on the appropriate remedy, *see id*., and on September 28, 2022, the district court vacated the prospective portion of the CY 2022 reimbursement rate for 340B-acquired drugs, *see Am. Hosp. Ass'n v. Becerra*, No. 1:18-cv-2084-RC, 2022 WL 4534617, at *5 (D.D.C.).[89] On January 10, 2023, the district court remanded without vacatur to give the agency the opportunity to determine the proper remedy for the reduced payment amounts to 340B hospitals under the payment rates in the final OPPS rules for CY 2018 through CY 2022. *See Am. Hosp. Ass'n v. Becerra*, No. 1:18-cv-2084-RC, 2023 WL 143337, at *6 (D.D.C.).[90]

e. Payment for 340B-Acquired Drug Claims for September 28, 2022 Through CY 2026

[89] *https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2018cv2084-79.*
[90] *https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2018cv2084-86.*

The agency complied with the district court's September 28, 2022 decision by uploading revised OPPS drug files to pay the default rate (generally ASP plus 6 percent) for all CY 2022 claims for 340B-acquired drugs paid from September 28, 2022, through the end of CY 2022.

In the CY 2023 OPPS/ASC final rule with comment period (87 FR 71970), we finalized a policy reversing the 340B Payment Policy so that going forward we would pay for 340B-acquired drugs no differently than we pay for drugs that are not acquired through the 340B Program. To do so, we first provided that drugs acquired through the 340B Program would be paid at the statutory default rate (generally ASP plus 6 percent) for CY 2023. Second, to ensure budget neutrality for CY 2023 OPPS payment rates as required by statute, we finalized a reduction of 3.09 percent to the 2023 OPPS conversion factor. This one-time adjustment to the conversion factor removed the effect of this aspect of the 340B Payment Policy, as originally adopted in CY 2018, for CY 2023 and subsequent years. This adjustment reduced the conversion factor to the conversion factor that would have been in place in CY 2023 if the 340B Payment Policy had never been implemented. For more detail on the payment rate for drugs acquired under the 340B Program for CY 2023 and the corresponding adjustment to the conversion factor to maintain budget neutrality as a result of reversing the 340B adjustment and paying for all separately payable drugs at ASP plus 6 percent (or WAC plus 3 or 6 percent or 95 percent of AWP), we refer readers to the CY 2023 OPPS/ASC final rule with comment period (87 FR 71973 through 71976).

For CYs 2024 through 2026, consistent with our policy finalized for CY 2023, we continued to pay the statutory default rate for 340B-acquired drugs (88 FR 81789 through 81791).

f. Remedy Payment Adjustment for 340B-Acquired Drugs from CY 2018 Through September 27, 2022

The agency complied with the district court's January 10, 2023, remand order by issuing the Final Remedy rule on November 8, 2023 (88 FR 81540). The purpose of this rule was to

address the reduced payment amounts to 340B hospitals under the reimbursement rates in effect for CY 2018 through September 27, 2022 and to comply with the statutory requirement to maintain budget neutrality under the OPPS.

To address the reduced payment amounts to 340B hospitals under the reimbursement rates in effect for CY 2018 through September 27, 2022, CMS made one-time lump sum payments to affected 340B covered entity hospitals, calculated as the difference between what an affected 340B covered entity hospital received for 340B-acquired drugs from CY 2018 through September 27, 2022 and what they would have received for those drugs if the 340B adjustment had not been in place. These one-time lump sum payments were issued in early 2024. For more information on the calculation and distribution of the one-time lump sum payments, see the Final Remedy rule (88 FR 77156 through 77170).

g. Prospective Adjustment to Payments for Non-Drug Items and Services to Offset the Increased Payments for Non-Drug Items and Services Made in CY 2018 Through CY 2022

As we described under section I.A.3. of the Final Remedy rule (88 FR 77151), to comply with statutory budget neutrality requirements, the decreased payments made to 340B hospitals for drugs in CY 2018 through September 27, 2022, were budget neutralized by corresponding increased payments to all hospitals for non-drug items and services starting in CY 2018 through CY 2022. When the past payments for these drugs were subsequently increased through the one-time lump sum payments in 2024, the same budget neutrality requirements obligated us to decrease the non-drug item and services payments made from CY 2018 through CY 2022.

To reduce the burden on providers of immediately offsetting the estimated $7.8 billion of increased non-drug item and services payments made from CY 2018 through CY 2022, we finalized a policy to implement the offset prospectively over the course of several years. As we explained in the Final Remedy rule (88 FR 77172), this approach was similar to the original budget neutrality adjustment in the 340B Payment Policy that increased the payment for every non-drug item and service for CY 2018 through CY 2022 to offset the downward adjustment in

the payment rate for drugs acquired under the 340B Program. We finalized in the Final Remedy rule that, beginning in CY 2026, we would reduce the conversion factor for non-drug items and services to all OPPS providers—except any hospital that enrolled in Medicare after January 1, 2018 (as described further in this section of the preamble)—by 0.5 percent each year until the total offset was reached (which we estimated would take approximately 16 years (88 FR 77181)).

As we stated in the Final Remedy rule, we believed an annual reduction in the conversion factor was appropriate because it balanced the need to address the past payments for non-drug items and services to ensure budget neutrality while also ensuring that the offset was not immediately financially burdensome on impacted entities, which we believed would be the case if we were to apply an adjustment for the full offset amount in a single year (88 FR 77170).

Accordingly, the Final Remedy rule finalized changes to the calculation of the OPPS conversion factor applicable to non-drug items and services beginning in CY 2026. Specifically, we codified a 0.5 percent reduction in the OPPS conversion factor applicable to non-drug items and services in the regulations as codified at § 419.32(b)(1)(iv)(B)(*12*). As currently implemented, this 0.5 percent reduction remains in effect until the estimated payment reduction reaches $7.8 billion, which we estimated will occur in CY 2041. For a full discussion of the CY 2026 adjustment to the conversion factor for non-drug items and services, see the Final Remedy rule (88 FR 77156 through 77170).

In finalizing our policy to apply a prospective adjustment, we recognized that any hospital that enrolled in Medicare after January 1, 2018 (hereinafter referred to as a "new provider") received less than the full amount of the increased non-drug item and service payments made during that time than they otherwise would have received if enrolled prior to that date (88 FR 44080). We therefore exempted these providers from the prospective rate reduction, which was predominantly designed to account for non-drug item and service payments made during CY 2018 through CY 2022. As we explained, that means we calculate payment rates for

new providers using the conversion factor before applying the 0.5 percent annual reduction to the conversion factor for non-drug items and services that apply to hospitals that are not "new providers" for purposes of this policy. For the purpose of designating a new provider, we define the date of enrollment in Medicare as the provider's CMS certification number (CCN) effective date. We codified the exclusion of these new providers from the prospective payment adjustment to the conversion factor for the duration of its application in the regulations by adding new paragraph (b)(1)(iv)(B)(*12*) to § 419.32.

The providers that were determined to be subject to the payment reduction based on our review of provider enrollment and OPPS billing records were listed in Addendum R - 340B Remedy Offset Providers to the CY 2026 OPPS/ASC final rule with comment period. We indicated in the CY 2026 OPPS/ASC final rule with comment period that providers not included on this list (providers that began billing Medicare under the OPPS after January 1, 2018) would not be subject to the payment reduction. For a complete discussion of our exclusion of new providers from the prospective payment adjustment, we refer readers to the Final Remedy rule (88 FR 77182 through 77185) and the CY 2026 final OPPS/ASC rule with comment period (90 FR 53709 through 53710).

h. CY 2026 Prospective Payment Adjustment

In the CY 2026 OPPS/ASC proposed rule, we proposed to revise the annual reduction to the OPPS conversion factor under § 419.32(b)(1)(iv)(B)(*12*) used to determine the payment amounts for non-drug items and services from 0.5 to 2 percent effective January 1, 2026 (90 33634). Under this revised rate, we expected it would take approximately 6 years to reach the total offset of $7.8 billion. As we explained in the CY 2026 OPPS/ASC proposed rule, while we continued to believe that a reduction to the OPPS conversion factor was the best way to effectuate budget neutrality, we questioned whether a 0.5 percentage point annual reduction for approximately 16 years best achieved the goal of the Final Remedy rule, which was to restore hospitals to as close to the financial position they would have been in had the 340B Payment

Policy never been implemented as is reasonably feasible. Specifically, we noted that the further away from CY 2018 through CY 2022 the conversion factor adjustments extend, the less likely it is that hospitals' relative utilization patterns of non-drug items and services would align with the relative utilization patterns of non-drug items and services from CY 2018 through CY 2022.

Because applying an annual reduction to the conversion factor for all non-drug items and services does not directly identify and recoup the specific amount owed by each hospital, but rather seeks to recoup the aggregate increased payments made to all hospitals for non-drug items and services starting in CY 2018 through CY 2022, it is important to apply the annual reduction to the OPPS conversion factor to the payment for non-drug items and services furnished during calendar years in which hospitals' utilization patterns for such non-drug items and services most closely resemble their utilization patterns during CYs 2018 through 2022. Doing so helps to ensure that each hospital repays an amount that best approximates the excess payments it received under the 340B Payment Policy.

We explained in the CY 2026 OPPS/ASC proposed rule (90 FR 53710) that a hospital's utilization of non-drug items and services would likely diverge more from CY 2018 utilization in CY 2041 than it would in CY 2031 or CY 2026. The longer the recovery timeframe, the more each hospital's utilization of non-drug items and services will likely diverge from what the hospital's utilization of non-drug items and services was during the 2018-2022 timeframe the 340B Payment Policy was in place. Consequently, under the current recovery timeframe, the cumulative reduction applied to each hospital is less likely to reflect the amount of payment the hospital received for increased non-drug services from 2018 through 2022. As a result, it is less likely that each hospital will be restored to the financial position it would have occupied had the 340B Payment Policy in effect from 2018 to 2022 not been implemented.

Another factor that caused us to question the appropriateness of a 16-year recovery timeframe was the fact that by beginning the decrease to non-drug item and service payments in CY 2026, there was already an 8-year delay between the first year of the OPPS 340B Payment

Policy and the first year of the prospective offset. (90 FR 53710). Thus, we observed, the longer it takes for us to fully recover the $7.8 billion, the less suited the relative burden on hospitals from the adjustments would be to the relevant benefits those hospitals previously received. We also recognized the possibility that at least some hospitals that benefited from the increased payments from CY 2018 through CY 2022 would leave the market before 2041, increasing the risk that the remaining hospitals might ultimately account for a larger share of the payment reductions than they would have if the annual reduction to the OPPS conversion factor concluded sooner. We additionally noted that the $7.8 billion dollar figure calculated in the Final Remedy rule (88 FR 77150) does not, and will not, account for inflation and does not contain interest even though the prospective offset is occurring many years after both the start of the 340B Payment Policy in CY 2018 as well as the lump sum remedy payments made in CY 2024.

We acknowledged in the CY 2026 OPPS/ASC proposed rule (90 FR 33635) that revising the annual reduction from 0.5 percent to 2 percent would be a change to the approach we finalized in the Final Remedy rule and that, at the time of the Final Remedy rule, we considered but did not adopt a suggestion from a commenter requesting that we recover the amount over a shorter timeframe than 16 years (88 FR 77179). We indicated that our basis for not accepting the suggestion in the Final Remedy rule was that the 0.5 percent rate/16-year timeframe "properly reverses the increased payments for non-drug items and services to comply with statutory budget neutrality requirements while at the same time accounting for any reliance interests and ensuring that the offset is not overly burdensome to impacted entities" (90 FR 33635). We stated in the CY 2026 OPPS/ASC proposed rule that this balancing insufficiently accounted for the main premise of the Final Remedy rule, which is to implement the budget neutrality requirement in a manner that restores affected 340B covered entity hospitals to the financial position they would have been in had the 340B Payment Policy not been implemented in 2018. We explained that, for the reasons described previously, we believed that a 6-year time frame better achieved that main goal and better balanced that goal and our budget neutrality obligations against hospital burden

and reliance interests. We noted that the 16-year timeframe was more than three times longer than the 5-year period the 340B Payment Policy was in place. The 6 years we expected that the revised policy would be in effect, by contrast, would be closer to the timeframe the 340B Payment Policy was in place, and that a 2 percent payment reduction was still well below the 3.19 percent payment increase hospitals received for that time period (82 FR 52624 through 52625). We also indicated that because we proposed this policy in advance of CY 2026 and before any rate reductions went into effect for OPPS and Medicare Fee for Service payments, any reliance interests hospitals had in a policy that had not been implemented yet for these payment systems would be minimal and outweighed by the other considerations discussed in the CY 2026 OPPS/ASC proposed rule (90 FR 33635).

We did not finalize our proposal to revise the annual reduction to the OPPS conversion factor under § 419.32(b)(1)(iv)(B)(*12*) in the CY 2026 OPPS/ASC final rule and the 0.5 percent reduction in the OPPS conversion factor applicable to non-drug items and services finalized in the Final Remedy rule went into effect on January 1, 2026. The decision not to finalize an increased reduction for CY 2026 was made in response to concerns brought forth by some commenters. Specifically, we said "[w]hile we disagree with many of the arguments these commenters raise, we are persuaded by the commenters to the extent that we will not finalize in CY 2026 our proposal to increase to 2 percent the 0.5 percent adjustment in 42 CFR 419.32(b)(1)(iv)(B)(*12*). We currently anticipate delaying a change for just 1 year. Thus, while we will retain the original 0.5 percent adjustment in the conversion factor in CY 2026, hospitals should anticipate that we will implement a larger adjustment (such as 2 percent or other adjustment greater than 0.5 percent) beginning in CY 2027. . . . [¶] We do so based on the unique circumstances here." (90 FR 53714).

i. CY 2027 Proposed Prospective Payment Adjustment

Effective January 1, 2027, we proposed to increase the annual reduction to the OPPS conversion factor under § 419.32(b)(1)(iv)(B)(*12*) used to determine the payment amounts for

non-drug items and services from 0.5 percent to 3 percent. Specifically, we proposed to revise § 419.32(b)(1)(iv)(B)(*12*) to limit the 0.5 percent reduction to CY 2026 and add a new paragraph (*13*) implementing an annual 3.0 percent reduction (excluding new providers with a CCN effective date of January 2, 2018, or later) starting in CY 2027 and continuing until the estimated payment reductions made in accordance with paragraphs (*12*) and (*13*) for all applicable hospital outpatient items and service reaches $7.769 billion. Under this revised rate, we stated that we expected that we would reach this total by the end of CY 2029 (see Table 62). We acknowledged that this proposed annual reduction was greater than the 2 percent annual reduction we originally proposed for CY 2026. We stated that we considered the following in establishing this proposal:

First, we explained that a 3 percent reduction was necessary to achieve the outcome for which we originally proposed the 2 percent annual reduction in CY 2026. That is, to implement the budget neutrality requirement in a manner that restores affected 340B covered entity hospitals to the financial position they would have been in had the 340B Payment Policy not been implemented in 2018. By recovering the funds during a timeframe that aligns with the period in which the funds were originally paid out and applying the reduction in calendar years for which a hospital's utilization of non-drug items and services is more likely to align with its utilization during the period when the 340B Payment Policy was in effect, CMS will better ensure that the reduction in payments to each hospital approximates the amount by which that hospital was overpaid. We stated that a total recoupment timeframe of roughly 6 years after the 340B remedy payments were made in CY 2024 would more closely align with the 5-year timeframe the 340B Payment Policy was in place, as compared to the 8 years from CY 2024 that we estimated a 2 percent recoupment would require (see Table 62). Based on our analysis, we explained that we believed that, as additional time elapses following the period during which the 340B Payment Policy was in effect, hospitals' utilization of non-drug items and services would be increasingly likely to diverge from their utilization patterns during that period. We further

explained that since CMS is recouping the increased payments made for nondrug items and services while the 340B Payment Policy was effective by applying a reduced conversion factor to non-drug items and services furnished during the calendar years following the 340B Payment Policy's end date, the farther out these reductions apply, the less likely it would be that the total recoupment for each hospital would align with the amount each hospital was overpaid. For example, if a hospital's utilization rate of non-drug items and services is three times greater in 2030 than it was in 2020, then a reduced conversion factor applied to the non-drug items and services furnished in 2030 could result in CMS recouping more than what the hospital was initially paid in 2020. Consequently, it is less likely that the hospital would be restored to the financial position they would have been in had the 340B Payment Policy never been in effect. A total recoupment timeframe of 6 years would recover the funds in a manner that limits this divergence in utilization while avoiding the burden on providers that would result from a shorter recovery timeframe.

Second, we explained that a 3 percent payment reduction was the most logical and appropriate percentage to apply as it closely approximates the 3.19 percent payment increase hospitals received for non-drug items and services from CYs 2018 through 2022 to budget neutralize the reduced drug payments resulting from the 340B Payment Policy. We noted that this approach was also consistent with the approach we adopted in CY 2023 (87 FR 71975) to maintain budget neutrality when we returned to our policy of paying ASP plus 6 percent for 340B-acquired drugs.

With respect to implementing a 3 percent reduction in CY 2027 versus delaying implementation until a later CY to provide hospitals with additional time to prepare, we indicated that we had determined that implementing this payment reduction starting CY 2027 would be appropriate. We noted that we had repeatedly emphasized that shorter recoupment windows would be considered and/or proposed in CY 2027. We indicated that in the CY 2026/ASC final rule with comment period, we expressly stated "hospitals should anticipate that

we will implement a larger adjustment (such as 2 percent or other adjustment greater than 0.5 percent) beginning in CY 2027" (90 FR 53714) and that elsewhere in that rule we stated that "we anticipate implementing a larger adjustment (such as 2 percent or other adjustment greater than 0.5 percent) in next year's rulemaking" (90 FR 53718). We also noted that we communicated this same message in the Medicare Fact Sheets and Press Releases for the CY 2026 OPPS/ASC final rule with comment period to ensure that hospitals were aware of the likely increase in the offset percentage in CY 2027.[91] Because hospitals had been aware that we would likely propose an increased payment reduction in CY 2027 rulemaking, we stated that we did not believe hospitals needed additional time to prepare for the proposed repayment schedule.

We sought comment on our proposal to increase the annual percent reduction to 3 percent. We also sought comment on the advisability of increasing the annual percent reduction to 2 percent.

TABLE 62: ILLUSTRATION OF THE PROPOSED 3 PERCENT AND ALTERNATIVE 2 PERCENT CONVERSION FACTOR ANNUAL REDUCTION TO THE OPPS NON-DRUG ITEMS AND SERVICES BEGINNING CY 2027 TO MAINTAIN BUDGET NEUTRALITY IN THE CY 2027 OPPS/ASC PROPOSED RULE

	CY 2024	**CY 2025**	**CY 2026**	**CY 2027**	**CY 2028**	**CY 2029**	**CY 2030**	**CY 2031**
Total Applicable OPPS Non-Drug Item and Service Spending (billions)	Remedy Payments Made in Q1 of CY 2024	No Remedy Offset Applied	67.5	77.0	83.6	90.6	97.7	105.1
			Alternative 2 Percent Payment Reduction					
Amount (millions)			300	1,500	1,700	1,800	2,000	500*
Estimated Total Cumulative Offset (millions)			300	1,800	3,500	5,300	7,300	7,769
			Proposed 3 Percent Payment Reduction					
Amount (millions)			300	2,300	2,500	2,700*		
Estimated Total Cumulative Offset (millions)			300	2,600	5,100	7,769		

* Note, the final year's offset is estimated to be less than 2 or 3 percent in order to meet the total estimated offset of $7.769 billion. The amounts illustrated in Table 62 reflect the total amount of reduced spending, which includes both Medicare and Beneficiary cost-sharing. Note, the figures in the table are rounded, which may create some display discrepancies, but all figures are calculated with the final recoupment amount being $7.769 billion.

[91] *https://www.cms.gov/newsroom/fact-sheets/calendar-year-2026-hospital-outpatient-prospective-payment-system-opps-ambulatory-surgical-center.*

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: A few commenters supported our proposal to revise the annual reduction to the OPPS conversion factor under § 419.32(b)(1)(iv)(B)(*12*) used to determine the payment amounts for non-drug items and services from 0.5 percent to 3 percent. A commenter stated that faster repayment would better align repayment with the hospitals that benefited from the earlier increase in non-drug OPPS payments. Another stated that the accelerated schedule would improve both the accuracy and the fiscal value of the remedy.

Response: We thank commenters for their support of our proposal.

Comment: Most commenters opposed our proposal to increase the annual percent reduction to 3 percent. Many of these commenters referenced previous comments they or others made to the Final Remedy rule alleging that CMS lacks the statutory authority to budget neutralize the remedy and that CMS' approach to budget neutrality is inconsistent with its past practices. Based on these reasons, these commenters requested that we abandon the proposal and rescind the regulation codified in that rule, 42 CFR 419.32(b)(1)(iv)(B)(*12*), to implement the offset.

Response: To briefly summarize our responses to these comments in the Final Remedy rule, we did not agree with commenters that sections 1833(t)(14) and (t)(2)(E) of the Act do not apply to the remedy payments we made and that, therefore, the budget neutrality requirements of those statutes also do not apply to the remedy payments. We also did not agree with commenters who stated that sections 1833(t)(14)(H), (t)(9)(B) and (t)(2)(E) of the Act did not provide us with the authority to unwind the non-drug item and service payments from the 340B Payment Policy. We were similarly not persuaded by commenters that our retroactive rulemaking authority in section 1871(e)(1)(A) of the Act does not authorize budget neutrality. We also disagreed with commenters who questioned our contention that, even if budget neutrality was not statutorily required, we could still exercise our authority under section 1833(t)(2)(E) of the Act and its

longstanding inherent and common-law recoupment authority to offset the extra payments. We direct readers to our full responses to these comments in the Final Remedy rule at 88 FR 77150 through 77194.

Comment: One commenter repeated their argument from the CY 2026 OPPS/ASC proposed rule that CMS does not have the legal authority to apply an additional 3 percentage point reduction to OPPS rates because, under section 1833(t)(3)(C)(iv) of the Act, CMS is required to update OPPS rates by the same update that applied under the IPPS. Since CMS has already finalized an update of 2.3 percent for the FY 2027 IPPS, the commenter stated that CMS must apply the same update to the OPPS for CY 2027 without further changes.

Response: As we stated in the CY 2026 OPPS/ASC final rule (90 FR 53713), we disagree with the commenter, who conflates two distinct statutory obligations. Under section 1833(t)(3)(C) of the Act, the Secretary updates the conversion factor used to determine the payment rates under the OPPS on an annual basis by applying the OPD fee schedule increase factor. The commenter is correct that we have implemented that fee schedule increase factor under section 1833(t)(3)(C)(iv) of the Act by applying the hospital inpatient market basket percentage increase applicable to hospital discharges under section 1886(b)(3)(B)(iii) of the Act, subject to sections 1833(t)(17) and (t)(3)(F) of the Act. As we explain in section XXVI. of this final rule with comment period, we continue to do so by increasing the OPD fee schedule for CY 2027 by a factor of 2.3 percent—the same as applicable to hospital discharges for fiscal year 2027 under section 1886(b)(3)(B)(iii) of the Act.

The commenter is incorrect, however, that the statute makes the fee schedule increase factor the only update the Secretary can make to the OPPS conversion factor each year. Section 1833(t)(3)(C)(iii) of the Act, for example, authorizes the Secretary further to modify the conversion factor in certain circumstances based on adjustments to service mix. And many parts of the OPPS statute require the Secretary to budget neutralize particular payments, including sections 1833(t)(2)(E), (t)(9)(B), and (t)(14)(H) of the Act. Since the very first payment rule

implementing the OPPS, we have implemented OPPS's budget neutrality requirements by adjusting the conversion factor (65 FR 18476 (implementing budget-neutrality requirement)). We have long rejected the commenter's suggestion that section 1833(t)(3)(C)(iv) of the Act means that the conversion factor cannot account for these budget neutrality requirements, explaining that the "[s]tatute requires us to ensure that a conversion factor for covered OPD services in subsequent years is an amount equal to the conversion factor applicable to the previous year before any increases due to the market-basket increase." (67 FR 66788.) We accordingly applied that same policy when we first decreased payments for 340B-acquired drugs in the CY 2018 OPPS/ASC final rule with comment period, which we budget neutralized through an upward adjustment of 1.0319 to the OPPS conversion factor on top of the annual OPD fee schedule increase factor under 1833(t)(3)(C)(iv) of the Act. (82 FR 59353 through 59371).

Comment: Several commenters reiterated arguments made to the CY OPPS/ASC 2026 proposed rule that the statute governing budget neutrality does not authorize CMS to impose an accelerated timeline and disagreed with CMS' stated justification for it, which these commenters characterized as "that a shorter offset period is preferable because it more closely aligns with the duration of the unlawful 340B payment policy from 2018-2022 and will better account for changes in drug utilization patterns." These commenters contended that the statute does not authorize CMS to "calibrate budget neutrality offsets based on temporal symmetry or administrative convenience" and that such an approach ignores the disproportionate impact that a 3 percent annual reduction will have on hospitals.

Response: We continue to disagree that the statute prohibits the proposed budget neutrality adjustment schedule or amount, or that our rationale for that proposed schedule is flawed based on hospitals' reduced payments for drugs acquired under the 340B program from CY 2018 through 2022. As we explained in the CY 2027 OPPS/ASC proposed rule (91 FR 41872), the main reason we proposed to shorten the timeframe for the adjustment was to

recognize that OPPS utilization changes over time. The purpose of any rate reduction is to unwind the 3.19 percent increase budget neutrality hospitals received from CY 2018 through 2022. For example, in the Final Remedy rule we explained that we finalized a minus 3.09 percent adjustment to the conversion factor in the CY 2023 OPPS/ASC final rule "as this adjustment removes the effect of the 340B policy as originally adopted in CY 2018 . . . . The CY 2023 adjustment to the conversion factor ensures it is equivalent to the conversion factor that would be in place if the 340B Payment Policy had never been implemented." (88 FR 77170). Current OPPS utilization for a hospital is a reasonable proxy for past OPPS utilization for a hospital, but it becomes a less accurate proxy the longer the recoupment timeframe. The commenter is wrong to suggest that our proposed policy would pursue symmetry for symmetry's sake. By pointing out that adjusting rates by 3 percent for 3 years is similar to the initial policy of adjusting rates by 3.19 percent for 5 years, we meant to illustrate both that the proposed larger decrease would still be the type of "adjustment" to payment rates authorized by sections 1833(t)(2)(E), (9)(B), and (14)(H) of the Act (88 FR 77158 through 77159) and that the reduction would still fall within the type of year-to-year rate fluctuations in OPPS rates that hospitals should reasonably expect in annual ratemaking. Nor was it inherently unreasonable for us to consider how long it will take fully to implement the adjustment; no statute requires us to implement our budget neutrality obligations or exercise our discretion so that a policy in place only from CY 2018 through 2022 still drives payment rates in 2040.

Comment: Many commenters reiterated the reliance-interest arguments that they made on last year's CY 2026 OPPS/ASC proposed rule. They emphasized that we finalized the 0.5 percent reduction in the Final Remedy rule and that they have relied on that amount in good faith in the nearly 3 years since to engage in financial planning and long-term investment decisions. These commenters stated that our proposal fails to account for the long-term, multi-year nature of hospital budgeting and they described the many expenditures (opening new facilities, buying new medical equipment, hiring staff and expanding services lines, etc.) they have allegedly made

based on the 0.5 percent reduction. One commenter opined that raising the offset from 0.5 percent to 3.0 percent barely a year after the 0.5 percent figure took effect "upends the expectations the agency itself created." Another commenter alleged that "the 2026 OPPS final rule specifically suggested CMS may in the future consider a recoupment larger than 0.5 percent, 'such as 2 percent.' At no point did CMS suggest an accelerated recoupment adjustment might exceed 2 percent, such as the currently proposed 3 percent adjustment."

A third commenter contended that it was unreasonable to assume that hospitals were on notice of the change because of our statement in the CY 2026 OPPS/ASC final rule that "hospitals should anticipate that we will implement a larger adjustment (such as 2 percent or other adjustment greater than 0.5 percent) beginning in CY 2027" (90 FR 537114) and our statement in the CY 2027 OPPS/ASC proposed rule that "[b]ecause hospitals have been aware that we would likely propose an increased payment reduction in CY 2027 rulemaking, we do not believe hospitals need additional time to prepare for this repayment schedule." (91 FR 41873). The commenter stated that "[a] proposed rule is not a final rule. It is completely unreasonable to expect hospitals to assume that policies being considered will in fact be implemented. To do so would be not only irresponsible but practically impossible." Echoing their comment from the previous year, the commenter additionally stated that "the only appropriate reliance interest for 340B hospitals is upon continued, stable and predictable payments in the OPPS" and that "CMS took this interest into account by deciding not to impose the 0.5 percent reduction until 2026 'allowing adequate time for impacted parties to assess and prepare for the new payment rates that will be calculated using a reduced conversion factor.'" The commenter further contended, again repeating their comment from the previous year, that the CY 2027 OPPS/ASC proposed rule "not only entirely fails to address hospitals' reliance interest as envisioned in the Final Remedy rule but also undermines the separate reliance interests that CMS allowed to be built from the date of the Final Remedy rule's publication to the CY 2026 OPPS/ASC rule's publication." The commenter explained that "many hospitals' budget process for CY 2027 may be substantially

complete and a 2-month planning period (assuming a November OPPS/ASC final rule with comment period release) is wholly unreasonable." The commenter concluded by stating that "[e]ven if hospitals were 'on notice' of a potential increase in the conversion factor reduction, hospitals were not similarly aware of the potential impact of CMS's proposed payment reductions in this Proposed Rule. Further, 340B hospitals have to balance and account for other unexpected changes impacting our finances, including the growing uninsured population, Medicaid cuts, the 340B rebate pilot program, and MDPNP, and the growing impact of manufacturer restrictions on 340B discounts. . . . CMS has not considered these impacts in developing its specific proposals, which belies a reasoned decision as required under the APA and risks recission on the grounds that it is arbitrary and capricious."

Response: We disagree that we have failed to provide hospitals with sufficient notice of our proposed increase or that we have failed to adequately consider the impact of our policies. As noted by commenters, in the CY 2026 OPPS/ASC final rule, we repeatedly emphasized that while we were not finalizing our proposal to increase the rate in CY 2026 that we anticipated doing so for CY 2027:

- "We currently anticipate delaying a change for just 1 year. Thus, while we will retain the original 0.5 percent adjustment in the conversion factor in CY 2026, hospitals should anticipate that we will implement a larger adjustment (such as 2 percent or other adjustment greater than 0.5 percent) beginning in CY 2027." (90 FR 53714).

- "As we noted previously, however, we anticipate implementing a larger adjustment (such as 2 percent or other adjustment greater than 0.5 percent) in next year's rulemaking, and we can consider additional alternatives at that time." (90 FR 53718).

- "As we note, while we are not finalizing that proposal at this time, we anticipate proposing a larger offset beginning in CY 2027." (90 FR 53720).

- "However, also for the reasons discussed previously and in the 2026 OPPS/ASC proposed rule, we anticipate implementing a larger percent reduction (such as 2 percent or other

reduction greater than 0.5 percent) beginning in CY 2027." (90 FR 53720).

As these repeated statements demonstrate, the commenter alleging that we at no point suggested an accelerated recoupment adjustment might exceed 2 percent is incorrect.

Additionally, in the 2023 Final Remedy rule we finalized outside the standard annual rulemaking cycle a 0.5 percent reduction to payment rates that would not begin for 2 years and explained that we were giving hospitals that second year before implementing the payment reduction in part "to provide entities additional time to prepare for the new payment rate" (88 FR 77180).

We also note that we changed hospital payments by over 3 percent through the annual ratemaking process for CY 2018 as part of our budget neutralization obligations, and so a 2.5 percentage point change through those same rulemaking procedures falls within the type of annual rate fluctuations hospitals can reasonably expect. Neither the APA nor the Medicare statute imposes a one-way ratchet in which we may increase payments through annual rulemaking but not decrease them through annual rulemaking.

Finally, while we recognize that the cumulative economic effect of the policies we are proposing for CY 2027, along with the alleged financial circumstances hospitals have faced over the past few years, may be significant for some hospitals, we believe these effects must be balanced against the windfalls hospitals received previously that we are statutorily obligated and/or have discretion to recover, our obligations under section 1833(t)(14) of the Act to periodically conduct surveys of hospitals' drug acquisition costs and take that data into account in setting payment rates, and our responsibility to adopt methods to control unnecessary increases in the volume of covered OPD services.

Further, even if an increased recoupment rate was not necessary to comply with our statutory budget neutrality obligations, we would nonetheless exercise our discretion under section 1833(t)(2)(E) of the Act and our longstanding inherent and common-law recoupment authority to make such an increase, as doing so is necessary to fulfill the purpose of the final

remedy rule which was to restore affected 340B covered entity hospitals to the financial position they would have been in had the 340B Payment Policy not been implemented in 2018. As we have explained, a recovery timeframe that would last 16 years, concluding 19 years after the year in which the 340B Payment Policy ended, would not achieve this outcome because the further away from CY 2018 through CY 2022 the adjustments extend (1) the less likely that relative hospital utilization of non-drug items and services would correlate to the relative hospital utilization of non-drug items and services from 2018 through 2022 and (2) the less likely that the hospitals that received the increased payments would be the same hospitals that bear the corresponding reductions due to hospitals leaving the market over time. A recovery time frame of either 4 years under a 3 percent recoupment rate or 6 years under a 2 percent recoupment rate would far better fulfill the objective of the Final Remedy rule to restore affected 340B covered entity hospitals to the financial position they would have been in had the 340B Payment Policy not been implemented in 2018 while continuing to avoid burdening hospitals with the single year recovery which we considered but did not finalize in that rule.

While we believe we have provided hospitals with more than adequate notice of the proposed increase, in recognition of hospitals' concerns about burden, we are finalizing a 2 percent reduction for CY 2027 rather than the proposed 3 percent reduction. Although a 2 percent reduction, for the reasons described previously, is less ideal than 3 percent reduction in implementing the budget neutrality requirement in a manner that restores affected 340B covered entity hospitals to the financial position they would have been in had the 340B Payment Policy not been implemented in 2018, we think that a 6-year recovery would nonetheless satisfy that objective while also allowing us to account for the burden concerns brought forth by commenters.

Comment: Many commenters observed, as they did to the CY 2026 OPPS/ASC proposed rule, that in the Final Remedy rule we rejected annual percent reductions greater than 0.5 based on our conclusion that a 0.5 percent reduction "properly reverses the increased payments for

non-drug items and services to comply with statutory budget neutrality requirements while at the same time accounting for any reliance interests and ensuring that the offset is not overly burdensome to impacted entities" (88 FR 77179). These commenters stated that CMS has failed to identify any material change that warrants changing the remedy in light of having specifically rejected shorter recovery periods when the remedy policy was finalized.

Response: We believe we have adequately explained our reasoning for revisiting and revising the recoupment timeframe. As we have explained in the CY 2026 OPPS/ASC proposed and final rules, the CY 2027 OPPS/ASC proposed rule, and this final rule, our motive for proposing to reduce the recoupment timeframe is to better fulfill the rationale underlying the Final Remedy rule: to implement the budget neutrality requirement in a manner that restores affected 340B covered entity hospitals to the financial position they would have been in had the 340B Payment Policy not been implemented in 2018. We proposed to increase the adjustment to 2 percent in CY 2026 and 3 percent in CY 2027 in furtherance of that goal: so that the hospital utilization that will ultimately determine each hospital's payment reduction would better map onto payment increases from CY 2018 through 2022 and to decrease the risk of hospitals subject to recovery leaving the marketplace before the recovery timeframe has concluded.

Comment: Several commenters contended that CMS abandoned the burden component of its rationale and has not provided a reasoned basis for its new approach. A commenter stated that CMS has "conspicuously changed" its criteria for judging the appropriate recoupment timeline criteria over time. Where previously the criteria was to "comply with statutory budget neutrality requirements while at the same time accounting for any reliance interests and ensuring that the offset is not overly burdensome to the impacted entities," it has now changed to "implement the budget neutrality requirement in a manner that restores affected 340B covered entity hospitals to the financial position they would have been in had the 340B Payment Policy not been implemented in 2018." The commenter contends that the burden consideration has been removed from the criteria and CMS has not adequately explained the change as required by

the "change-in-position" doctrine." The commenter concludes that even if CMS had attempted to explain the decision, no justification could rationally support it due to the immense burden placed upon hospitals.

Response: We disagree that we have failed to consider the burden on providers in proposing to increase the recoupment timeframe or that we have not adequately explained the reasoning behind our proposal. As we stated in the Final Remedy rule, in determining the specific annual percent reduction by which to recover the funds from hospitals, our goal was to appropriately balance our statutory budget neutrality obligations against hospitals' burden and reliance interests. The adjustment we proposed in the CY 2027 OPPS/ASC proposed rule to the percent reduction we finalized in the Final Remedy rule is our attempt to more precisely balance these elements. We would also remind the commenter that the consideration of burden that the commenter claims we have abandoned is reflected in the multi-year nature of the remedy itself. Despite having received payment for the 340B drug underpayments that occurred from CY 2018 through 2022 in a single lump sum in early 2024, hospitals were not required to correspondingly repay the non-drug item and service overpayments they received during that timeframe as a lump sum. In fact, hospitals were not required to pay anything back until January of this year, and that repayment will continue for years to come. We also disagree that we have failed to adequately explain the decision. As the U.S. Supreme Court recently explained, when changing positions, "the agency does not need to show that the reasons for the new policy are *better* than the reasons for the old one" or "provide a more detailed justification than what would suffice for a new policy created on a blank slate" so long as it remains "cognizant" that "longstanding" policies might have engendered reliance interests. *Food & Drug Admin. v. Wages & White Lion Invs., L.L.C.*, 604 U.S. 542, 570 (2025) (internal quotation marks omitted and emphasis in original). We identified in the CY 2027 OPPS/ASC proposed rule that we were proposing to change our policy, and we gave an explanation for why we believed our proposed new policy reasonably balanced the relevant interests. We specifically considered reliance interests in the CY 2027

OPPS/ASC proposed rule and in this final rule with comment period. As we have explained in responses to previous comments above, we have determined that other interests and policy concerns outweigh any reliance interests in this context. Nothing more is required. *See, e.g.*, *Dep't of Homeland Sec. v. Regents of Univ. of Cal.*, 591 U.S. 1, 32 (2020) (''[E]ven if [an agency] ultimately concludes that the reliance interests rank as serious, they are but one factor to consider. [The agency] may determine, in the particular context before it, that other interests and policy concerns outweigh any reliance interests.'').

Comment: Many commenters stated, as they did in comments to the CY 2026 OPPS/ASC proposed rule, that our proposal fails to appreciate the financial strain the proposed increased reduction would impose on hospitals that are already operating on tight margins and facing "severe financial headwinds." In these commenters' view, CMS' proposal does not account for adverse financial trends that have occurred since 2023, such as increased costs of labor, supplies and pharmaceuticals, aging hospital infrastructure, inflation, changing practice patterns, inadequate government reimbursements that lag behind inflation, eroding margins, supply chain disruptions, an aging population with more complex, chronic conditions, the lingering effects of the COVID-19 PHE, Medicare sequestration, the OBBBA's reduction to Medicaid and Health Insurance Marketplace payments, and impending economic strains such as the Working Families Tax Cut Act, IRA drug reductions, and HRSA's 340B Rebate Model. These commenters stated that the financial burden imposed by the proposal would threaten the services that they provide.

Response: As we emphasized in our response to similar concerns expressed by commenters last year, while we recognize that hospitals may have experienced financial strain in recent years, there are other statutory provisions that address many of the issues hospitals raise like inflation or the medical complexity of the Medicare population, and we do not believe that relaxing OPPS's budget neutrality provisions, which are required by law, is the proper policy response. With respect to interest specifically, we note that the first of the increased payment

amounts occurred in 2018, whereas the last of the recoupment amounts may not be until after 2031—in effect a more than 10-year loan without any attached interest. Ultimately, though, we cannot ignore the financial windfall that hospitals received from 2018 to 2022 and our statutory obligation and/or discretion to recover that windfall.

Comment: Many commenters expressed concern about the combined economic effect of the remedy proposal, the 340B drug payment proposal and the site neutral proposal. These commenters urged CMS not to view these proposals in isolation but to evaluate their cumulative effect. Several commenters suggested that CMS conduct a comprehensive assessment of the cumulative effect of these proposals on 340B hospitals, particularly hospitals providing complex outpatient services and serving significant Medicare and Medicaid populations. One commenter suggested that if CMS proceeds with shortening the recoupment timeframe, it should sequence any acceleration with drug payment reductions so that hospitals do not absorb multiple cuts simultaneously. Another commenter requested that CMS publish year-by-year effects for hospitals in the highest quartile of 340B intensity and exclude hospitals simultaneously subject to the ASP minus 33.4 percent reduction.

Response: We recognize that the cumulative economic effect of the policies we are proposing for CY 2027, along with the financial circumstances hospitals have faced over the past few years, may be significant for some hospitals. However, we believe these effects must be balanced against the windfalls hospitals received previously that we are statutorily obligated and/or have discretion to recover, our obligations under section 1833(t)(14) of the Act to periodically conduct surveys of hospitals' drug acquisition costs and take that data into account in setting payment rates, and our responsibility to adopt methods to control unnecessary increases in the volume of covered OPD services. We note that our finalization of a 2 percent increase rather than a 3 percent increase, for the reasons previously described, will help mitigate the combined impact of these policies.

Comment: Many commenters characterized the offset, whether increased or not, as a

penalty, arguing that it is unfair for hospitals to be penalized for mistakes or past unlawful actions by CMS.

Response: As we indicated last year in response to this characterization, the offset is not a penalty on hospitals. Rather, it is a rate adjustment under section 1833(t) of the Act that accomplishes an incremental and interest-free recovery of windfall payments to hospitals. It is calibrated to the amount of extra money hospitals received and thus achieves payment precision, not punishment. It returns hospitals to the position they would have been absent the unlawful 340B Payment Policy and ensures that the only money ultimately spent is the money authorized to be spent by the statute.

Comment: Multiple commenters expressed concern about the disproportionate financial effect the increased rate of recoupment would have on safety-net providers, rural providers, 340B hospitals and teaching hospitals and stated that the recoupment would reduce resources available to provide services to their patients, particularly to low-income, rural, underserved and vulnerable populations.

Response: As we said in response to similar concerns expressed by commenters in the Final Remedy rule, we recognize that our proposal to decrease future payments will have a financial impact across all hospitals paid under the OPPS, except for new providers, and we are particularly mindful of the impact on vulnerable patients and communities. But, as we also stated in the Final Remedy rule, future decreases are, on aggregate, the mirror image of prior payment increases that would otherwise be a windfall to providers and such windfalls are not cost-free; the costs are ultimately borne by beneficiaries and taxpayers—including the vulnerable patients and communities served by the hospitals to which commenters themselves refer. In fact, this remedy will reduce any beneficiary cost sharing obligations, and incrementally reduce beneficiary Part B premiums, for all Medicare beneficiaries, including the vulnerable patients to which the commenters refer. (88 FR 77180 through 77181).

Comment: Many commenters expressed concern that, if implemented, the 3 percent

reduction would effectively wipe out the CY 2027 OPPS rate increase.

Response: Commenters are referencing distinct statutory obligations or potential future statutory obligations. Section 1833(t)(3)(C)(ii) of the Act requires the Secretary to update the conversion factor used to determine the payment rates under the OPPS on an annual basis by applying the OPD fee schedule increase factor. Sections 1833(t)(9)(B), (t)(14)(H) and (t)(2)(E) of the Act require that the OPPS be a budget neutral system, and we decline the commenters' suggestion to implement those budget neutrality provisions in a way that defeats the purpose of other statutory policies. We note, however, that our finalization of a 2 percent reduction rather than a 3 percent reduction, for the reasons previously described, will lessen the effect of the increased offset percentage on the CY 2027 OPPS rate increase.

Comment: Many commenters recognized our statutory obligation to implement a budget neutral recoupment but, based on concern about the financial impact of a 3 percent reduction, requested the reduction to remain at 0.5 percent. Some commenters requested that the reduction be no larger than 1 percent. One commenter requested that the reduction be no larger than 1.5 percent. A few commenters supported a 2 percent reduction.

Response: We appreciate commenters' acknowledgement of our statutory obligation to budget neutralize the recoupment and their suggestions for alternative annual percent reductions to do so. With respect to a 1 or 1.5 percent reduction, we do not believe that an approximately 8 to 12 year recoupment timeframe would appropriately implement the budget neutrality requirement in a manner that restores affected 340B covered entity hospitals to the financial position they would have been in had the 340B Payment Policy not been implemented in 2018. This would exceed the timeframe that the 340B Payment Policy was in place and exacerbate the concern that was driving our proposal to increase the reduction—that the longer it takes to complete the recoupment, the more likely hospital utilization or other payment factors will change from CY 2018 through 2022, and so the less each hospital's total payment reduction will correspond with that hospital's payment increase from CY 2018 through 2022. With respect to

the 2 percent reduction, we are finalizing this reduction amount for CY 2027 for the reasons previously discussed.

Comment: Some commenters requested that if we proceeded with an increase that it should be phased-in. Others requested that the effective date of any increase be delayed until CMS has had the opportunity to conduct additional analysis.

Response: We appreciate commenters' suggestions and note that we are finalizing a 2 percent reduction rather than the 3 percent reduction we proposed, which may address some of the commenters' concerns. However, we think delaying or phasing-in the implementation of the increase would be inconsistent with the goal of restoring affected 340B covered entity hospitals to the financial position they would have been in had the 340B Payment Policy not been implemented in 2018.

Comment: Several commenters suggested that if we could not maintain the 0.5 percent reduction then we should exempt various hospitals from the increase, such as all non-340B hospitals, physician-owned hospitals, rural hospitals, sole community hospitals, Medicare-dependent hospitals, low-volume hospitals, teaching hospitals and legacy providers' newly established or expanded outpatient facilities.

Response: We acknowledge the commenters' concerns; however, we are statutorily required and/or have the discretion to recover the overpayments hospitals received for non-drug items and services as a result of the 340B payment policy, including hospitals of the type suggested for exemption by the commenters. Since these hospitals, including those hospitals that might have recently established additional outpatient facilities, received the increased payments for non-drug items and services, it would be inconsistent with our budget neutrality obligations, and an unwarranted windfall for the hospitals, for us not to recoup the funds.

Comment: Several commenters suggested that if we proceed with an increased reduction that we should conduct robust monitoring for any unintended consequences and consideration of flexibilities or targeted supports for safety-net and teaching hospitals that may be

disproportionately affected. Other commenters suggested that CMS report annually on the cumulative recoupment of the $7.8 billion.

Response: We agree that it is important to monitor the effects of the increase for any unintended consequences and will take the commenter's suggestion under consideration for future rulemaking. We also appreciate the commenter's suggestion with respect to future consideration of flexibilities or targeted supports for hospitals based on that monitoring. We will also consider this for future rulemaking.

Comment: One commenter identified an error in the first row in Table 62,"total applicable OPPS non-drug item and service spending (millions)." The commenter pointed out that the row lists $77.0 million of spending in CY 2027 but it should be $77.0 billion.

Response: We thank the commenter for identifying this error and it has been corrected.

Comment: A commenter expressed skepticism about our claim that the risk that hospitals that benefitted from the increased payments from CY 2018 through CY 2022 would leave the market before 2041 and other hospital providers would have to account for a larger share of the payment reductions justified increasing the recoupment rate. The commenter stated that increasing the payment offset would accelerate the closure of any hospital that was operating at a breakeven margin and make it more likely the facility will close.

Response: We appreciate the commenter's concern; however, there are many reasons that might cause a hospital to leave the market over time, such as declining patient volume, aging infrastructure or other factors, and the longer the recoupment period, the smaller the pool of hospitals that will be subject to recoupment regardless of the recoupment rate. Given that reality, we think that a recoupment timeframe of 6 years at 2 percent will result in a more equitable recovery distribution amongst hospitals then a timeframe of 16 years at 0.5 percent.

Comment: Several commenters expressed concern about the indirect implications of the proposed reduction in OPPS non-drug payments for providers that contract with Medicare Advantage (MA) organizations. Several commenters stated that the accelerated recoupment rate

would create a discrepancy between rates CMS pays to MA organizations and rates MA organizations pay to providers. Specifically, commenters stated that MA capitated prospective payment rates for CY 2026 and CY 2027 include a 0.5 percent prospective recoupment, while MA organizations frequently negotiate provider payments based on Original Medicare (OM) rates, and are required to base out-of-network payments for covered services on OM rates. Commenters expressed concern that this discrepancy would create a windfall for MA organizations and would harm providers, while providing no benefit to Medicare beneficiaries or the Part B trust fund.

Further, commenters stated that CMS has provided remedy payments under OM following *AHA v. Becerra* in accordance with the Final Remedy rule. Commenters further stated that MA organizations that adopted a similar reimbursement rate for 340B-acquired drugs during CYs 2018-2022 have not made the corresponding remedy payments to providers. Commenters emphasized that this could leave hospitals disadvantaged as they may not have received the benefit of a remedy payment from MA organizations, and they may be subject to the prospective reductions to provider reimbursement for non-drug payments. Several commenters stated that this dynamic unfairly shifts resources to MA organizations and compounds the financial strain on hospitals, particularly given high and growing MA enrollment.

Commenters requested CMS provide additional guidance to MA organizations to mitigate the impact of this proposed adjustment and to ensure the same standard of compliance and accountability as OM. Commenters specifically recommended CMS clarify that MA organizations are expected to make hospitals whole for 340B-acquired drugs administered between 2018-2022 and to prevent the prospective reductions from being passed through to providers absent repayment by MA organizations.

Response: We appreciate commenters' feedback on this issue. Under the MA program, CMS provides monthly, risk-adjusted capitated prospective payments to MA organizations, and in return, MA organizations must furnish, arrange for, or pay providers for the enrollee's

Medicare Part A and Part B benefits. CMS calculated and paid CY 2018-2022 MA capitated prospective payment rates under the Advance Notice and Rate Announcement, and those MA prospective payment rates reflected the OM policies as of the time they were finalized. The statutory and regulatory provisions of the MA program constitute a broader bidding and payment structure that is distinct from the OM program. MA plan bids are an estimate of projected costs that plans expect to incur, in part based on policies under the OM program that are generally established each year before MA prospective payment rates are finalized and bids are submitted.

We acknowledge commenters' concerns regarding the potential implications of the Final Remedy rule for MA organizations' payments to providers. We understand from commenters that many MA organizations base their privately contracted reimbursement rates with providers on OM rates set by CMS and that existing MA contracts may not account for the remedy provisions established in the Final Remedy rule. However, CMS establishes payment policies and payment rates for services payable under OM through a separate, distinct process that is not directly related to the terms of private contracting arrangements between MA organizations and providers. Further, section 1854(a)(6)(B)(iii) of the Act prohibits CMS from requiring an MA organization to contract with a particular hospital, physician, or other entity to furnish items and services, including 340B-acquired drugs, or requiring a particular price structure for payment under such a contract. Providers and MA organizations may engage in dispute resolution under existing contracts and any contract negotiations or re-negotiations independently of CMS.

Section 1852(a)(2) of the Act mandates that MA organizations reimburse non-contract providers at least the amount they would have received under OM. We expect that MA organizations will comply with this statutory requirement. We note that the Final Remedy rule excluded providers that enrolled in Medicare after January 1, 2018, from the prospective rate reduction.

After consideration of public comments received, for the reasons discussed previously, we are finalizing an increase to the annual reduction to the OPPS conversion factor under 42

CFR 419.32(b)(1)(iv)(B)(*12*) used to determine the payment amounts for non-drug items and services for hospitals for whom this adjustment applies from 0.5 percent to 2 percent. Specifically, we are finalizing (1) a revision to § 419.32(b)(1)(iv)(B)(*12*) to limit the 0.5 percent reduction to CY 2026 and (2) the addition of a new paragraph (*13*) implementing an annual 2.0 percent reduction (excluding new providers with a CCN effective date of January 2, 2018, or later) starting in CY 2027 and continuing until the estimated payment reductions made in accordance with paragraphs (*12*) and (*13*) for all applicable hospital outpatient items and service reaches $7.769 billion, which we estimate will occur in CY 2031. Please see Table 63, for an estimate of the impacts of the offset for CY 2027.

TABLE 63: ILLUSTRATION OF THE FINALIZED 2 PERCENT CONVERSION FACTOR ANNUAL REDUCTION TO THE OPPS NON-DRUG ITEMS AND SERVICES BEGINNING CY 2027 TO MAINTAIN BUDGET NEUTRALITY

<table>
<tr><th></th><th>CY 2024</th><th>CY 2025</th><th>CY 2026</th><th>CY 2027</th><th>CY 2028</th><th>CY 2029</th><th>CY 2030</th><th>CY 2031</th></tr>
<tr><td>Total Applicable OPPS Non-Drug Item and Service Spending (billions)</td><td rowspan="7">Remedy Payments Made in Q1 of CY 2024</td><td rowspan="7">No Remedy Offset Applied</td><td>67.5</td><td>79.0</td><td>85.4</td><td>92.6</td><td>99.8</td><td>107.4</td></tr>
<tr><td></td><td colspan="6">Finalized 2 Percent Payment Reduction</td></tr>
<tr><td>Amount (millions)</td><td>300</td><td>1,600</td><td>1,700</td><td>1,900</td><td>2,000</td><td>300*</td></tr>
<tr><td>Estimated Total Cumulative Offset (millions)</td><td>300</td><td>1,900</td><td>3,600</td><td>5,500</td><td>7,500</td><td>7,769</td></tr>
<tr><td></td><td colspan="6"></td></tr>
<tr><td>Amount (millions)</td><td colspan="6"></td></tr>
<tr><td>Estimated Total Cumulative Offset (millions)</td><td colspan="6"></td></tr>
</table>

* Note, the final year's offset is estimated to be less than 2 percent in order to meet the total estimated offset of $7.769 billion. The amounts illustrated in Table 63 reflect the total amount of reduced spending, which includes both Medicare and Beneficiary cost-sharing. Note, the figures in the table are rounded, which may create some display discrepancies, but all figures are calculated with the final recoupment amount being $7.769 billion.

7. All-Inclusive Rate (AIR) Add-On Payment for High-Cost Drugs Provided by Indian Health Service and Tribal Facilities

a. Background

In the CY 2000 OPPS final rule (65 FR 18434), CMS implemented the PPS for hospital outpatient services furnished to Medicare beneficiaries, as set forth in section 1833(t) of the Act.

In the CY 2000 OPPS final rule, we noted that the OPPS applies to covered hospital outpatient services furnished by all hospitals participating in the Medicare program with a few exceptions. We identified one of these exceptions as "outpatient services provided by hospitals of the Indian Health Service (IHS)." We stated that these services would "continue to be paid under separately established rates which are published annually in the **Federal Register**" and, in the CY 2002 OPPS/ASC final rule (66 FR 59856), we finalized a revision to § 419.20 (Hospitals subject to the hospital outpatient prospective payment system) by adding paragraph (b)(4), which specifies that hospitals of the IHS are excluded from the OPPS.

In the intervening years, IHS and tribal facilities have been paid under the separately established All-Inclusive Rate (AIR). On an annual basis, the IHS calculates and publishes, in the **Federal Register**, calendar year reimbursement rates.[92] Due to the higher cost of living in Alaska, separate rates are calculated for Alaska and the lower 48 States. For CY 2026, the Medicare Outpatient per visit rate is $733 for the lower 48 States (hereinafter referred to as "the lower 48 AIR") and $1,233 for Alaska.[93]

In the CY 2025 OPPS/ASC final rule with comment period (89 FR 94280 through 94286), we finalized a policy to separately pay IHS and tribal hospitals for high-cost drugs, biologicals, and radiopharmaceuticals (hereinafter referred to as "drugs" for the purpose of this section) furnished in hospital outpatient departments through an add-on payment in addition to the AIR using the authority under which the AIR is calculated.[94] We finalized a continuation of this policy, without modification, in the CY 2026 OPPS/ASC final rule with comment period (90 FR 53722 through 53723). We note that the AIR and the add-on payment are paid out of the Part B trust fund and are not subject to OPPS budget neutrality.

We defined high cost drugs (that is, drugs qualifying for the add-on payment) for the

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[92] *https://www.ihs.gov/BusinessOffice/reimbursement-rates/*.
[93] 91 FR 2787 (January 22, 2026); *https://www.federalregister.gov/documents/2026/01/22/2026-01178/reimbursement-rates-for-calendar-year-2026*.
[94] Sections 321(a) and 322(b) of the Public Health Service Act (42 U.S.C. 248(a) and 249(b)), Pub. L. 83-568 (42 U.S.C. 2001(a)), and the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

purpose of the policy as all drugs covered under Medicare Part B and for which payment would otherwise be made under the OPPS whose per-day cost exceeds two times the lower 48 AIR amount in effect at the time of the release of each year's OPPS/ASC final rule with comment period. In the CY 2026 OPPS/ASC final rule with comment period, this amount was identified as $1,436 (2 times the CY 2025 lower 48 AIR of $718).

To determine the calculated per-day cost for each drug HCPCS code, we employed a methodology similar to our longstanding methodology used to calculate the per-day cost of drugs for OPPS payment purposes. Specifically, to calculate the per-day cost for CY 2026, we used an estimated payment rate based on the ASP methodology payment rate, which for purposes of the policy was generally ASP plus 0 percent (which is the payment rate for separately payable IHS drugs under the policy). We then used the manufacturer-submitted ASP data from the fourth quarter of CY 2024 to determine the per-day cost. For drugs that did not have either an ASP-based payment rate or a payment rate based on WAC, we used arithmetic MUC of the items derived from the CY 2024 hospital claims data to determine their per-day cost. For HCPCS codes for drugs that were proposed for separate payment in the CY 2026 OPPS/ASC proposed rule with comment period but then had per-day costs equal to or less than $1,436 (2 times $718) in the CY 2026 OPPS/ASC final rule with comment period, based on the updated ASPs and hospital claims data used for the CY 2026 OPPS/ASC final rule with comment period, those drugs received separate payment in CY 2026.

We finalized that the amount of the add-on payment for a high-cost drug would be the ASP for the drug with no additional payment (that is, ASP plus 0 percent). We note that this add-on payment was implemented on a per-dose basis. In the event ASP pricing information was not available for a particular drug, we paid the WAC plus 0 percent and if WAC pricing information was not available, we paid 89.6 percent of AWP. If AWP was not available, we paid the arithmetic MUC. We also adopted a drug packaging threshold exception for biosimilars in which the add-on payment is made for biosimilars whose per-day costs do not exceed the

threshold of two times the lower 48 AIR but whose reference products do exceed the threshold.

To implement this policy, we finalized in the CY 2025 OPPS/ASC final rule with comment period a recurring annual process in which the lower 48 AIR in effect at the time of the release of each year's OPPS/ASC final rule with comment period would be used to create a list of drugs qualifying for the add-on payment for the following calendar year. Once the drugs qualifying for the add-on payment were determined, the payment rate for a unit of the drug would be determined in accordance with the previously described pricing hierarchy. The results of that process for CY 2025 were displayed in Addendum Q to the CY 2025 OPPS/ASC final rule with comment period. We additionally finalized that during the calendar year, the list of drugs would be modified on a quarterly basis (January, April, July, October) to add new-to-market drugs with per-day costs that exceeded two times the lower 48 AIR and to update qualifying drugs' ASPs.

We finalized a continuation of this annual process, without modification, in the CY 2026 OPPS/ASC final rule and the results of that process for CY 2026 were displayed in Addendum Q to the CY 2026 OPPS/ASC final rule. For a full discussion of the AIR add-on payment policy for high cost drugs provided by IHS and tribal hospitals, we refer readers to the CY 2025 OPPS/ASC final rule with comment period (89 FR 94280 through 94286) and the CY 2026 OPPS/ASC final rule with comment period (90 FR 53722 through 53723).

b. AIR Add-On Payment for High-Cost Drugs Provided by IHS and Tribal Facilities Policy for CY 2027

For CY 2027, we proposed to continue the policy as described in the CY 2025 and CY 2026 OPPS/ASC final rules.

Consequently, for CY 2027, we proposed to continue to separately pay IHS and tribal hospitals for high-cost drugs furnished in hospital outpatient departments through an add-on payment in addition to the AIR using the authorities under which the AIR is calculated.

We proposed to continue to define high cost drugs (that is, drugs qualifying for the add-

on payment) for the purpose of the policy as any drugs covered under Medicare Part B and for which payment would otherwise be made under the OPPS which have per-day costs exceeding two times the lower 48 AIR amount in effect at the time of the release of the CY 2027 OPPS/ASC final rule with comment period. For CY 2027, we proposed that if the CY 2026 lower 48 AIR amount is in effect at the time of the release of the CY 2027 OPPS/ASC final rule with comment period, this amount would be $1,466 (2 times the CY 2026 lower 48 AIR of $733).

To determine the calculated per-day cost for each drug HCPCS code, we proposed to continue using an estimated payment rate based on the ASP methodology payment rate (generally ASP plus 0 percent) and then using the manufacturer-submitted ASP data from the fourth quarter of CY 2025 to determine the per-day cost. For drugs that do not have either an ASP-based payment rate or a payment rate based on WAC, we proposed to continue to use the arithmetic MUC of the items derived from the CY 2025 hospital claims data to determine their per-day cost.

We proposed that the amount of the add-on payment for each dose of a high-cost drug would continue to be the ASP for the drug with no additional payment (that is, ASP plus 0 percent). In the event ASP pricing information is not available for a particular drug, we proposed to continue to pay the WAC plus 0 percent. If WAC pricing information is not available, we proposed to continue to pay 89.6 percent of AWP. If AWP pricing information is not available, we proposed to continue to pay the arithmetic MUC. Finally, we proposed to continue the drug packaging threshold exception for biosimilars in which the add-on payment is made for biosimilars whose per-day costs do not exceed the threshold of two times the lower 48 AIR but whose reference products do exceed the threshold.

c. List of Drugs Qualifying for the Add-on Payment for CY 2027

Using two times the lower 48 AIR amount of $733 that is in effect for CY 2026 and applying the previously described per-day cost methodology and pricing hierarchy, we included

as Addendum Q to the CY 2027 OPPS/ASC proposed rule a preliminary list of the drugs that would qualify for the proposed add-on payment and their proposed add on payment rates for CY 2027.

We proposed to create a final Addendum Q in the CY 2027 OPPS/ASC final rule with comment period using the claims data (units used per day) and ASPs, or pricing hierarchy, available at that time. We also proposed that for HCPCS codes for drugs that are proposed for separate payment in CY 2027, but then have per-day costs equal to or less than $1,466 (2 times $733) in the CY 2027 OPPS/ASC final rule with comment period, based on the updated ASPs and hospital claims data used for the CY 2027 OPPS/ASC final rule with comment period, those drugs would still receive separate payment in CY 2027.

Finally, as we did in CY 2025 and CY 2026, we proposed to modify the list on a quarterly basis (January, April, July, October) to add new-to-market drugs with per-day costs that exceed two times the lower 48 AIR and to update qualifying drugs' ASPs.

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: All commenters supported our proposal to continue to separately pay IHS and tribal hospitals for high-cost drugs furnished in hospital outpatient departments through an add-on payment in addition to the AIR using the authorities under which the AIR is calculated.

Response: We thank commenters for their support.

Comment: A commenter, referring to the CY 2027 OPPS/ASC final rule with comment period generally, suggested that CMS should specifically evaluate how the proposed payment and policy changes would affect rural hospitals, Rural Emergency Hospitals, Indian Health Service facilities, Tribal health programs, and other safety-net providers. The commenter recommended that CMS include rural and Tribal impact assessments into future OPPS and ASC rulemaking and consult directly with nurses, Tribal leaders, rural hospital administrators, patients, and community representatives.

Response: We thank the commenter for their input and will keep it in mind for future rulemaking.

After consideration of the public comments we received, we are finalizing our proposed policy without modification to continue to separately pay IHS and tribal hospitals for high-cost drugs furnished in hospital outpatient departments through an add-on payment in addition to the AIR using the authorities under which the AIR is calculated.

8. Medicare OPPS Drugs Acquisition Cost Survey

a. Background

(1) Publication of Notice of Intent to Conduct Medicare OPPS Drugs Acquisition Cost Survey

Section 1833(t)(14)(A)(iii) of the Act requires the Secretary to set payment rates for specified covered outpatient drugs (SCODs)[95] beginning in 2006 at the amount the Secretary determines to be the average acquisition cost for the drug for that year, at least when certain hospital acquisition cost survey data is available. To collect the cost survey data for the Secretary to use for 2006 payment rates, section 1833(t)(14)(D)(i)(I) of the Act required the Comptroller General of the U.S. to conduct a survey in each of 2004 and 2005 to determine the hospital acquisition cost for each SCOD. To inform payment rates in later years, section 1833(t)(14)(D)(ii) of the Act requires the Secretary periodically to conduct surveys of hospital acquisition costs for each SCOD. In developing that survey, section 1833(t)(14)(D)(i)(II) of the Act requires the Secretary to take into account certain recommendations from the Comptroller General regarding frequency and methodology of subsequent surveys.

The GAO conducted the required surveys in 2004 and 2005, and, in reporting the results in 2006, recommended that the Secretary thereafter validate, "on an occasional basis—possibly every 5 or 10 years—ASP data that manufacturers report to CMS for developing SCOD payment rates."[96] As noted in the CY 2026 OPPS/ASC proposed rule (90 FR 33653), in the years

[95] For the definition of a SCOD, see section 1833(t)(14)(B) of the Act at *https://www.ssa.gov/OP_Home/ssact/title18/1833.htm.*

[96] *https://www.gao.gov/assets/gao-06-372.pdf.*

following the GAO's recommendation, CMS had not yet conducted a survey of the acquisition costs for each SCOD for all hospitals paid under the OPPS. Additionally, on April 18, 2025, President Trump signed Executive Order (E.O.) 14273, "Lowering Drug Prices by Once Again Putting Americans First."[97] Section 5 of the E.O., "Appropriately Accounting for Acquisition Costs of Drugs in Medicare," directs the Secretary to publish in the **Federal Register** a plan to conduct a survey under section 1833(t)(14)(D)(ii) of the Act so he can determine the acquisition costs for SCODs at hospital outpatient departments.

Accordingly, in the CY 2026 OPPS/ASC proposed rule (90 FR 33653), we announced that under section 1833(t)(14)(D)(ii) of the Act we would be conducting a survey of the acquisition costs for each separately payable drug acquired by all hospitals paid under the OPPS, including SCODs, and drugs and biologicals CMS historically treats as SCODs. We indicated that we intended for the survey to open starting at the end of CY 2025 to early CY 2026. We also stated that we had reviewed and taken into account the Comptroller General's recommendations regarding the frequency and methodology of these surveys in developing our proposed survey, and that we intended for the survey to be completed in time for the survey results to be used to inform policy making beginning with the CY 2027 OPPS/ASC proposed rule. We indicated that we intended to propose and seek comment on any payment rates for SCODs based on the survey results in CY 2027 rulemaking.

In the CY 2026 OPPS/ASC final rule (90 FR 53754 through 53766 and 54049 through 54052), after responding to public comments, including those received through the proposed survey Paperwork Reduction Act (PRA) submission process, we finalized our proposal outlining our intent to conduct a required outpatient drug acquisition cost survey to all hospitals paid under the OPPS, pending final approval from the Office of Management & Budget (OMB). OMB

[97] *https://www.govinfo.gov/content/pkg/FR-2025-04-18/pdf/2025-06837.pdf.*

approval was granted on December 29, 2025 (OMB control number 0938-1487, expires December 31, 2028).[98]

(2) OPPS Drug Acquisition Cost Survey Design and Implementation

(a) Study Population

We identified approximately 4,500 entities for inclusion in the survey study population due to their submission of at least one qualifying Fee-For-Service claim under the OPPS during the survey study period (July 1, 2024 through June 30, 2025). Qualifying claims met all defined criteria: (1) claim date of service (July 1, 2024 and June 30, 2025), (2) claim type (Part B outpatient), (3) facility type code (12 [hospital inpatient/home heath], 13 [hospital outpatient], 14 [hospital other], and 76 [community mental health center]), (4) payment amount (greater than zero), and (5) status indicator denoting separately payable drugs or other relevant Part B outpatient services with status indicators (G, H, J1, J2, K, Q1, Q2, Q3, Q4, R, S, T, U, OR V). We removed all claims billed by hospital types that are not paid under the OPPS.[99] Finally, we ensured that each entity had valid Medicare enrollment during the survey study period using the Provider Enrollment, Chain, and Ownership System (PECOS). There was no sampling as all OPPS hospitals were invited to participate in the survey and provide the required data.

As described in the information collection approved by OMB under the PRA, we expect to survey these hospitals every four (4) years. We believe that this frequency will appropriately balance the burden imposed on hospitals of completing the survey with ensuring that we capture the required data to inform payment rates as required under section 1833(t)(14)(D)(ii) of the Act. However, this frequency is an intention and could be revised.

(b) Survey Scope and Design

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[98] *https://www.reginfo.gov/public/do/PRAViewICR?ref_nbr=202511-0938-014* and *https://www.reginfo.gov/public/do/PRAViewICR?ref_nbr=202512-0938-024*.

[99] As stated in 42 CFR 419.20(b), the following hospital types are not paid under the OPPS: critical access hospitals; Maryland waiver hospitals; hospitals located outside the 50 states, the District of Columbia, and Puerto Rico; Indian Health Service hospitals; and rural emergency hospitals. *https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-419/subpart-B/section-419.20.*

The guiding principle in the design of the survey was to collect the data necessary to inform payment policy as required by statute in a manner that imposed the least amount of burden to the extent practicable on the hospitals providing the data. The survey collected acquisition cost data for separately payable outpatient drugs at the 11-digit National Drug Code (NDC) level for 1,843 NDCs, which correspond to 519 drug HCPCS.[100] We note that more than one NDC may be associated with a given HCPCS code and vice versa. These NDCs were identified by analyzing the drugs and biologicals that were separately payable under the OPPS during the survey period of July 1, 2024 through June 30, 2025 and for which there was a payment made under the OPPS during that period. We excluded NDCs with either an expiration date or a marketing end date prior to July 1, 2024, using FDA national drug code and structured product labeling data elements (NSDE) data[101] because these drugs would no longer be available for purchase during the study survey period.[102]

(c) Acquisition Date Reporting and Data Elements

The survey captured acquisition data for drugs purchased between July 1, 2024 and June 30, 2025. This 12-month time period aligns with GAO's 12-month survey period for their original study of July 1, 2003 through June 30, 2004. This time period also provided a 6-month window between the end of the survey period and the start of the survey submission window to ensure adequate time for all rebates, discounts, and price concessions to be finalized, so they could be included into the NDC acquisition cost submitted by hospitals.

The survey instructed hospitals to report 4 pieces of data for each NDC purchased during the 1-year survey period:

- Total Units Purchased - Non-340B
- Total Net Acquisition Cost - Non-340B

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[100] ODACS Acquisition Data Template: *https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient-pps/outpatient-prospective-payment-system-opps-drug-acquisition-cost-survey*.
[101] https://www.fda.gov/industry/structured-product-labeling-resources/nsde.
[102] The expiration date is the expiration date of the last lot distributed. The marketing end date signifies that the drug is no longer actively manufactured or promoted, or the company has officially decided to stop commercializing it.

- Total Units Purchased - 340B
- Total Net Acquisition Cost - 340B

Net acquisition cost was defined as the total amount paid by the hospital inclusive of all discounts, rebates, and price concessions applicable at the NDC level.

This design reflected our recognition that certain discounts may apply depending on which provider furnished the drug and whether an eligible patient received the drug (for example, for drugs acquired through the 340B Program). Consequently, the survey requested hospitals to separately list their acquisition costs for drug NDCs acquired through the 340B Program and drug NDCs acquired outside of the 340B Program to ensure that all discounts were accurately captured and represented the hospital's acquisition costs.

(d) Treatment of Discounts and Price Concessions

The survey requested hospitals to include all rebates and discounts in their acquisition cost for each NDC. This included both discounts able to be directly applied to each individual NDC and those discounts that were not necessarily linked to a single NDC (e.g., invoice-level discounts, wholesaler rebates, prompt pay discounts, and other financial concessions, or other discounts). Respondents were also requested to separately provide information about any non-NDC-specific discounts or rebates received as a result of membership in a Group Purchasing Organization (GPO) or other buying group.

(e) Data Collection Process

Data were collected through the CMS Fee-for-Service Data Collection System (FFSDCS) via the Medicare OPPS Drug Acquisition Cost Survey (hereinafter referred to as "ODACS") module. Hospitals first designated a Hospital Point of Contact (POC) and a Submitter responsible for data submission. Submitters then submitted data through (1) uploading of a standardized Excel (.xlsx) file; or (2) manual data entry through the FFSDCS via the ODACS module. Once the Submitter uploaded or entered the required data, they then officially submitted

that data to CMS and attested to the validity, integrity, and completeness of the data being submitted.

(f) Data Validation and Quality Assurance

The FFSDCS ODACS module included automated validation checks to promote completeness, formatting accuracy, and logical consistency. For uploaded data, errors and missing information were flagged on the module upload page, accompanied by error explanations. For manually entered data, the module provided hover-over tips for data entry fields and was programmed to accept data only in specific formats. The system alerted users if data was formatted incorrectly. Submitters were able to correct and reupload data during the collection window prior to final attestation.

(g) Survey Window

The ODACS module opened on January 1, 2026 and closed on April 7, 2026. The original survey window was January 1, 2026 through March 31, 2026; however, after the survey window opened we extended the window for an additional week, through April 7, 2026, based on hospitals' request for additional time to respond. We believe that approximately 14 weeks was sufficient for hospitals to respond to the survey, particularly given the outreach and education that CMS engaged in prior to and during the survey window.

(h) Outreach and Education

We engaged in extensive outreach and education to hospitals in advance of the survey start date to ensure that respondents were aware of the survey and how to complete it. CMS began reaching out to hospitals using provider enrollment and other publicly available contact information in September 2025. Specifically, CMS identified a hospital POC from each hospital paid under the OPPS and reached out to them to make them aware of the survey and provide them with instructions on selecting a hospital representative (Submitter) to register with the CMS Identity Management System (IDM) to access the survey module and report the survey data. To walk respondents through this process, a step-by-step registration guide was issued by CMS in

November 2025 and a data submission guide was provided on January 1, 2026.[103] These guides were posted to a new ODACS-specific webpage[104] that was created by CMS to serve as a central hub for information and resources for hospitals. CMS also conducted two educational webinars[105] with hospitals in December 2025, which were recorded and posted to the ODACS webpage. To ensure that respondents had the support they needed during the survey, CMS established a dedicated email address and helpline to provide technical assistance. To address frequently asked questions, CMS posted a FAQ document[106] to the ODACS webpage and updated it during the survey to reflect additional questions requested by respondents via email and the helpline as the survey progressed. Finally, prior to and throughout the survey period, CMS sent periodic communications to POCs to remind them of upcoming deadlines and resources available for assistance.

b. Data Analysis and Methodology

(1) Selection of a Methodology to Calculate Acquisition Cost Margins

In accordance with section 1833(t)(14)(D)(ii) of the Act, we took into account GAO's recommendations and analyzed the survey data to validate whether the manufacturers' reported drug ASP data appropriately and accurately reflects hospitals' drug acquisition costs. To do so, we compared hospitals' survey-reported acquisition costs for all survey-eligible drugs to the equivalent ASP-based Medicare payment amount for those drugs under the OPPS, less any drug-specific payment rate add-ons. This comparison was constructed as a percent difference between these two values, termed the acquisition cost margin.

We calculated this acquisition cost margin by first finding the difference between (1) the total acquisition costs reported for all NDCs in the survey and (2) the volume-weighted sum of their corresponding ASP payment rates, the latter of which was calculated by multiplying the

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[103] *www.cms.gov/files/document/submitter-user-guide.pdf*.
[104] *https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient-pps/outpatient-prospective-payment-system-opps-drug-acquisition-cost-survey*.
[105] *https://www.cms.gov/files/document/odacs-training-webinar.pdf*.
[106] *https://www.cms.gov/files/document/odacs-faq.pdf*.

survey reported units purchased for each NDC by its applicable ASP plus 0 rate.[107] We then divided that difference by the total ASP-based payment to find the percent margin between acquisition costs and ASP. Negative values indicate that hospitals reported acquisition costs below ASP and positive values indicate that hospitals reported acquisition costs above ASP.

We used the volume-weighted sum of all survey-eligible NDCs' ASP payment rates in order to produce a representative estimate of aggregate Medicare payments that would be comparable to hospitals' aggregate acquisition costs reported for those NDCs. This approach is consistent with longstanding OPPS principles of basing payment policy on observed utilization and resource use. We believe it is appropriate to compare hospitals' total acquisition costs to this weighted sum of ASPs rather than compare average acquisition costs to ASP because total acquisition costs encompass both the reported per-unit cost and the reported purchase volume for each NDC. In the absence of weighting by reported per-unit cost, drugs that encompass a very low percentage of hospitals' total acquisition costs could exert a disproportionate influence on the aggregate margin between acquisition costs and ASPs. And in the absence of weighting by reported purchase volume, the ASPs for drugs with relatively low reported volume but atypical acquisition costs could exert a disproportionate influence on the aggregate margin. By contrast, the volume-weighted approach ensures that the ASPs for the drugs representing a larger share of total purchasing activity contribute more significantly to the estimated margin. We will illustrate using the following fictitious example:

- Ten units of NDC 1 were purchased for $8 (average acquisition cost of $0.80 per unit) and NDC 1 has an adjusted ASP[108] of $1. The volume-weighted ASP is $10. NDC 1 was reported as purchased with a margin of minus 20 percent, or 20 percent below ASP.

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[107] ASP plus 0 is the ASP without any drug-specific payment rate add-ons (ASP plus 6 percent for most drugs and biologicals, ASP plus 8 percent for qualifying biosimilar products, or AMP plus 3 percent for select other drugs and biologicals).

[108] Since ASPs are reported by HCPCS billing unit, ASPs were adjusted to the NDC package units where necessary using an NDC-HCPCS adjustment factor.

- One unit of NDC 2 was purchased for $14 (average acquisition cost of $14 per unit) and NDC 2 has an adjusted ASP of $10. The volume-weighted ASP is $10. NDC 2 was reported as purchased at a margin of plus 40 percent, or 40 percent above ASP.

Aggregating the two above NDCs, the total acquisition cost is $22 ($8 + $14) and the volume-weighted sum of ASPs is $20 ($10 + $10). Calculating the percent difference yields a plus 10 percent margin, calculated as 100 * (($22 – $20) / $20). However, if no volume weighting methodology was applied, the sum of ASPs would be $11, and calculating the percent difference would yield a plus 100 percent margin, calculated as 100 * (($22 – $11) / $11).

We also considered weighting ASP payment rates for survey-eligible drugs by outpatient claims volume for survey-relevant HCPCS codes. We recognize the value of using OPPS claims data as it directly reflects real-world utilization. However, we did not adopt this approach because we believe it is appropriate to rely on a consistent survey-based framework for both acquisition costs and volume measures. We believe that weighting by survey-reported purchase volume avoids potential inconsistencies between external claims data and survey responses, ensures that the resulting margins are fully grounded in the reported acquisition cost data, better reflects the distribution of hospital drug purchasing activity as captured via the survey instrument, and is consistent with the statutory objective of approximating average acquisition cost in a manner that is both representative and methodologically sound. However, we sought comment on this approach to volume weight the average acquisition cost based on survey utilization data rather than OPPS claims data utilization.

We performed this acquisition cost margin calculation separately for non-340B and 340B drug purchases to analyze the data in the same manner in which it was collected. We then calculated acquisition cost margins using different ASP benchmarks, at different levels of data aggregation, and across a variety of scenarios to detect specific trends and variations in the submitted data. First, given that a drug's ASP can vary by quarter, we calculated each margin using both the mean ASP and median ASP across the four quarters of the specified time period

(Q3 of 2024 to Q2 of 2025). Determining acquisition costs relative to both the median and mean ASP ensured that we properly accounted for any fluctuations in payment rate over time while mitigating the influence of any quarters with abnormal payment rates and allowed us to assess any differences in the margins that resulted from the two ASP benchmarks. Second, we calculated margins at the NDC level as well as aggregated to the HCPCS level; in the latter, acquisition costs were adjusted to the HCPCS level using the billing units per NDC package. Third, we calculated margins stratified by drug therapeutic class and hospital characteristics (340B participation status, ODACS drug purchase volume, outpatient drug claims billing volume, hospital size, rurality, geographic location, GPO membership, GPO discount amount, and teaching status). These various analytic scenarios were all undertaken to determine the differential between reported acquisition costs and ASP along relevant stratifications and characteristics as well as validate the robustness of the findings used in our proposal.

(2) Selection of a Methodology to Identify and Trim Outliers

In analyzing the survey data, it is appropriate to mitigate the influence of extreme and potentially anomalous observations that may reflect atypical purchasing arrangements, data anomalies, or reporting inconsistencies and could distort estimates of hospital drug acquisition costs. Consistent with standard statistical practice and our general approach under the OPPS to ensure that payment methodologies are based on representative data, we considered two different methods for identifying and excluding anomalous survey responses from the dataset. In both methods, the outlier identification and trimming process was performed separately for 340B and non-340B drug acquisitions, producing tailored outlier thresholds based on the unique data distribution for each drug through each purchasing channel.

First, we considered a trimming approach that excludes all observations with a per-unit acquisition cost more than three standard deviations from the geometric mean per-unit cost for each NDC. This approach is consistent with our standard methodology for processing extreme

outliers to develop policy under the OPPS.[109] Application of the geometric mean trimming methodology necessitated removal of NDCs for which fewer than 10 survey respondents reported their purchase because outlier values cannot be detected with nine or fewer observations using this method.

We also considered the Tukey interquartile range (IQR) method[110] as an alternate outlier trimming approach and tested the impact of excluding outliers using the geometric mean approach compared to the IQR-based approach. Using the geometric mean approach to trim outliers removed 2,051 survey records (defined as the unique combination of hospital, NDC, and 340B or non-340B purchase from each survey response), or 1.3 percent of the total 160,430 original records while using the IQR approach to trim outliers removed 15,563 records, or 9.7 percent of the total 160,430 records. Upon manual review of the survey responses that were trimmed using each outlier approach and the data distribution for each NDC, we believed that the IQR approach erroneously identified some records as outliers despite their per-unit acquisition cost being generally in-line with the overall data distribution for that NDC. This is likely due to the distributional characteristics of the survey data, including evidence of skew in the distribution of reported acquisition costs for some NDCs. It has been established that the effectiveness of Tukey's IQR lessens when data are skewed and may lead to overidentification of observations as outliers.[111,112,113] In addition, we were concerned about the large number of survey records removed by the IQR trimming methodology, as one of our goals in conducting this survey was to

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[109] *https://www.cms.gov/files/document/2026-nfrm-opps-claims-accounting.pdf.*

[110] Under this approach, for each NDC, we would calculate the first quartile (Q1) and third quartile (Q3) of per-unit acquisition cost based on the empirical distribution of hospitals' reported average acquisition cost values, and define the IQR as Q3 minus Q1. We would then establish outlier thresholds as follows: (1) an upper threshold equal to Q3 plus 1.5 times the IQR; and (2) a lower threshold equal to Q1 minus 1.5 times the IQR. Observations with per-unit acquisition costs that fall outside these thresholds are identified as outliers. Application of the IQR-based trimming methodology would necessitate removal of NDCs for which fewer than four survey respondents reported their purchase because outlier values cannot be detected with three or fewer observations using the Tukey IQR method.

[111] M. Hubert and E. Vandervieren, "An adjusted boxplot for skewed distributions," *Computational Statistics & Data Analysis* 52, no. 12 (August 15, 2008): 5186–5201, *https://doi.org/10.1016/j.csda.2007.11.008*.

[112] Neil C. Schwertman, Margaret Ann Owens, and Robiah Adnan, "A simple more general boxplot method for identifying outliers," *Computational Statistics & Data Analysis* 47, no. 1 (August 1, 2004): 165–174, *https://doi.org/10.1016/j.csda.2003.10.012.*

[113] Arefeh Mazarei et al., "Online boxplot derived outlier detection," *International Journal of Data Science and Analytics* 19 (2025): 83–97, *https://doi.org/10.1007/s41060-024-00559-0.*

analyze survey-reported drug acquisition costs using the largest amount of reasonable data received from hospitals as possible. Consequently, we did not propose to adopt the IQR-based outlier trimming methodology.

Rather, we proposed to use the geometric mean approach to exclude identified outlier observations from the analyses used to estimate acquisition cost relationships. Specifically, we proposed to trim records with per-unit acquisition costs more than three standard deviations from either the 340B or non-340B geometric mean per-unit acquisition cost for that NDC. We proposed this approach to maintain consistency with the standard OPPS outlier trimming methodology. It also ensured that we retain the maximum number of responses with nonextreme values to estimate acquisition cost relationships from the survey data. By ensuring that the resulting estimates are based on data that are representative of typical hospital acquisition costs and are not unduly influenced by a small number of extreme observations, this approach was consistent with our longstanding objective of analyzing reliable and representative data to determine payment policy changes. We sought comment on our proposal to trim records with per-unit acquisition costs more than three standard deviations from either the 340B or non-340B geometric mean per-unit acquisition cost for that NDC.

(3) Application of Data Refinements to Remove Anomalous Data

Consistent with our general approach to ensuring that payment methodologies are based on reliable and internally consistent data, we reviewed the survey responses for values that were not plausible given statutory requirements that covered entities cannot be required to pay more than the 340B ceiling price for drugs acquired under the 340B Program or that exhibited clear inconsistencies in reporting. We identified five scenarios in which reported data displayed anomalous values, which appeared to be the result of data entry error, miscalculation, or other respondent confusion. Below we detail each identified scenario and the number of survey records that fall into each. We proposed to exclude these survey responses from the analyses used to

assess acquisition cost relationships to ensure that these calculations were not unduly influenced by implausible values.

First, we identified instances in which respondents that were not participating in the 340B Program during the relevant study time period (as verified using the 340B Office of Pharmacy Affairs Information System (340B OPAIS)) reported acquisition cost data in the 340B fields of the survey. These observations likely reflected reporting errors, given that these hospitals could not have accessed 340B discounts. Therefore, we proposed to exclude 340B acquisition cost data submitted by non-340B hospitals from analyses of 340B acquisition cost to maintain consistency with the survey design and statutory framework. This refinement removed 850 records out of the 160,430 records received through the survey.

Second, we identified instances in which respondents reported purchasing drugs through the 340B Program for 58 NDCs that did not have a 340B ceiling price during the survey time period. These observations may reflect reporting errors, such as reporting acquisition data for the incorrect NDC within a drug that was intended, given that no 340B agreement, or associated discount, was available for these NDCs. In some cases, where these NDCs had 340B ceiling prices during other quarters outside the survey time period, these observations may be the result of respondent confusion over the survey reporting period or the time period when these NDCs had a 340B ceiling price in place. Alternatively, hospitals may have acquired non-340B NDCs through the 340B Prime Vendor Platform (PVP) without receiving a 340B discount price;[114] while hospitals may have considered these purchases to be 340B acquisitions for the purposes of their survey reporting, evaluating these responses as part of 340B margin calculations would provide an inaccurate picture of the acquisition costs for NDCs with 340B discounts. We also did not elect to evaluate these responses as part of non-340B margin calculations as it was impossible to separate instances of reporting errors from non-340B purchases made through the

[114] The 340B PVP website states that "The [PVP]…works with 155 manufacturers to obtain lower drug pricing for [340B covered entities] on non-340B items, such as vaccines…."

340B PVP. Therefore, we proposed to exclude 340B survey responses for these NDCs without 340B ceiling prices from analyses of both 340B and non-340B acquisition cost to maintain consistency with the survey design and statutory framework. This refinement removed 839 records out of the 160,430 records received through the survey.

Third, we identified a small number of responses from hospital subunits that submitted identical data to their parent unit. Hospital subunits were identified as entities where the third digit of its CMS Certification Number (CCN) is T (representing inpatient rehabilitation units) or S (representing psychiatric units). Parent units were identified as entities where all six digits of its CCN are numeric.[115] To identify a parent unit for each subunit, the T or S in the third digit was replaced with the numeric digit associated with the provider type of that subunit (either 0, 2, 3, or 4). If this replacement yielded more than one possible parent unit, the subunit was further matched with a parent unit based on CCN name and ZIP code. Identical parent–subunit data were identified as survey responses with the exact same number of total units and total net acquisition costs reported for the exact same NDCs. These observations likely reflect duplicative data reported by one submitter who was responsible for multiple entities. Accordingly, we proposed to exclude these duplicative responses from subunits in favor of only retaining the equivalent responses from the parent unit. We identified 27 subunits with duplicative data to their parent unit, and this refinement removed 4,799 records out of the160,430 records received through the survey.

Fourth, we identified instances in which reported acquisition costs for drugs purchased under the 340B Program exceeded the maximum applicable 340B ceiling price during the survey time period. By statute, covered entities cannot be required to pay more than the 340B ceiling

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[115] Hospital type for each parent unit was identified based on the final four digits of its CCN. Short-term (general and specialty) hospitals were identified as those in the range 0001–0899; long-term care hospitals were identified as those in the range 2000–2299; rehabilitation hospitals were identified as those in the range 3025–3099; children's hospitals were identified as those in the range 3300–3399; psychiatric hospitals were identified as those in the range 4000–4499; and IPPS-exempt freestanding cancer hospitals were identified as CCNs listed on the CMS website *https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/pps-exempt-cancer-hospitals-pchs.*

price for drugs acquired under the 340B Program. Such observations are not representative of actual acquisition costs and are likely attributable to reporting or data entry errors (for example, miscalculations or incorrect decimal placement). Accordingly, we proposed to exclude 340B drug purchases with average acquisition costs above the maximum ceiling price from our analysis. This refinement removed 4,667 records out of the 160,430 records received through the survey.

Fifth, we observed that certain respondents reported units for specific drugs, including clotting factors and certain respiratory therapies, in international units (IU) or milligrams (MG) rather than the required NDC-based units. IU is the HCPCS billing unit for the clotting factors and MG is the HCPCS billing unit for the respiratory therapies;[116] however, because the survey requires reporting at the NDC level, the use of IU- or MG-based units would result in substantial distortions in calculated per-unit acquisition costs, typically producing extremely high reported unit volumes and correspondingly low per-unit costs. These observations are not comparable to properly reported NDC-level data. To avoid possible selection bias that may result from specifically excluding responses with units reported in IU or MG, we therefore proposed to exclude all survey responses for affected NDCs with units reported in IU or MG from the analysis. This refinement removed 4,398 records out of the 160,430 records received through the survey. We note, if CMS included this data, the acquisition cost margins would have been significantly lower than Medicare payment rates.

The exclusion of these anomalous observations, in conjunction with the application of the outlier trimming methodology and other data standardization approaches described previously, improved the reliability and validity of the resulting estimates of acquisition costs. In particular, it ensured that the resulting estimates reflect plausible and internally consistent acquisition costs while minimizing the influence of erroneous or noncomparable data. Moreover, applying these

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[116] *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/Downloads/ASP-Report-in-units-other-than-NDC.pdf.*

five data refinement exclusions did not have a substantial impact on the overall number of survey records included in analyses of acquisition cost. Collectively, these five refinements removed 14,313 records out of the 160,430 records received through the survey. In other words, after applying these five exclusions, there remained 146,117 survey records in the dataset, 91.1 percent of the total 160,430 original records we received from respondents. We note that there are some overlaps in each individual exclusion of survey records, where the same survey record was excluded for meeting more than one exclusion criterion.

For each of the five scenarios discussed previously, we proposed to exclude survey responses for values that are not plausible given statutory requirements or that exhibit clear inconsistencies in reporting. Specifically, we proposed to exclude survey responses that were identified as meeting at least one of the five scenarios listed previously based on our manual review of the data, ASP pricing files, Health Resources and Services Administration (HRSA) 340B ceiling pricing files, and relevant policy and billing guidance. We believed that this approach represented the most appropriate and methodologically sound means of estimating the typical margin in the survey data between hospitals' survey-reported acquisition costs and ASP. We solicited comment on our approach to identifying and excluding anomalous data, as well as on the overall methodology used to evaluate the survey data for purposes of our proposal.

c. OPPS Drug Acquisition Cost Survey Results

(1) Survey Response Rate and Respondent Characteristics

We first determined the response rate and hospital characteristics of survey respondents to understand which entities had submitted a survey response, then compared them to the characteristics of nonrespondents and the survey-eligible population to assess their representativeness relative to the overall population. We also applied a methodology to refine the population of survey-eligible hospitals to more precisely reflect those entities with meaningful outpatient acquisition volume for drugs included in the survey.

Approximately 43.6 percent of the 4,494 entities eligible for OPPS payment (hereinafter referred to as "survey-eligible hospitals") submitted a survey response and approximately 29.8 percent of eligible hospitals reported that they had acquisition costs during the survey time period. We received a number of responses, many of which appeared to be coordinated form letters, from eligible hospitals indicating that they would not be providing their acquisition data and explaining their reasons for not doing so. Before refining the population, approximately 34.9 percent of non-340B hospitals and approximately 23.1 percent of 340B hospitals responded to the survey and reported that they had acquisition costs for survey-eligible drugs during the surveyed time period (Table 64).

TABLE 64: DESCRIPTIVE SURVEY RESPONDENT STATISTICS

Category	Non-340B Hospitals	340B Hospitals	Total Hospitals
Number of Survey-Eligible Hospitals	2,537	1,957	4,494
Number of Overall Respondents	1,421	537	1,958
Percent of Overall Respondents	56.0%	27.4%	43.6%
Number of Respondents Reported Data	885	453	1,338
Percent of Respondents Reported Data	34.9%	23.1%	29.8%

However, claims analysis of the eligible hospital population determined that a subset of entities that were included in the survey had zero outpatient claims for survey-relevant HCPCS codes during the survey study period. Many of these entities did not submit a survey response, likely because they did not acquire any survey-relevant drugs during the time period. Other entities were hospital subunits that did not submit a survey response or submitted a response reporting zero acquisition costs, but their parent unit submitted a survey response reporting acquisition data.

Consequently, we applied population refinements to consolidate subunits with their parent units and to remove entities from the survey that neither reported acquisition costs nor had outpatient billing volume for HCPCS codes corresponding to NDCs included in the survey during the specified time period. These refinements resulted in a slightly smaller population that may more appropriately reflect the universe of eligible hospitals with meaningful and relevant

outpatient drug acquisition volume. This population was almost exclusively composed of short-term acute care hospitals: 2,977 out of 3,147 total CCNs (94.6 percent) in the refined population are short-term acute care hospitals as compared to 3,018 out of 4,494 total CCNs (67.2 percent) in the original population. This change occurred for two reasons. First, by consolidating subunits with their parent unit, all subunits (that is, psychiatric units and inpatient rehabilitation units), which had accounted for 742 (16.5 percent) in the original population no longer appear in the population as distinct hospitals. Second, this refinement also markedly reduced the number of psychiatric hospitals, long-term care hospitals, and rehabilitation hospitals in the refined population because the majority of these hospitals neither reported acquisition costs nor billed any relevant outpatient claims.

Of this refined study population, approximately 41.4 percent of hospitals responded to the survey and reported that they had acquisition costs during the surveyed study period. Additionally, approximately 53.3 percent of non-340B hospitals and approximately 28.6 percent of 340B hospitals in the refined population responded to the survey and reported that they had acquisition costs during the surveyed study period (Table 65). For discussion of analyses that we undertook to confirm that this response rate is sufficiently large to yield a statistically valid sample, we refer readers to the calculation of confidence intervals in section (3) Population Weight Adjustment and Statistical Validity.

TABLE 65: DESCRIPTIVE SURVEY RESPONDENT STATISTICS (REFINED POPULATION)

Category	Non-340B Hospitals	340B Hospitals	Total Hospitals
Refined Number of Survey-Eligible Hospitals Number	1,639	1,508	3,147
Refined Number of Respondents Reported Data	873	431	1,304
Refined Percent of Respondents Reported Data	53.3%	28.6%	41.4%

Using the refined population, we then compared observable hospital characteristics of survey respondents that reported acquisition costs to the characteristics of the survey-eligible

population (Table 66). Compared to the overall survey-eligible population, hospitals that responded to the survey and reported acquisition cost data were slightly more likely to have lower claims billing volume, be smaller, be located in a rural area, and not be major teaching hospitals.

Given these slight differences in hospital characteristics between respondents and the overall population, we performed inverse probability weighting (IPW) to confirm that respondents' data yielded statistically representative estimates of hospital outpatient drug acquisition costs. We refer readers to the discussion of IPW-adjusted margins in section (3) Population Weight Adjustment and Statistical Validity.

TABLE 66: COMPARISON OF HOSPITAL RESPONDENTS VS NONRESPONDENTS (REFINED POPULATION)

Hospital Characteristic	All Survey-Eligible Hospitals		Respondents Reporting Acquisition Cost Data		Nonrespondents	
	Number	Percentage	Number	Percentage	Number	Percentage
All Hospitals	***3,147***	***100.0%***	***1,304***	***100.0%***	***1,804***	***100.0%***
Outpatient Drug Claims Volume						
Bottom Quintile	591	18.8%	287	22.0%	287	15.9%
Second Quintile	622	19.8%	327	25.1%	284	15.7%
Third Quintile	626	19.9%	256	19.6%	364	20.2%
Fourth Quintile	627	19.9%	221	16.9%	403	22.3%
Top Quintile	628	20.0%	160	12.3%	466	25.8%
No Billing	53	1.7%	53	4.1%	0	0.0%
Hospital Size (Number of Beds)						
Bottom Quintile	502	16.0%	263	20.2%	230	12.7%
Second Quintile	542	17.2%	236	18.1%	293	16.2%
Third Quintile	647	20.6%	267	20.5%	373	20.7%
Fourth Quintile	715	22.7%	284	21.8%	424	23.5%
Top Quintile	741	23.5%	254	19.5%	484	26.8%
Geographic Rurality						
Metropolitan	2,320	73.7%	937	71.9%	1,356	75.2%
Micropolitan	544	17.3%	224	17.2%	315	17.5%
Rural	283	9.0%	143	11.0%	133	7.4%
Census Region						
New England	136	4.3%	33	2.5%	101	5.6%
Middle Atlantic	346	11.0%	129	9.9%	212	11.8%
South Atlantic	518	16.5%	219	16.8%	295	16.4%

Hospital Characteristic	All Survey-Eligible Hospitals		Respondents Reporting Acquisition Cost Data		Nonrespondents	
	Number	Percentage	Number	Percentage	Number	Percentage
East North Central	484	15.4%	166	12.7%	314	17.4%
East South Central	266	8.5%	129	9.9%	128	7.1%
West North Central	237	7.5%	87	6.7%	148	8.2%
West South Central	504	16.0%	295	22.6%	199	11.0%
Mountain	226	7.2%	100	7.7%	124	6.9%
Pacific	388	12.3%	125	9.6%	263	14.6%
Puerto Rico	42	1.3%	21	1.6%	20	1.1%
Teaching Status						
Major Teaching	400	12.7%	134	10.3%	265	14.7%
Not Major Teaching	2,657	84.4%	1,128	86.5%	1,495	82.9%
Unknown	90	2.9%	42	3.2%	44	2.4%

Note: The number of hospitals shown in the "Respondents Reporting Acquisition Cost Data" and "Nonrespondents" columns does not sum to the total number of hospitals in the "All Survey-Eligible Hospitals" column because 39 survey respondents that reported no drug acquisitions during the survey period are excluded from this table. Of these hospitals, 28 (71.8 percent) were non-340B hospitals and 11 (28.2 percent) were 340B hospitals. The 39 survey respondents that reported no drug acquisitions during the survey period are excluded from Table 66. These hospitals generally had low outpatient drug billing volume, tended to be smaller facilities, and were predominantly located in metropolitan areas. The hospitals were geographically distributed across Census regions, and only one hospital was classified as a major teaching hospital.

We received public comments on our survey response rate and respondent characteristics. The following is a summary of the comments we received and our responses.

Comment: Two commenters raised concerns about the creation of the refined hospital population, especially in relation to analysis of the survey response rate. A commenter pointed out that the refinements resulted in a larger increase in the response rate for non-340B hospitals (from 34.9 percent to 53.3 percent) than for 340B hospitals (from 23.1 percent to 28.6 percent).

Response: The population of 4,494 CCNs that CMS initially identified for ODACS eligibility was intended to be maximally inclusive in order to identify all entities paid under the OPPS that could have purchased survey-relevant outpatient drugs during the ODACS study period. However, further claims analysis revealed that a subset of the 4,494 eligible CCNs did not submit any OPPS claims for survey-relevant HCPCS codes during the study period. Many of these entities, which were predominantly subunits or non-acute care hospitals, also did not submit an ODACS response or submitted a response reporting zero drug acquisitions. These observations are not unexpected given that many subunits likely acquire their outpatient drugs in

conjunction with their parent unit and some non-acute care entities do not acquire or administer the specific outpatient drugs included in the survey at all.

To create a population with evidence of survey-relevant OPPS drug utilization—either via their ODACS response or claims data—CMS applied two refinements. CMS refers readers to Section 3.1.2 of the ODACS Technical Report for details on these refinements and their impact on the hospital population. Consequently, the refined population of 3,147 CCNs more precisely reflects the universe of hospitals with meaningful and relevant outpatient acquisition volume for drugs included in the survey and, in turn, better focuses on the universe of hospitals that would be impacted by the proposed policy change.

The survey response rate changes as a result of these refinements because the denominator of response rate changes. The response rate is calculated as the number of CCNs that submitted an ODACS response divided by all survey-eligible CCNs. In the initial population, the denominator of 4,494 CCNs yields a response rate of 29.8 percent ; in the refined population, the denominator of 3,147 CCNs yields a response rate of 41.4 percent. CMS believes that the refined population response rate of 41.4 percent better represents the share of hospitals that reported acquiring surveyed NDCs out of all hospitals that could have reasonably been expected to report OPPS acquisitions of the surveyed NDCs. These refinements had a larger impact on the non-340B response rate only because the vast majority of subunits and non-acute care entities in the initial population are non-340B entities.

Comment: Many commenters contended that the response rate, especially from 340B hospitals, does not meet section 1833(t)(14)(D)(iii) of the Act's statutory threshold of a "large sample of hospitals" and is therefore too low to justify the proposed policy change. One commenter cited the 2005 acquisition cost survey conducted by GAO, which aimed to receive responses from 1,000 hospitals after sampling 1,400 hospitals out of an initially eligible 3,450 hospitals, to justify a 29.8 percent response rate as meeting the requirement for a large sample. Some commenters also linked the response rate to concerns over data representativeness, arguing

that because the response rate among 340B hospitals was lower than among non-340B hospitals, it calls into question the representativeness and comparability of the 340B and non-340B respondent populations.

Response: We note that CMS sampled more hospitals than the GAO. Rather than limit the survey to a subset of hospitals, CMS ensured through its methodology that the maximum number of hospitals could participate and fulfill their statutory obligation to respond to the survey. For a discussion of this statutory requirement, see the CY 2026 OPPS/ASC final rule (90 FR 53764–53765). Nowhere in statutory language is "a large sample of hospitals" defined nor is a particular threshold set for achieving "a large sample of hospitals." Moreover, determining adequate sample size in any survey-based quantitative analysis is a complex challenge that involves evaluating factors unique to that analysis, including the sampling design, population size, and population variability. For instance, the 2005 GAO survey design employed a stratified random sampling methodology that explicitly sampled from the initial hospital population; therefore, applying a threshold of 29.8 percent is not comparable to CMS's ODACS survey design, which did not employ a sampling methodology. Rather, CMS invited all 4,494 hospitals identified as paid under the OPPS to respond to the survey and contribute any acquisition data for surveyed NDCs. A response-rate floor defined for a stratified sample does not have an established meaning for a census survey.

Consistent with generally accepted statistical practice, sample size sufficiency was evaluated through the calculation of confidence intervals (CIs) and IPW adjustment rather than seeking to meet an arbitrary threshold. CMS notes that a smaller sample size does not necessarily make a sample less representative; rather, representativeness is governed by response mechanism instead of sample size. Large samples can be more skewed in certain characteristics, yielding potentially larger biases. This possibility is why CMS performed IPW adjustment and statistical diagnostic tests to understand and account for potential sample size and data representativeness issues. The IPW adjustment and calculation of CIs indicated that the response rate yielded

sufficiently precise estimates of hospitals' acquisition costs. As we explained in Section 3.5.2 of the ODACS Technical Report, to evaluate whether the number of survey responses received was sufficient to produce statistically valid estimates of hospitals' acquisition costs, we calculated CIs for both unadjusted and IPW adjusted acquisition cost margins. The CIs provide measures of whether the response rate adequately captures true population results. When response rate is insufficiently low, CIs are wide due to the high degree of uncertainty regarding where the true result lies. Conversely, when response rate is sufficient, CIs narrow as uncertainty lessens. CMS calculated the CIs using a bootstrap methodology. First, the full dataset of survey records (after applying data refinements and excluding geometric mean outliers) was repeatedly sampled with replacement using hospitals as the sample unit; acquisition cost margins were recalculated for each repeated sample. This process was repeated 10,000 times to generate distributions of unadjusted and IPW-adjusted acquisition cost margin estimates. Finally, the 95% CIs were identified for each margin estimate using the 2.5th percentile as the lower bound and the 97.5th percentile as the upper bound.

We reported the impact of IPW adjustment and CI calculation on acquisition cost margins in Section 4.4.2 of the ODACS Technical Report which described that applying IPW adjustment had minimal impact on acquisition cost margins for either non-340B or 340B acquired drugs. For drugs acquired outside the 340B Program, hospitals' survey-reported acquisition costs were 2.7 percent above the mean ASP before IPW adjustment and 2.8 percent above the mean ASP after IPW adjustment. For drugs acquired through the 340B Program, hospitals' survey-reported acquisition costs were 33.4 percent below the mean ASP before IPW adjustment and 33.1% below the mean ASP after IPW adjustment (Table 67). The consistency between unadjusted and IPW-adjusted results supports the robustness and representativeness of the acquisition cost margins derived from survey responses.

TABLE 67: COMPARISON OF UNADJUSTED TO IPW-ADJUSTED ACQUISITION COST MARGINS AND CONFIDENCE INTERVALS

Aggregate Margin Calculations: Methodology Specifications	Non-340B Drugs			340B Drugs		
	Mean ASP Margin	95% CI Lower Limit	95% CI Upper Limit	Mean ASP Margin	95% CI Lower Limit	95% CI Upper Limit
Unadjusted	+2.7%	–3.8%	+6.9%	–33.4%	–34.7%	–32.3%
IPW-Adjusted	+2.8%	–1.6%	+6.5%	–33.1%	–34.3%	–32.1%

The 95 percent CIs for both unadjusted and IPW-adjusted acquisition cost margins did not substantially differ from each other, indicating that the weighting adjustment had minimal impact on the resulting estimates. For non-340B drugs, the CIs spanned 3.8 percent below the mean ASP to 6.9 percent above the mean ASP for the unadjusted margin and between 1.6 percent below the mean ASP to 6.5 percent above the mean ASP for the IPW-adjusted margin. For 340B-acquired drugs, the CIs were much narrower and spanned 34.7 percent to 32.3 percent below the mean ASP for the unadjusted margin and from 34.3 percent to 32.1 percent below the mean ASP for the IPW-adjusted margin.

The narrow CIs for 340B-acquired drugs support the statistical validity of the survey results on 340B drugs and indicate that the received sample is sufficiently large to produce reliable estimates of hospital outpatient drug acquisition costs for 340B drugs. The CIs for the non-340B drugs span a wider range of potential acquisition cost margins, which is expected given the greater distributional spread in the survey data for non-340B drugs.

Comment: Many commenters noted slight differences in composition between the respondent population and overall population of survey-eligible hospitals along observable hospital characteristics. Some alleged that CMS had not demonstrated data representativeness for groups of their interest such as major teaching hospitals, rural hospitals, and high-volume purchasers. Other commenters also requested more information about representation along particular stratifications (e.g., payer mix and patient populations) and for particular groups (e.g., rural referral centers, Disproportionate Share Hospital [DSH] status), expressing concern that

there could be differences in population composition along these factors that were not considered. Finally, some commenters raised concerns that the outlier trimming and data exclusions could disproportionately impact certain hospital characteristics, impairing representativeness.

Response: CMS previously published results that evaluated data representativeness along many of the hospital characteristics mentioned by commenters, including, hospital size, geographic rurality and location, 340B participation, academic teaching status, and OPPS drug claims volume. CMS refers readers to Table 6 of the ODACS Technical Report for these results. CMS acknowledges that the population composition differed slightly across some of these characteristics between the respondent population and the overall survey-eligible population. These differences are precisely why CMS applied IPW, a widely used statistical technique that reweights received data to account for under- or overrepresentation of particular hospital characteristics such that the weighted sample replicates the characteristics of the overall population. Applying IPW adjustment had minimal impact on acquisition cost margins for non-340B and 340B-acquired drugs, supporting the robustness and representativeness of the acquisition cost margins derived from survey responses. CMS refers readers to Section 4.4.2 of the ODACS Technical Report for a full discussion of the IPW adjustment methodology and results.

To address commenters' concerns that the respondent population is not representative along additional hospital characteristics not previously discussed, CMS conducted further analysis of the population by share of Medicare patients, DSH percentage, and hospital type. Unadjusted results show that the respondent population does not meaningfully differ from the overall population of survey-eligible hospitals by either Medicare share or DSH percentage, two indices of payer mix and patient population. When stratifying by hospital type, the respondent population is composed of slightly more IPPS hospitals and slightly fewer RRCs or RRC/SCHs, relative to all survey-eligible hospitals. CMS then integrated these three new variables as

covariates in our IPW adjustment, and their inclusion had no impact on existing acquisition cost margins for either 340B-acquired or non-340B drugs.

Comment: Many commenters raised concerns that CMS's IPW adjustment methodology does not adequately address the risks of nonresponse bias and therefore does not ensure representativeness of the resulting acquisition cost margins. Commenters noted that IPW adjustment, which uses observable hospital characteristics to reweight population composition, can be insufficient if either or both of (i) the likelihood of survey response and (ii) drug acquisition costs are influenced by unobservable factors. Commenters offered various examples of potential unobservable factors that could hypothetically be exerting influence, including administrative complexity, drug purchasing arrangements, health system affiliation, and access to bulk purchasing discounts. As such, commenters stated that CMS lacks evidence that the adjustors and covariates are able to close potential gaps in responses or acquisition costs. Additionally, some commenters stated that the narrow confidence intervals produced by the margin analyses indicate consistency among the respondent hospitals but do not demonstrate that the respondents accurately reflect the population as a whole. Finally, one commenter questioned why CMS did not report the distribution of respondents by OPPS drug volume quintile after IPW adjustment.

Response: As CMS describes below, we believe the acquisition cost data received are representative of acquisition costs among the eligible hospital population. We acknowledge that to sufficiently account for all determinants of hospital response and acquisition cost is a complex challenge given that acquisition costs for nonrespondents are, by definition, unobservable. CMS conducted an internal analysis to address concerns about nonresponse bias, with the specific goal of addressing whether nonresponse is correlated with acquisition costs. We used cost-to-charge ratios (CCR) from hospital cost reports and claim line charges from each providers' Fee-For-Service (FFS) drug claims data to create a proxy measure of acquisition cost that could be evaluated for the full population of survey-eligible hospitals. This analysis found that, for the

340B hospital population, respondents and nonrespondents had no statistically significant difference in costs, and the magnitude of the difference was close to zero, suggesting that a hospital's cost burden was not associated with their likelihood of response. CMS believes the consistency of proxy drug acquisition costs among respondents and nonrespondents supports the conclusion that the narrow confidence intervals obtained through the analysis do not simply reflect a homogenous respondent group, but rather are consistent with a sample that is representative of the eligible hospital population in terms of acquisition cost.

CMS conducted other tests to ensure the appropriateness of the IPW model and its covariates. First, we ran diagnostics on the distribution of estimated propensity scores and the resulting weights. In none of our IPW models did the estimated response probabilities fall below 10 percent; this is within the range where weight instability is not a concern and implies that weight trimming or truncation is not necessary. Second, CMS calculated Kish's effective sample size for each model, a diagnostic that summarizes how concentrated influence is across the weighted sample (a value close to the actual sample size indicates that weights are spread evenly across hospitals, while a value near 1 would indicate the estimate is driven by a single observation). In all cases, the effective sample size was close to the actual sample size, indicating that no small set of high-weight hospitals exerted disproportionate influence on the results.

As to why CMS did not report the distribution of respondents by OPPS drug volume quintile after IPW adjustment, OPPS drug volume quintile was highly correlated with the hospital size (bed count) quintile variable; given this, OPPS drug volume quintile was not included as a covariate in the IPW adjustment model to avoid collinearity issues. To address this comment, CMS also tested whether the final IPW weights balance the observed OPPS drug volume quintiles. We found that the reweighted sample effectively replicates the distribution of the OPPS drug volume quintiles in the population, even when this variable was not directly included. See Table 60.

(2) Margins Between Survey-Reported Hospital Acquisition Costs and Volume-Weighted ASP

Using the methodology, refinements, and processes discussed throughout Section (2)(b) Data Analysis and Methodology, we evaluated the received survey data to determine the difference between hospitals' survey-reported acquisition costs and ASP-based Medicare payment amounts. We first identified the percent margin between aggregate acquisition costs and volume-weighted ASP for both non-340B and 340B drug acquisitions, then performed an analogous calculation to identify the margin between 340B ceiling prices and ASP as additional context for the 340B acquisition cost margins. Next, we tested alternate methodological specifications to evaluate whether these margins varied depending on the methods used. Finally, we stratified margins by individual therapeutic classes to identify possible variation in acquisition costs relative to ASP along drug type.

The survey provides valuable information regarding hospitals' drug acquisition costs. Following the GAO recommendation to validate Medicare payment rates using hospital acquisition costs, we assessed the survey data for trends where acquisition cost did not align with Medicare payment. The most immediately evident difference was between Medicare payment rates and acquisition cost data for 340B-acquired drugs by 340B-participating hospitals. Based on the survey response data and applying the methodologies discussed previously, we found that for drugs acquired through the 340B Program, hospitals' reported acquisition costs during the specified time period were approximately 33.4 percent below both the mean and the median ASP. For drugs acquired outside of the 340B Program, hospitals' survey-reported acquisition costs during the specified time period were approximately 2.7 percent above the mean ASP and 2.8 percent above the median ASP.

To help validate these findings, we compared aggregate 340B ceiling prices for drugs included in the survey during the corresponding survey period to ASP amounts.[117] Based on this

[117] The 340B ceiling prices are the maximum statutory amounts drug manufacturers can charge covered entities for outpatient prescription drugs. They are calculated by subtracting the unit rebate amount (URA) which is the

analysis, during the survey study period 340B ceiling prices were, in aggregate, 28.0 percent below the mean ASP and 29.2 percent below the median ASP, respectively. These findings help validate the survey response data for 340B-acquired drugs, as the ceiling price average discount is generally representative of the maximum acquisition cost and minimum discount, though hospitals can negotiate additional discounts resulting in a sub-ceiling acquisition cost. This is reflected in the survey results where the aggregate 340B acquisition cost margin is approximately 33.4 percent below the mean ASP— several percentage points lower than the aggregate ceiling price margin of 28.0 percent below the mean ASP.

We sought to ensure that the resulting margins precisely reflected the relationship between hospitals' acquisition costs and ASP, and did not manifest substantial changes under different methodological specifications. To do so, we tested the impact of weighting acquisition cost margins by OPPS claims volume and retaining 340B survey responses above the maximum ceiling price (Table 68). Although we did not propose to adopt these alternative methodologies at this time for the reasons outlined in section V.B.8.b of this final rule with comment period, calculating acquisition cost margins with these specifications emphasizes two key points about 340B-acquired drugs. First, regardless of how one analyzes the data, there are considerable differences between hospitals' acquisition costs for 340B-acquired drugs and ASP-based payment amounts for 340B drugs. Second, these alternate methodologies had minimal impact on the acquisition cost margins for 340B-acquired drugs; regardless of calculation methodology, hospitals' survey-reported acquisition costs remained relatively consistent between approximately 29.9 percent and 33.4 percent below the average ASP and between 29.8 percent and 33.4 percent below the median ASP.

Application of different methodological specifications resulted in slightly more variation in the estimated margin between hospitals' survey-reported acquisition costs and mean or median

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Medicaid rebate manufacturers must pay to the government from the average manufacture price (AMP) which is the average price paid to the manufacturer by wholesalers for a given drug.

ASP-based payments for drugs acquired outside the 340B Program. This greater variability could be attributed to wider distributional spread in the reported acquisition costs for non-340B drugs; this, in turn, could cause the non-340B margins to be more sensitive to application of different weighting methodologies.

TABLE 68: ODACS STATISTICAL DATA METHODOLOGIES AND RESULTS

Aggregate Margin Calculations: Methodology Specifications			Acquisition Cost to ASP Margin			
			Non-340B		340B	
			Mean ASP Margin	Median ASP Margin	Mean ASP Margin	Median ASP Margin
Geometric Mean Outliers Removed	Weighted by Survey Purchase Volume	Responses > Ceiling Price Included	2.7%	2.8%	–31.9%	–31.8%
		Responses > Ceiling Price Excluded			–33.4%	–33.4%
	Weighted by Outpatient Claims Volume	Responses > Ceiling Price Included	6.7%	6.7%	–29.9%	–29.8%
		Responses > Ceiling Price Excluded			–31.2%	–31.1%

To assess whether the magnitude of margins remained the same across different drug categories, we also examined acquisition cost margins by therapeutic class[118] for both 340B-acquired and non-340B-acquired drugs. Hospitals' survey-reported 340B acquisition costs were at least 28.9 percent below the mean ASP—and for most therapeutic classes lower than that—for drugs in all high-spending therapeutic classes (that is, those with more than $100 million in reported acquisition costs) (Table 69). Again, this reinforces the significant, and consistent, differences between hospitals' acquisition cost for 340B-acquired drugs and ASP for these drugs regardless of therapeutic class.

The margins for non-340B drugs displayed greater variation relative to the 340B drugs, which is likely attributable to greater heterogeneity in drug mix, provider type, and purchasing

[118] Therapeutic class assignments were based on the Medi-Span Generic Product Identifier (GPI) classification system.

arrangements present outside the 340B Program. For instance, only certain drugs and biologicals can be acquired through the 340B Program and only certain types of hospitals can enroll as 340B participants. These restrictions necessarily limit which drugs and hospitals can be included in the 340B calculations, leading to a somewhat more homogenous population. These restrictions do not play a role in the non-340B calculations. Additionally, and perhaps most significantly, certain types of 340B-participating hospitals have historically been prohibited from purchasing covered outpatient drugs through GPO arrangements,[119] which limits the purchasing arrangements applicable to 340B drugs, while non-340B drugs can be purchased under a variety of GPO or other buying group arrangements.

TABLE 69: ACQUISITION COST MARGINS BY THERAPEUTIC CLASS FOR 340B DRUGS

Therapeutic Class	340B	
	Mean ASP Margin	Median ASP Margin
Antineoplastics and Adjunctive Therapies	–28.9%	–28.8%
Hematopoietic Agents	–38.3%	–37.8%
Endocrine and Metabolic Agents	–52.6%	–52.8%
Passive Immunizing and Treatment Agents	–30.8%	–30.4%
Gastrointestinal Agents	–29.3%	–29.1%
Psychotherapeutic and Neurological Agents	–31.2%	–31.3%
Miscellaneous	–29.6%	–29.6%
Analgesics	–71.4%	–71.4%
Neuromuscular Agents	–31.8%	–31.9%

We received public comments on the margins between survey-reported hospital acquisition costs and volume-weighted ASP. The following is a summary of the comments we received and our responses.

Comment: Several commenters suggested that the published 340B acquisition cost margin of ASP minus 33.4 percent may be influenced by respondents with particular characteristics (e.g., large hospitals that could access bulk purchasing discounts) and requested that CMS release additional details about these margins stratified by hospital characteristics.

[119] *https://www.hrsa.gov/sites/default/files/hrsa/opa/prohibition-gpo-participation-02-07-13.pdf.*

Response: CMS recognized the possibility of acquisition costs varying by hospital characteristic and calculated margins along these traits in our initial analysis. Results show remarkably little variation based on all measured hospital characteristics; regardless of stratification, acquisition cost margins for 340B drugs range from 30.4 percent to 39.7 percent below the mean ASP and 30.3 percent to 39.6 percent below the median ASP.

TABLE 70: Acquisition Cost Margin for 340B Drugs by Hospital Characteristic

Hospital Characteristic	340B Drugs	
	Mean ASP Margin	Median ASP Margin
ODACS Drug Acquisition Volume		
Bottom Quintile	–38.9%	–39.0%
Second Quintile	–37.6%	–37.5%
Third Quintile	–35.5%	–35.4%
Fourth Quintile	–32.5%	–32.4%
Top Quintile	–33.9%	–33.8%
OPPS Drug Billing Volume		
Bottom Quintile	–35.5%	–35.4%
Second Quintile	–34.4%	–34.3%
Third Quintile	–39.7%	–39.6%
Fourth Quintile	–35.2%	–35.0%
Top Quintile	–32.3%	–32.2%
No Billing	–33.0%	–32.8%
Hospital Size (Number of Beds)		
Bottom Quintile	–34.7%	–34.6%
Second Quintile	–33.6%	–33.6%
Third Quintile	–32.1%	–32.0%
Fourth Quintile	–33.0%	–33.0%
Top Quintile	–33.7%	–33.6%
Geographic Rurality		
Metropolitan	–33.5%	–33.4%
Micropolitan	–32.8%	–32.7%
Rural	–32.6%	–32.5%
Census Region		
New England	–38.3%	–38.2%
Middle Atlantic	–32.1%	–32.1%
South Atlantic	–31.9%	–31.9%
East North Central	–31.7%	–31.7%
East South Central	–32.3%	–32.2%
West North Central	–32.6%	–32.6%
West South Central	–35.8%	–35.7%
Mountain	–33.3%	–33.3%
Pacific	–35.4%	–35.3%

Hospital Characteristic	340B Drugs	
	Mean ASP Margin	Median ASP Margin
Teaching Status		
Major Teaching Hospital	–34.8%	–34.8%
Not Major Teaching Hospital	–32.7%	–32.6%
Unknown	–31.6%	–31.5%
Share of Medicare Patients		
Bottom Quintile	–34.9%	–34.8%
Second Quintile	–31.3%	–31.3%
Third Quintile	–35.4%	–35.3%
Fourth Quintile	–32.1%	–32.0%
Top Quintile	–33.4%	–33.3%
Unknown	–31.6%	–31.5%
Disproportionate Share Percent		
Bottom Quintile	–30.4%	–30.3%
Second Quintile	–34.2%	–34.1%
Third Quintile	–31.6%	–31.5%
Fourth Quintile	–33.4%	–33.4%
Top Quintile	–34.8%	–34.7%
Not Applicable	–31.6%	–31.5%
Hospital Type		
IPPS Hospital	–34.5%	–34.5%
Rural Referral Center (RRC)	–32.6%	–32.6%
Sole Community Hospital (SCH)	–32.5%	–32.4%
RRC/SCH	–33.9%	–33.9%
Other/Unknown	–31.6%	–31.5%

Comment: Several commenters discussed concerns regarding variation in acquisition costs by individual drug and/or therapeutic class, pointing out that a single adjustment to ASP may lead to underpayment for certain drugs and overpayment for others. Commenters referenced Table 53 from the proposed rule, which presents margins by drug class, as illustrating that acquisition costs for 340B drugs vary substantially by drug type. Commenters consequently noted against the implementation of any payment adjustments that are not drug-specific.

Response: As we noted in the CY 2027 OPPS/ASC proposed rule, we considered calculating payment rates derived from individual acquisition cost amounts for 340B drugs; however, given the dynamic nature of drug pricing, we concluded that it would be more appropriate to apply a single discount factor to ASP. We also explained that we believed that

this approach would be more appropriate as ASP is also dynamic in nature. ASP changes over time (quarter to quarter), so tying the payment amount to an average discount of ASP results in a more accurate payment amount, by quarter, than if hospitals had to wait until the next survey cycle. Each drug HCPCS code has its own specific payment rate calculated that is unique to the drug described by the applicable HCPCS code. We indicated that we would apply an average discount, calculated as described under V.B.9.b. and V.B.9.c.(2). of the proposed rule, to the drug-specific ASP amount. This would make our proposed payment rate specific to the average acquisition cost for the drug. We also stated that applying the payment rate in this manner would allow for this average discount to apply to newly calculated ASPs as they are updated on a quarterly basis. We further explained that it would not be practical to calculate a drug-specific payment rate for each NDC, and each HCPCS code, based on the survey data, as the survey-collected data is based on a snapshot in time and would not reflect future changes in average acquisition costs. Therefore, as drug prices change, we believe it is appropriate and reasonable to continue to update the calculated ASPs and then to reduce payments by an appropriate percentage of ASP to better align payment with the average cost of the drug.

With respect to commenters' observation that a single adjustment to ASP may lead to underpayment for certain drugs and overpayment for others, we emphasize that the purpose of our policy is to better align payment for 340B-acquired drugs with their acquisition costs in the aggregate, not to ensure that hospitals receive a payment amount greater than the cost of acquisition for every drug purchase. This approach is not unique to the policy for 340B-acquired drugs; because the OPPS is a prospective payment system, payment for an individual item or service may be more or less than a hospital's cost in any specific case. We would additionally note that the alternative payment rate that we are finalizing, ASP minus 28 percent, is greater than the ASP minus 33.4 percent amount demonstrated by the survey and would therefore partially mitigate commenters' concerns.

We also note that payment rates are already set on a drug-by-drug basis using the ASP methodology, and this policy will similarly reflect the differing acquisition costs of specific drugs. The percentage adjustment applied to ASP has never been tailored to individual HCPCS codes and this policy is consistent with that longstanding approach. Further, CMS chose to volume-weight the proposed ASP percentage adjustment to reflect the relative utilization and differing margins of individual drugs.

CMS performed an additional variation of the IPW analysis in an effort to further address concerns about differences in drug utilization mix across providers. We first analyzed drug utilization by therapeutic class in the respondent and non-respondent populations. For those drug classes that displayed differences between the two groups, we included variables measuring each respondent's utilization of the drug classes of interest into the IPW adjustment. The introduction of these drug mix variables showed no impact on the existing aggregate margins, indicating that differing drug mix across providers does not appear to be exerting undue influence on the comparisons of acquisition costs to ASP.

(3) Application of Population Weight Adjustment and Calculation of Confidence Intervals to Assess Statistical Validity

In accordance with section 1833(t)(14)(D)(iii) of the Act, after completing initial analysis of survey respondents' acquisition costs, we evaluated whether survey respondents comprised a large sample that is sufficient to generate statistically significant and representative estimates of hospitals' acquisition costs. To do so, we conducted sensitivity analyses using inverse probability weighting (IPW) and confidence intervals, which we believe support the statutory objective of obtaining acquisition cost estimates from survey responses that are accurate and representative of the outpatient drug acquisition costs incurred by all hospitals paid under the OPPS.

(i) IPW Methodology

IPW is a widely used statistical technique in survey research[120,121,122,123,124] to ensure that sample data produce estimates that accurately represent the population of interest. We applied IPW to account for the potential underrepresentation or overrepresentation of hospitals with particular characteristics among survey respondents and to evaluate whether acquisition cost margins derived from survey responses sufficiently reflected outpatient drug acquisition costs for all OPPS hospitals.

For purposes of the IPW analysis, we constructed respondent and nonrespondent populations that align with the refined hospital population discussed previously in (1) Survey Response Rate and Respondent Characteristics. We defined the respondent population as hospitals that submitted a survey response reporting the purchase of at least one surveyed NDC during the survey study period. We defined the nonrespondent population as survey-eligible hospitals that did not submit a survey response but billed at least one Fee-For-Service outpatient claim associated with a survey-relevant HCPCS code during the same period. Because acquisition cost margins were calculated separately for drugs purchased through the 340B Program and drugs purchased outside the 340B Program, we further stratified hospitals based on evidence of 340B drug use. Hospitals were identified as 340B participants using HRSA's 340B OPAIS enrollment information and claims submitted with 340B modifiers. Hospitals that neither submitted an ODACS response nor billed relevant outpatient claims during the survey period were excluded from the IPW-adjusted population. Subunits were collapsed with their corresponding parent unit prior to constructing the respondent and nonrespondent populations.

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[120] "Behavioral Risk Factor Surveillance System: Weighting the Data (2011 Weighting Formula)," U.S. Centers for Disease Control and Prevention, last modified July 19, 2013, *https://www.cdc.gov/brfss/annual_data/2011/2011_weighting.htm.*

[121] "National Health and Nutrition Examination Survey – Weighting," U.S. Centers for Disease Control and Prevention, n.d., *https://wwwn.cdc.gov/nchs/nhanes/tutorials/weighting.aspx.*

[122] "Weighting," U.S. Census Bureau, last modified January 12, 2022, *https://www.census.gov/programs-surveys/cps/technical-documentation/methodology/weighting.html.*

[123] "Weighting," U.S. Census Bureau, last modified August 19, 2022, *https://www.census.gov/programs-surveys/sipp/methodology/weighting.html.*

[124] "Consumer Expenditures and Income: Calculation," U.S. Bureau of Labor Statistics, last modified September 12, 2022, *https://www.bls.gov/opub/hom/cex/calculation.htm*.

After identifying the respondent and nonrespondent groups, we calculated response propensity scores using logistic regression models based on observed hospital characteristics, including number of beds, teaching hospital status, geographic rurality, and Census division. Propensity scores were estimated separately for hospitals purchasing drugs outside the 340B Program and hospitals purchasing drugs through the 340B Program. A higher propensity score means that the hospital was more likely to submit a survey response; a lower propensity score means that the hospital was less likely to submit a survey response.

We then calculated inverse probability weights equal to the inverse of each hospital's estimated probability of responding to the survey. Hospitals with a higher likelihood of responding received smaller weights, while hospitals with a lower likelihood of responding received larger weights. The weights were used to adjust for differential representation of hospital characteristics between the respondent sample and the broader population of survey-eligible hospitals. Down-weighting hospitals with a high probability of response (which are overrepresented in the received sample) while upweighting CCNs with a low probability of response (which are underrepresented in the received sample) accounted for the differential representation of hospital characteristics in the sample as compared to the full population.

Finally, we calculated the IPW-adjusted acquisition cost margins by first applying the calculated weights to hospitals' average acquisition costs and corresponding ASP-based payment amounts, then recalculating aggregate acquisition cost margins by finding the difference between the IPW-adjusted acquisition costs and IPW-adjusted ASP-based payment and then dividing that difference by the IPW-adjusted ASP-based payment. We also applied the same methodology when calculating IPW-adjusted margins between acquisition costs and 340B ceiling prices.

(ii) Confidence Intervals Methodology

To evaluate whether the number of survey responses was sufficient to produce statistically valid estimates of hospitals' acquisition costs, we calculated confidence intervals for both unadjusted and IPW-adjusted acquisition cost margins. The confidence intervals provide

measures of whether the survey response rate adequately captures true population-level results. When response rate is insufficiently low, confidence intervals are very wide due to the high degree of uncertainty regarding where the true result lies. Conversely, when response rate is sufficient, confidence intervals become narrower as uncertainty lessens.

We calculated confidence intervals using a bootstrap methodology. Specifically, we repeatedly sampled with replacement from the original survey dataset and recalculated acquisition cost margins for each repeated sample. We repeated this process 10,000 times to generate distributions of unadjusted and IPW-adjusted acquisition cost margin estimates. We then identified the 95 percent confidence intervals for each acquisition cost margin estimate using the 2.5th percentile as the lower bound and the 97.5th percentile as the upper bound.

(iii) Results of Population Weight Adjustments and Confidence Intervals from ODACS Data

Application of inverse probability weighting improved the alignment between the distribution of respondent hospital characteristics and the broader population of survey-eligible hospitals. We found that IPW-adjusted respondent characteristics more closely resembled the full population across measures such as rural/urban, teaching status, Census division, and 340B participation (Table 71).

TABLE 71: POPULATION WEIGHT ADJUSTMENT BY HOSPITAL CHARACTERISTIC

Hospital Characteristic	Non-340B Drugs			340B Drugs		
	ODACS-Eligible Population	Unadjusted ODACS Respondents	IPW-Adjusted ODACS Respondents	ODACS-Eligible Population	Unadjusted ODACS Respondents	IPW-Adjusted ODACS Respondents
340B Enrollment						
340B Hospital	48.1%	32.8%	50.0%	100.0%	100.0%	100.0%
Non-340B Hospital	51.9%	67.2%	50.0%	N/A	N/A	N/A
Number of Beds						
Bottom Quintile	15.8%	20.0%	16.2%	7.4%	9.6%	6.9%
Second Quintile	17.1%	18.3%	16.9%	13.8%	16.7%	13.7%
Third Quintile	20.6%	20.6%	20.8%	17.5%	17.0%	17.7%
Fourth Quintile	22.7%	21.6%	23.4%	26.4%	27.0%	26.6%
Top Quintile	23.8%	19.6%	22.7%	35.0%	29.7%	35.2%
Rurality						

Hospital Characteristic	Non-340B Drugs			340B Drugs		
	ODACS-Eligible Population	Unadjusted ODACS Respondents	IPW-Adjusted ODACS Respondents	ODACS-Eligible Population	Unadjusted ODACS Respondents	IPW-Adjusted ODACS Respondents
Metropolitan	73.8%	71.8%	74.6%	71.8%	69.5%	71.9%
Micropolitan	17.3%	17.2%	16.7%	20.0%	19.2%	20.3%
Rural	8.9%	11.0%	8.7%	8.3%	11.3%	7.8%
Census Region						
New England	4.3%	2.6%	4.6%	4.8%	3.4%	4.5%
Middle Atlantic	10.9%	9.7%	10.7%	12.1%	9.8%	13.1%
South Atlantic	16.6%	16.8%	16.0%	14.1%	11.8%	15.0%
East North Central	15.5%	12.9%	16.3%	17.0%	18.4%	16.6%
East South Central	8.3%	9.9%	8.3%	8.6%	9.8%	8.6%
West North Central	7.5%	6.6%	7.0%	8.3%	8.1%	8.1%
West South Central	15.8%	22.7%	15.9%	12.9%	18.2%	12.6%
Mountain	7.2%	7.7%	6.4%	6.3%	3.9%	6.4%
Pacific	12.6%	9.7%	13.0%	15.4%	15.0%	14.6%
Puerto Rico	1.2%	1.4%	1.9%	0.5%	1.5%	0.5%
Teaching Status						
Major Teaching	12.8%	10.2%	11.8%	19.5%	16.7%	19.5%
Not Major Teaching	84.4%	86.6%	85.6%	77.3%	79.1%	77.4%
Unknown	2.8%	3.3%	2.6%	3.2%	4.2%	3.1%

(iv) Weighted Adjusted Acquisition Cost Margins

We found that application of IPW had minimal impact on estimated acquisition cost margins for either non-340B drugs or 340B-acquired drugs. For drugs acquired outside the 340B Program, the analysis conducted estimated that acquisition costs were approximately 2.7 percent above the mean ASP prior to IPW adjustment and approximately 2.8 percent above the mean ASP after IPW adjustment. For drugs acquired through the 340B Program, the analysis estimated that acquisition costs were approximately 33.4 percent below the mean ASP prior to IPW adjustment and approximately 33.1 percent below the mean ASP after IPW adjustment. The consistency between unadjusted and IPW-adjusted results supports the robustness and representativeness of the acquisition cost margins derived from survey responses (Table 72).

TABLE 72: EFFECT OF INVERSE PROBABILITY WEIGHT ADJUSTMENT ON ACQUISITION COST MARGINS AND 95 PERCENT CONFIDENCE INTERVALS (CI)

Aggregate Margin Calculations: Methodology Specifications		Acquisition Cost to Mean ASP Margin					
		Non-340B Drugs			340B Drugs		
		Mean ASP Margin	95% CI Lower Limit	95% CI Upper Limit	Mean ASP Margin	95% CI Lower Limit	95% CI Upper Limit
Responses > Ceiling Price Included	Unadjusted	+2.7%	–3.8%	+6.9%	–31.9%	–33.9%	–29.4%
	IPW-Adjusted	+2.8%	–1.6%	+6.5%	–31.6%	–33.4%	–29.3%
Responses > Ceiling Price Excluded	Unadjusted				–33.4%	–34.7%	–32.3%
	IPW-Adjusted				–33.1%	–34.3%	–32.1%

The 95 percent confidence intervals for both unadjusted and IPW-adjusted acquisition cost margins were not substantially different from each other, indicating the weighting adjustment had minimal impact on the resulting estimates. For non-340B drugs, the confidence intervals ranged from approximately 3.8 percent below the mean ASP to 6.9 percent above the mean ASP for unadjusted margin and between 1.6 percent below the mean ASP to 6.5 percent above the mean ASP for the IPW-adjusted margin. For 340B-acquired drugs, the confidence intervals were much narrower and ranged from approximately 34.7 percent to 32.3 percent below the mean ASP for the unadjusted margin and from 34.3 percent to 32.1 percent below the mean ASP for the IPW-adjusted margin (Table 72).

We believe the relatively narrow confidence intervals for 340B-acquired drugs support the statistical validity of the survey results on 340B drugs and indicate that the received sample is sufficiently large to produce reliable estimates of hospital outpatient drug acquisition costs for 340B drugs. We note that the confidence intervals for the non-340B drugs span a wider range of potential acquisition cost margins. This is expected given the greater distributional spread in the survey data for non-340B drugs, as discussed in this section V.B.2.8. of this final rule with comment period.

For an additional summary of our analysis of the survey results we refer readers to the 2026 Outpatient Prospective Payment System Drug Acquisition Cost Survey Technical Report

posted on the Medicare Outpatient Prospective Payment System (OPPS) Drug Acquisition Cost Survey website.[125] We solicited comment on our process for how we evaluated ODACS data to determine the magnitude of the margins between hospitals' survey-reported acquisition costs and ASP-based Medicare payment amounts.

We received public comments on the application of population weight adjustment and calculation of confidence intervals to assess statistical validity. The following is a summary of the comments we received and our responses.

Comment: One comment noted that the quarterly ASP payment rate fluctuates across quarters. While CMS accounted for this fluctuation by publishing results comparing acquisition costs to both the mean and median ASP payment rate across the four quarters of the ODACS study period, this commenter suggests that a volume-weighted mean ASP would be a better comparison for scenarios when purchase volume is not evenly distributed across quarters.

Response: CMS thanks the commenter for raising this consideration. CMS did not volume-weight the mean ASP payment rate for two key reasons. First, the ASP payment rates for most drugs did not vary substantially across the quarters in the study period, so volume-weighting was not needed to make the mean ASP an appropriate measure. Additionally, drugs may not be acquired in the same quarter as they are administered, leading to potential misalignment between hospitals' acquisition cost and the applicable ASP payment rate. Still, CMS did perform additional analyses comparing reported acquisitions costs to the minimum, or lowest, payment rate published for each HCPCS during the study period in order to construct lower bound estimates of the margin between ASP and hospitals' acquisition costs. These analyses revealed only a small impact on the aggregate margins.[126] Thus, CMS proceeded with

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[125] *https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient-pps/outpatient-prospective-payment-system-opps-drug-acquisition-cost-survey.*

[126] Comparing against the minimum ASP rather than the mean ASP yields an overall 340B margin of 31.8 percent instead 33.4 percent.

comparisons to the mean ASP as more representative of average payment rate during the study period.

Comment: Some commenters took issue with CMS's selected methodology to weight each drug's ASP by the total number of NDC units reported by all respondents. A commenter stated that because NDCs reported in higher volume have a greater impact on aggregate acquisition cost margins, these margins would be biased if respondents do not reflect the overall survey-eligible population. Another commenter compared the selected methodology with an alternate approach that CMS considered to weight by OPPS claims volume, contending that the latter is more appropriate because it would better reflect the services that would be impacted by the proposed 340B-acquired drug payment change. Commenters noted that the two methodologies yielded slightly different aggregate acquisition cost margin results and contended that CMS had arbitrarily chosen to weight by survey-reported unit volume without sufficient justification.

Response: CMS is unpersuaded by arguments that volume-weighting by survey-reported unit volume is inappropriate. Rather, this approach ensured that the ASPs for NDCs that represented a larger share of total survey-reported purchasing activity were proportionally represented in the estimated acquisition cost margins. Of key importance is the fact that hospitals' acquisition cost survey data captures all outpatient drug purchases, making weighting by survey volume necessary for internal consistency, whereas volume-weighting by OPPS unit volume only reflects Medicare FFS drug utilization. Additionally, there can be time lags between when a hospital purchased a drug and when it is administered, which would lead to misalignments between survey-reported unit volume for drugs purchased during the surveyed time period and OPPS claims volume for drugs billed during the surveyed time period. Accordingly, CMS believes that the selected volume-weighting method should consider all reported utilization volume, not just that for Medicare FFS beneficiaries, and ensure alignment with the surveyed time period to enable fair comparisons between survey-reported acquisitions

and equivalent Medicare payment amounts. CMS does not find it problematic that the acquisition cost margins differ slightly between weighting methodologies. Slight divergences are to be expected given that unit volume is not identical between survey responses and billed claims for the two reasons listed above, and CMS believes that the merits of selecting the survey-reported unit volume weighting approach have been sufficiently justified. Finally, CMS refers readers to the discussion of representativeness analyses in section V.B.8.c. of this final rule with comment period to address concerns regarding potential respondent bias related to drug utilization volume.

Comment: Some commenters requested additional information and rationale regarding the selected outlier trimming methodology, noting that this methodological decision has significant impacts on the resulting acquisition cost margins. A commenter requested that CMS publish acquisition cost margins calculated before outliers were removed to better understand the impacts of the outlier trimming approach. Another commenter contended that using the geometric mean outlier trimming approach was inappropriate for these data and would result in only high outliers being removed while retaining low outliers in cases where three standard deviations below the mean is less than $0, thereby driving down the calculated acquisition cost margins. This comment suggested that CMS should have considered winsorizing these outlier observations instead of trimming them.

Response: CMS selected the geometric mean trimming approach to be consistent with our standard methodology for processing extreme outliers to develop policy under the OPPS.[127] This outlier identification was performed separately for 340B and non-340B drug acquisitions of each NDC, producing tailored outlier thresholds based on the unique data distribution for each drug through each purchasing channel. While CMS also considered the Tukey interquartile range (IQR) method as an alternate approach to trim outliers, we chose not to adopt it for reasons

[127] "Medicare CY 2026 Outpatient Prospective Payment System (OPPS) Final Rule Claims Accounting," *CMS*, accessed June 16, 2026, *https://www.cms.gov/files/document/2026-nfrm-opps-claims-accounting.pdf*.

outlined in Section 3.4.1 of the ODACS Technical Report. CMS also notes that the majority of outliers, approximately 82 percent, identified and removed through the selected outlier trimming methodology were non-340B purchases. Due to the clustering of reported 340B acquisition costs at or closely below ceiling price, far fewer 340B responses were identified and trimmed as outliers.

When including survey responses that were identified as geometric mean outliers (while still applying all five data exclusions enumerated in Section 3.3 of the ODACS Technical Report), the calculated acquisition cost margin for 340B-acquired drugs was ASP minus 35.9 percent when compared to both the mean and median ASP and for non-340B drugs was ASP minus 0.2 percent (mean ASP) or ASP minus 0.1 percent (median ASP). In other words, the aggregate acquisition cost margin for both 340B and non-340B drugs was slightly lower with outliers retained, contrary to commenter's hypothesis. This indicates that, in aggregate, the geometric mean trimming method did not systematically remove only high outliers; on the contrary, including these outliers would have suggested that hospitals' acquisition costs are even lower than Medicare payment rates. CMS thanks the commenter for their suggestion of winsorizing outliers and may consider this approach in any future survey analyses, as applicable.

TABLE 73: Acquisition Cost Margins With and Without Geometric Mean Outliers Included

Aggregate Margin Calculations: Methodology Specifications	Non-340B Drugs		340B Drugs	
	Mean ASP Margin	Median ASP Margin	Mean ASP Margin	Median ASP Margin
Geometric Mean Outliers Included	–0.2%	–0.1%	–35.9%	–35.9%
Geometric Mean Outliers Removed	+2.7%	+2.8%	–33.4%	–33.4%

Comment: Multiple commenters indicated that there are scenarios in which covered entities' acquisition costs for 340B drugs may exceed the published ceiling price (e.g., obtaining products during drug shortages or supply chain disruptions when 340B inventory is unavailable; drugs purchased at WAC price before 340B replenishment). Thus, these commenters contend

that survey responses above the ceiling price should have been retained in the 340B margin calculations.

Response: CMS appreciates the additional context discussed in these comments. CMS notes that any such acquisitions that were ultimately acquired through non-340B channels should have been reported as non-340B purchases in the survey data. Additionally, drugs initially purchased at WAC price should have had their acquisition costs reported post-340B replenishment, with all adjustments to comply with ceiling pricing already factored in. That said, in the event that these purchases were still reported as 340B acquisitions with costs exceeding the ceiling price, CMS conducted sensitivity analyses to assess the impact of retaining these observations. These results showed only a small impact, less than 2 percent, on the observed margins. Still, given the likelihood that responses above the ceiling price were not reported in accordance with survey guidance, CMS proceeded with excluding these observations.

Comment: One commenter requested more information regarding CMS's exclusion of certain clotting factor and respiratory therapy NDCs because CMS identified a subset of survey records for these NDCs were reported in IU or MG rather than NDC package units. The commenter requested CMS to clarify how these records were identified, how many records were reported in IU or MG units out of all records received for those NDCs, and whether conversion of IU or MG figures into NDC package units was considered as an alternative to exclusion. Finally, the commenter contended that the exclusion of these drugs meant that CMS was unable to determine acquisition cost estimates for the affected NDCs.

Response: CMS identified survey records as reported in IU or MG units by comparing each record's average acquisition cost to the average ASP and maximum ceiling price (reported in IU or MG) and average adjusted ASP (adjusted for NDC package size using an NDC-HCPCS conversion factor) for the NDC. As stated in Section 3.3.5 of the ODACS Technical Report, survey records reported in IU or MG units also displayed extremely high unit counts relative to

their acquisition costs, which is to be expected given that hundreds – or even thousands – of IU or MG units are contained in one NDC package.

Between one-quarter and one-third of total survey records for these NDCs were identified as reported in IU or MG units; in many cases, the same hospital reported in IU/MG for multiple affected NDCs. These percentages were high enough that IU- and MG-based records were unable to be comprehensively detected as outliers using either of the two tested outlier methodologies. As such, including these NDCs in acquisition cost calculations (while applying all other data exclusions enumerated in Section 3.3 of the ODACS Technical Report and trimming geometric mean outliers) yielded a substantially lower aggregate 340B acquisition cost of ASP minus 55.3 percent. This is due to the substantial distortions in per-unit costs for IU/MG-reported survey records.

CMS tested the impact of fixing the IU/MG records by converting their units to NDC package units. With this adjustment, the 340B margin remained ASP minus 33.4 percent and the non-340B margin slightly lowered to ASP plus 2.6 percent (instead of ASP plus 2.7 percent). Margins with affected NDCs adjusted were very similar to the margins with affected NDCs removed because converting the IU/MG units to NDC package units greatly reduced their reported unit volume, so their margins had much less impact on the volume-weighted aggregate calculation. As such, CMS was in fact able to produce acquisition cost estimates including these NDCs.

However, CMS ultimately chose to not pursue this approach given our overarching objective to not alter hospital-submitted data. CMS was also unable to conduct outreach to hospitals submitting affected data given limited time and resources, particularly because a large number of entities did not submit their response until the end of the data collection period.

Comment: Some commenters felt that the proposed rule's analyses showing ceiling prices to be 28.0 percent below ASP overall introduced uncertainty regarding the main analyses comparing hospital-reported acquisition costs and ASP, particularly when they compared this

percentage with the proposed ASP adjustment of ASP minus 33.4 percent. They requested further explanation for the difference between these two percentages.

Response: CMS believes these comments reflect a misunderstanding of what the ceiling price represents, as it is logical and expected that the results comparing ceiling price to ASP differ from results comparing hospital-reported 340B acquisition cost to ASP. The ceiling price is the maximum amount that covered entities can be required to pay by manufacturers, but hospitals are able to acquire drugs for less than the ceiling amount, and often reported doing so in the survey data. This is why the 340B acquisition cost data shows a larger percentage discount relative to ASP than the ceiling price data.

Comment: Several commenters expressed concerns with what they characterized as differential interpretation and treatment of the 340B and non-340B data received from hospitals via the ODACS. They requested clarity on why CMS is choosing to take action on payment rates impacting 340B covered entities while stating that more data and analysis are necessary before proposing any policy changes to payment rates affecting non-340B hospitals. A commenter noted that since CMS is proposing to vary payment rates based on hospital group, it must determine not only acquisition costs for the 340B hospital group but also how those compare to the relative acquisition costs for the non-340B hospital group.

Response: CMS analyzed the data received for 340B and non-340B drugs using identical methodological approaches. What differed, however, were the results obtained from these analyses.

TABLE 74: Comparison of Unadjusted to IPW-Adjusted Acquisition Cost Margins and CIs for 340B and Non-340B Drugs

Aggregate Margin Calculations: Methodology Specifications	Non-340B Drugs			340B Drugs		
	Mean ASP Margin	95% CI Lower Limit	95% CI Upper Limit	Mean ASP Margin	95% CI Lower Limit	95% CI Upper Limit
Unadjusted	+2.7%	–3.8%	+6.9%	–33.4%	–34.7%	–32.3%
IPW-Adjusted	+2.8%	–1.6%	+6.5%	–33.1%	–34.3%	–32.1%

The acquisition cost margin calculated for 340B drugs of ASP minus 33.4 percent displayed a clear and substantial difference from the existing payment rate of ASP plus 6 percent. This finding was strengthened after calculating IPW-adjusted margins and 95 percent CIs for both the unadjusted and IPW-adjusted point estimates. Across both methodologies, 340B margins ranged from ASP minus 34.7 percent to ASP minus 32.1 percent, a narrow range spanning only 2.6 percentage points. The narrow CIs for 340B-acquired drugs support the statistical validity of the survey results on 340B drugs and underscore the stark difference between hospital-reported acquisition costs and current Medicare payment policy.

On the contrary, the acquisition cost margin calculated for non-340B drugs of ASP plus 2.7 percent was only slightly below the existing ASP plus 6 percent payment rate. CMS notes that this is consistent with GAO's findings in 2004 and 2005, which found average purchase prices for drugs in their survey to equal roughly ASP plus 3 percent. The data are not conclusive enough for CMS to take policy action at this time regarding non-340B-acquired drugs. The data must be analyzed further by CMS, including the addition of GPO discounts, and CMS seeks more information to understand whether hospital acquisition costs for drugs purchased outside the 340B Program differ notably from the existing ASP plus 6 percent payment rate.

340B covered entities may, and often do, acquire drugs outside of the 340B Program, and these acquisitions would continue to be paid at the ASP plus 6 percent rate in recognition of the fact that 340B covered entities cannot access the 340B discount price for those purchases.

Comment: Some commenters noted that the proposed rule did not discuss the impact of "penny pricing" scenarios, in which manufacturers are required to sell 340B drugs to covered entities at a price of $0.01, on the aggregate survey results. Comments expressed concern that including these observations would exert a substantial downward influence on the observed margins.

Response: Very few survey responses (approximately 0.5 percent of received records) were submitted to ODACS that reported acquisitions of apparently penny-priced drugs. This is

somewhat of a departure from the 340B drug acquisition cost survey conducted in 2020, which received more responses indicating penny-priced acquisition, therefore necessitating dedicated methodological specifications to analyze these observations. CMS did not explicitly exclude these responses from ODACS in the interest of retaining the largest amount of available data. However, sensitivity analyses that excluded penny-priced drugs showed minimal impact on the final 340B margin. Therefore, in the interest of retaining a maximally large dataset, CMS proceeded with results derived with these observations included.

Comment: A couple commenters raised concerns that respondents may have differentially interpreted how to report financial concessions that could not be reasonably attributed to a specific NDC, leading to some hospitals including a particular rebate or discount into their NDC-level acquisition costs and other hospitals reporting the same type of rebate entirely in the separate Price Concessions field of the ODACS module. Commenters contended that this would produce inconsistencies in acquisition costs across respondents such that they could not be comparable, and that these issues would have a larger impact on non-340B hospitals because most 340B hospitals subject to the proposed policy change have historically been prohibited from using GPOs. Finally, one commenter stated that GAO's previous survey analysis found that hospitals were unable to report accurately or comprehensively on such rebates.

Response: CMS acknowledges the complexity and room for interpretation associated with reporting aggregate (i.e., non-NDC-specific) price concessions, including those obtained through participation in a GPO. After consulting subject matter experts on GPOs, additional consideration is needed to assess how best to apply the reported numbers; however, all approaches considered would have lowered the final estimated average acquisition cost given that the reported GPO data would have applied an additional discount to hospitals' reported acquisition costs. However, given that the ASP minus 33.4 percent policy change applies only to 340B-acquired drugs and most 340B hospitals subject to the proposed policy change have

historically been subject to restrictions regarding GPO participation, concerns over the consistency and comparability of hospital-reported aggregate GPO discount amounts do not meaningfully impact CMS's policy decision on payment for 340B-acquired drugs. These important nuances raised by commenters are one reason why CMS has elected to not advance policy changes to non-340B-acquired drugs at this current time and will continue to assess how to appropriately analyze and include GPO discounts for non-340B drug purchases.

Comment: Commenters brought up a variety of factors, both related to the survey design and external influences, that they state may have impacted the validity of the received data and its applicability to inform Part B drug policymaking. First, commenters mentioned that several drugs included in ODACS were in shortage and/or experienced supply chain challenges during the surveyed time period of July 1, 2024 to June 30, 2025; according to these commenters, these disruptions may have influenced acquisition costs, product mix, and purchasing behavior in ways that do not reflect normal market conditions. Second, commenters contended that the one-year survey time period may be insufficient to comprehensively capture hospitals' acquisition costs and does not account for year-to-year variation in acquisitions; in their view, analyzing data from additional years would provide a more robust basis for refining Part B drug payment policy. Third, commenters raised concerns that because the collected data reflect a historical period (i.e., July 1, 2024 to June 30, 2025), their applicability to the current and future Federal drug-pricing landscape is limited given continued evolution in policymaking (e.g., the forthcoming implementation of negotiated Maximum Fair Prices for selected Part B drugs and ongoing consideration of alternative mechanisms for effectuating 340B ceiling prices) and the impact of these developments on hospitals' financial environment.

Response: CMS notes that all survey analyses inherently represent a point-in-time estimate based on when data were collected. Lengthening the surveyed time period would have increased the administrative burden for hospitals to complete the survey, given increased time necessary to review their purchasing records and aggregate data. Additionally, drugs may

experience shortage or supply chain interruptions in any year and the Federal drug policymaking landscape is in continuous evolution, making it impossible to designate a particular time period as "normal" or baseline market conditions against which to form comparisons. CMS notes that the surveyed time period of one year (July 1, 2024 to June 30, 2025) aligns with the GAO-selected time period of one year (July 1, 2003 to June 30, 2004).

Comment: Some commenters pointed to CMS's discussion of the five exclusions applied to remove anomalous or duplicative survey records as evidence that the received data were low quality. A commenter specifically cited that 8.9 percent of all received records were excluded due to these criteria, alleging that this represented a large share of total records.

Response: Records that were excluded due to meeting at least one of the five criteria listed in Section 3.3 of the ODACS Technical Report do not necessarily represent inaccurate or low-quality data. In many cases, these records reflect drug- and context-specific misunderstandings of or misalignments with the exact survey design rather than being indicative of larger data quality issues. CMS refers readers to Section 3.3 of the ODACS Technical Report for discussion of each situation and possible explanations underlying these observed anomalies. For the exclusion described in section 3.3.5 specifically, CMS notes that not all responses for affected clotting factor and respiratory therapy NDCs displayed the unit-misalignment issue, but were removed to avoid potential selection bias from specifically excluding those survey records with units reported in IU or MG; therefore, this exclusion removes more than just records featuring the anomaly. Nevertheless, CMS elected to remove records in these five exclusion criteria to promote data alignment with the stated survey design and ensure consistency in analyzing the data.

These five specific exclusions, associated with likely misunderstandings of the exact survey design, resulted in exclusions that only composed a small share of total records. After applying these data restrictions, 146,117 records remained, 91.1 percent of the original records received, with which CMS calculated acquisition cost margins. Moreover, these 146,117 records

detail the acquisition cost of drugs that comprise approximately 97 percent of payment for survey-relevant outpatient drugs from July 1, 2024 to June 30, 2025. Compared to this preponderance of data retained, these five data restrictions excluded a small share of total records.

Comment: Many commenters requested additional detail on CMS's methodology (including outlier identification and weighting), sensitivity analyses, representativeness of the survey data, and IPW model specifications. Numerous commenters also requested the release of the survey instrument and data collected, with or without anonymization applied.

Response: Hospitals were assured that their acquisition cost data would remain confidential as part of the ODACS data collection and analysis process, and this protection will be honored. Publishing de-identified survey data with anonymized hospital characteristics appended still presents an immense confidentiality risk due to the small number of respondent hospitals identified in multiple specific categories (e.g., rural hospitals in specific Census regions). For details on methodology and results, CMS refers commenters to the ODACS Technical Report. Further, CMS has provided additional detail on methods and analysis results in comment response throughout this final rule with comment period.

C. CY 2027 OPPS Payment Methodology for 340B Purchased Drugs Based on Survey Results

As described previously, section 1833(t)(14)(D)(ii) of the Act requires the Secretary to conduct periodic surveys to determine the hospital acquisition cost for each SCOD for use in setting the payment rates for SCODs under section 1833(t)(14)(A) of the Act. Section 1833(t)(14)(A)(iii)(I) of the Act provides that the payment amount for a SCOD for a year is equal to the average acquisition cost for the drug (which at the option of the Secretary, may vary by hospital group) as determined by the Secretary, taking into account the survey data collected under subparagraph (D) of section 1833(t)(14) of the Act. Based on our analysis of the survey data, the most immediately evident and significant difference found between Medicare payment and acquisition cost was for 340B drugs acquired by 340B-participating hospitals, where the

selected methodology shows that aggregate acquisition costs were approximately ASP minus 33.4 percent. This indicates average acquisition costs that were 37.2 percent lower than the general OPPS payment rate (ASP plus six percent). These results clearly demonstrate that ASP plus 6 percent is not an appropriate payment proxy for hospitals that acquire drugs through the 340B Program. Consequently, we proposed to adjust the OPPS payment policy for 340B drugs to better align payment with the acquisition costs demonstrated by the survey. Specifically, for CY 2027, we proposed to pay for drugs acquired under the 340B Program at ASP minus 33.4 percent.

Conversely, for non-340B drugs, after taking into account the survey data, we proposed to maintain the current payment rate, which is generally ASP plus 6 percent, under the authority at section 1833(t)(14)(A)(iii)(I) of the Act. As displayed in Table 67, the heterogeneity in acquisition costs for non-340B drugs is slightly greater than for 340B drugs; this variation has led us to believe this area warrants additional analysis by CMS and input from interested parties. The results of the survey for non-340B drugs generally indicate lower acquisition costs than current OPPS payment; however, the discrepancy is not as clear and significant as with 340B drugs. Therefore, we are continuing to analyze the data from this survey, aligning those reported costs with hospital claims billing patterns, to see if any additional significant trends exist that merit further adjustments to OPPS payment policy in future years. We are also assessing billing patterns among those hospitals that did not respond. Finally, we collected and analyzed information on non-NDC-specific GPO discounts that hospitals receive and are still considering how these discounts could be factored into future analysis and policymaking. We will consider these issues for future rulemaking.

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: Many commenters supported our proposal to pay for 340B-acquired drugs at ASP minus 33.4 percent based on the survey results. These commenters stated that aligning the

340B payment rate more closely with hospitals' actual acquisition costs, as reflected by the survey data, would improve the accuracy of Medicare payment, reduce incentives to choose more expensive drugs or shift drug administration to higher-cost settings, promote transparency and accountability, direct statutorily-required budget-neutral savings toward non-drug OPPS services and help ensure beneficiaries share in the value of 340B discounts through lower cost sharing. A commenter stated that CMS's findings are consistent with analyses from the Medicare Payment Advisory Commission (MedPAC) and the U.S. Department of Health and Human Services Office of Inspector General (HHS OIG) showing that Medicare payments for 340B-acquired drugs have substantially exceeded 340B drug acquisition costs. A commenter endorsed the proposal on the basis that it is a reasonable and overdue correction to the way Medicare pays hospitals for administering drugs. Another commenter stated that this policy reflects that Federal payment rates should rest on evidence of what something actually costs. A commenter stated that the survey made evident that the acquisition cost for SCODs through the 340B Program is far lower than the statutory default rate of ASP plus six percent and that with this clear survey data, CMS is required to set payment based on the average acquisition cost for 340B-acquired drugs. Citing our example of a beneficiary's coinsurance alone exceeding the entire price the hospital paid for the drug, many commenters emphasized the positive effect the proposed policy would have in reducing beneficiary drug copayments due to those copayments being calculated based on the amount Medicare pays the hospital rather than the hospital's acquisition cost for the drug.

Response: We thank commenters for their support.

Comments: Many of these commenters additionally provided criticisms of the 340B Program generally and proposed various reforms for CMS to consider to address those criticisms.

Response: We note feedback related to 340B Program policies are outside the scope of the proposed rule and are not addressed in this final rule with comment period. However, we

thank the commenters for their insights and concerns.

Comment: A few commenters commented on our observation in the proposed rule (91 FR 41880) that we received a number of letters in response to the survey, many of which appeared to be coordinated form letters, from eligible hospitals indicating that they would not be providing their acquisition data and explaining their reasons for not doing so. A commenter stated that they supported our proposed payment policy, despite what the commenter believes was a concerted effort to obstruct the survey. Another commenter challenged our observation that we received a number of responses, many of which appeared to be coordinated form letters, from eligible hospitals indicating that they would not be providing their acquisition data and explaining their reasons for not doing so. The commenter stated that there is no proof of coordinated non-response among 340B-participating hospitals.

Response: We disagree that there is no proof of a coordinated response. The hundreds of nearly identical letters and email templates themselves supply evidence of such coordination. We find it highly unlikely that hundreds of hospitals would independently submit letters informing us that they would not be providing their acquisition cost data and explaining their alleged reasons for not doing so using identical or nearly identical language. The record also reflects that several large law firms publicly promoted such a strategy.[128]

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[128] *See* K&L Gates LLP, *The 2026 OPPS Final Rule: Hospitals Now at a Decision Point Regarding Drug Acquisition Cost Survey* (Dec. 1, 2025) (advising that hospitals should consider "[r]espond[ing] to the survey only to state that the hospitals' costs are not minimal, but that the hardships in responding preclude the full response CMS is seeking"), *https://www.klgates.com/thought-leadership/The-2026-OPPS-Final-Rule-Hospitals-Now-at-a-Decision-Point-Regarding-Drug-Acquisition-Cost-Survey-12-1-2025*; McDermott Will & Schulte LLP, *Strategic Defenses and the "Silence Option" in the CY 2026 OPPS Drug Cost Survey* (Dec. 16, 2025) (advising that "[c]onsultation with legal counsel may be helpful in making the decision whether to report some or all drug acquisition cost data in response to the CMS survey"), *https://www.mcdermottlaw.com/insights/strategic-defenses-and-the-silence-option-in-the-cy-2026-opps-drug-cost-survey/*; K&L Gates LLP, *The 2026 OPPS Drug Acquisition Cost Survey: Additional Considerations as Deadline Nears* (Mar. 6, 2026) (advising that "for any entity not responding [to the survey], it should consider filing a submission to CMS that states that the burden to obtain and present the requested data is far larger than CMS had estimated"), *https://www.klgates.com/thought-leadership/The-2026-OPPS-Drug-Acquisition-Cost-Survey-Additional-Considerations-as-Deadline-Nears-3-9-2026*; K&L Gates LLP, *The 2026 OPPS Drug Acquisition Cost Survey: Response Deadline Extended* (Mar. 25, 2026) (advising that "if large numbers of hospitals do not respond to the survey request, then CMS, by statute, will not be able to use its results to cut reimbursement to 340B-covered entities"), *https://www.klgates.com/thought-leadership/The-2026-OPPS-Drug-Acquisition-Cost-Survey-Response-Deadline-Extended-3-25-2026*; *see also* Ganny Belloni, *Hospitals Rebuff HHS's Request to Survey Drug Acquisition Costs*, Bloomberg Law (Apr. 22, 2026) (quoting a K&L Gates LLP partner as stating that "CMS truly got an anemic response [to the survey] . . . . If CMS does move forward and the response is as low as some of

Additionally, shortly after the survey first launched, several major hospital associations purporting to represent more than 3,000 hospitals paid under OPPS jointly issued a widely publicized letter to CMS claiming that it was wrong of CMS to tell hospitals they "are to" respond to the survey.[129] CMS made this requirement clear by publishing in numerous places throughout the CY 2026 OPPS/ASC proposed and final rule, the OMB-approved PRA package, and educational materials that the survey was required of hospitals. These hospital associations made no known attempt to help their member hospitals complete the survey and fulfil their statutory obligation; rather, the record reflects that these hospital associations cast doubt on the requirement for survey participation and encouraged non-compliance among their member hospitals. These same hospital associations now criticize the response rate to the survey, incorrectly claiming that not enough hospitals responded for CMS to make the necessary, statutory payment determinations.

Comment: Many commenters stated that the payment reductions would threaten their ability to continue providing services, particularly to low-income, uninsured, under-insured, geographically isolated, medically complex and other vulnerable patients. Many commenters stated that the effect of the payment reductions and corresponding budget neutrality increase would be to subsidize for-profit hospitals at the expense of 340B hospitals and the vulnerable populations they serve.

Response: We are not persuaded that more closely aligning our payment amounts for 340B-acquired drugs with their acquisition costs would threaten 340B hospitals' ability to continue to provide services to vulnerable patients or would constitute a subsidization of for-profit hospitals at the expense of 340B hospitals and those patients. Although 340B hospitals would receive reduced payment for 340B drugs, they would also receive the same percentage

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us think it is, then it's going to be a battle of statisticians in court"), *https://www.bloomberglaw.com/product/blaw/bloomberglawnews/bloomberg-law-news/XLG9V0G000000.*

[129] Press Release, Am. Hosp. Ass'n, et al., *AHA, other groups: It's wrong to tell hospitals they 'are to' complete drug acquisition cost survey* (Jan. 12, 2026), *https://www.aha.org/news/headline/2026-01-12-aha-other-groups-its-wrong-tell-hospitals-they-are-complete-drug-acquisition-cost-survey*; *see also* Belloni, *Hospitals Rebuff HHS's Request to Survey Drug Acquisition Costs* (discussing associations' joint letter to CMS).

increase to payments for non-drug items and services as non-340B hospitals. Further, this policy ensures that the reduced drug costs, and associated reduced drug cost sharing obligations, are passed directly to the beneficiaries that these hospitals serve. We acknowledge that some hospitals will potentially experience greater reductions to drug payments than increases to non-drug items and services as a consequence of our policy. However, that does not change our statutory obligation under section 1833(t)(14) of the Act to conduct a survey of drug acquisition costs and adjust payment rates taking those costs into account.

Comment: Many commenters stated that the proposed reduction was contrary to the Congressional intent behind the 340B program, which was designed to enable covered entities to stretch scarce Federal resources as far as possible to provide services to low-income and uninsured patients. Many commenters also stated that CMS had failed to account for the effect of the proposal on 340B hospitals and that failure renders the proposed policy arbitrary and capricious.

Response: We disagree that we have failed to account for the effect of the proposal in formulating and proposing our policy, and we do not agree with commenters that our proposed policy is contrary to the Congressional intent behind the 340B program. We are fulfilling our statutory obligation under section 1833(t)(14) of the Act to periodically conduct a survey of hospital acquisition costs and use the resulting data to inform payment rates. The purpose of the proposed policy is to better align our payment amounts for 340B-acquired drugs with their actual acquisition costs as demonstrated by the survey.

Comment: Many commenters expressed concern about the combined economic effect of the 340B drug payment proposal, the remedy proposal and the expansion of the volume control method. Many of these commenters cited the millions of dollars they expected to lose as a result of these policies. These commenters urged CMS not to view these proposals in isolation but to evaluate their cumulative effect. Many of these commenters additionally referenced “severe financial headwinds” that they are experiencing due to a variety of past and impending economic

factors.

Response: We recognize that the cumulative economic effect of the policies we are proposing for CY 2027, along with the financial circumstances hospitals have faced over the past few years, may be significant for some hospitals. However, we believe these effects must be balanced against the windfalls hospitals received previously that we are statutorily obligated and/or have the discretion to recover, our obligations under section 1833(t)(14) of the Act to periodically conduct surveys of hospitals' drug acquisition costs and take that data into account in setting payment rates, and our responsibility to adopt methods to control unnecessary increases in the volume of covered OPD services.

Comment: Many commenters urged us to delay or phase-in (or both) the implementation of the proposal. Commenters suggested that delaying implementation would provide additional time for CMS to conduct a more complete hospital-level impact analysis of the combined effect of the 340B drug payment proposal, the remedy proposal and the site neutral proposal and other OPPS payment changes. Another commenter suggested that CMS could use the delay to establish a limit on how much money hospitals could lose if they rely heavily on 340B drugs and develop a methodology that would ensure a more equitable distribution of the savings resulting from the proposed payment reduction. Commenters also noted that an implementation delay would provide interested parties with additional time to comment on the payment proposal and underlying survey. Commenters that recommended phasing-in the payment policy recommended that we do so over multiple years and stated that it would allow hospitals and CMS to evaluate the actual effects on access, service availability, beneficiary cost sharing, and hospital financial stability before the full reduction takes effect. Commenters also stated that it would give hospitals time to adapt to the financial impact of the policy and help avoid abrupt disruptions to patient services.

Response: We understand commenters' emphasis on taking a measured approach to implementing the proposal. However, we believe that the payment misalignment that our

proposed policy will address has been in effect for many years and it is important to implement this policy now that we have conducted the required survey and have data clearly demonstrating that the existing payment rate for 340B-acquired drugs is not even close to a representative proxy for the cost of their acquisition. Given the extent of the payment misalignment identified by the survey results and the length of time the misalignment has likely been in place, we think that delaying or phasing-in the changes would be inconsistent with our obligations under section 1833(t)(14) of the Act and our goal of ensuring that Medicare and Medicare beneficiaries are paying for drugs commensurate with the cost of their acquisition.

Comment: Many commenters opposed the proposal on the grounds that it would establish a dangerous precedent that non-Medicare payers might follow. These commenters stressed that Medicare payment policies often influence other entities, such as Medicaid or commercial payers, to "piggyback" off CMS' payment decisions. These commenters expressed concern that this would fundamentally undermine the purpose and effectiveness of the 340B program to financially assist hospitals that serve a high volume of low-income patients.

Response: We do not have control over how our proposed policy might influence other non-CMS payers in the future. What those other payers may or may not do in the future would not be a valid reason for us to refrain from better aligning OPPS payment for 340B-acquired drugs with their acquisition costs as demonstrated by the survey, consistent with section 1833(t)(14)(iii)(I) of the Act.

Comment: Several commenters expressed concern about the indirect implications of the proposal to pay ASP minus 33.4 percent for 340B-acquired drugs for providers that contract with Medicare Advantage (MA) organizations. Commenters stated that MA organizations and private PBMs will cite these OPPS rate reductions as justification to impose their own cuts for 340B drugs, further weakening the ability to utilize 340B savings. Commenters urged CMS to clarify that the proposed payment methodology of ASP minus 33.4 percent, including any downstream budget neutral impacts, is Original Medicare (OM) payment policy and does not itself establish,

require or permit a corresponding payment reduction under MA contracts.

Response: We appreciate feedback on this issue. CMS establishes payment policies and payment rates for services payable under OM through a separate, distinct process that is not directly related to terms of private contracting arrangements between MA organizations and providers. Further, section 1854(a)(6)(B)(iii) of the Act prohibits CMS from requiring an MA organization to contract with a particular hospital, physician, or other entity to furnish items and services, including 340B-acquired drugs, or requiring a particular price structure for payment under such a contract. Providers and MA organizations may engage in dispute resolution under existing contracts and any contract negotiations or re-negotiations independently of CMS. MAOs must pay non-contract providers or facilities for services and items at least the amount they would have received under OM payment rules, in accordance with section 1852(a)(2) of the Act.

1. Statistically Significant Estimate

Under section 1833(t)(14)(D)(iii) of the Act, the periodic surveys conducted by the Secretary under section 1833(t)(14)(D)(ii) of the Act must "have a large sample of hospitals that is sufficient to generate a statistically significant estimate of the average hospital acquisition cost for each specified covered outpatient drug." Our survey results meet this standard, particularly because hospital acquisition cost is a price measure.[130] Reliable price measures require far less sampling than quantity or revenue measures because markets tend to compress this distribution of prices across transactions but do not compress the distribution of quantities or expenditures.[131] While hospital acquisition cost for a branded drug would not be exactly equal across hospitals in the 340B Program, it would not differ by a factor of 1000 and rarely even a factor of 2. Because

[130] Hospital acquisition cost is the price paid in a business-to-business market, particularly in transactions between hospitals and wholesalers or distributors. Unlike revenue, hospital acquisition cost is measured per unit quantity.
[131] With some exaggeration, this is known in economics as the "law of one price." The Chicago Price Theory textbook explains with more nuance that "[p]rice is sometimes easier to measure than quantity because price can be seen from a sample; just go to one of the sellers in the market — say, a grocery store — and look at their price for eggs. Quantity measurement can be more difficult — you have to ask every seller what they sold; you'd need some kind of census of sellers." (Sonia Jaffe, Robert Minton, Casey B. Mulligan and Kevin M. Murphy, *Chicago Price Theory*, 2019, p. 48).

the standard errors of the 340B-hospital sample mean and the non-340B-hospital sample mean are each proportional to the standard deviation of the underlying population, a compressed price distribution translates directly into small standard errors and high statistical significance.[132]

As discussed previously and shown in Table 74, the 95 percent confidence intervals for 340B drugs were relatively narrow, ranging from approximately 34.7 percent to 32.3 percent below ASP for the unadjusted margin and from approximately 34.3 percent to 32.1 percent below ASP for the IPW-adjusted margin. These results support the statistical validity of the estimated acquisition cost margins and indicate that the survey data provide reliable estimates of the acquisition cost discounts realized by 340B hospitals relative to ASP. These sampling requirements for price measurement are well known in national accounting. For example, the Department of Labor's Bureau of Labor Statistics measures prices for the Consumer Price Index (CPI) using about 100,000 commodity-and-service price observations per month, while the Producer Price Index (PPI) uses approximately 64,000 monthly price quotations from about 16,000 establishments.[133] These samples are tiny relative to the transactions they are designed to represent: the CPI commodity-and-service sample alone is less than 0.01 percent of such payments.[134]

In our efforts to obtain data from a statistically significant sample of hospitals paid under the OPPS, we initially included for survey participation 100 percent of OPPS hospitals. From this, we received replies from 53.3 percent of non-340B hospitals and 28.6 percent of 340B hospitals. These response rates are similar to past surveys of health care providers as determined

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[132] Weighting observations by volume shares, as the CMS sample does, further reduces standard errors and further increases statistical significance.

[133] Bureau of Labor Statistics, "Handbook of Methods: Consumer Price Index—Data Sources" (last modified Jan. 30, 2025), *https://www.bls.gov/opub/hom/cpi/data.htm* and Bureau of Labor Statistics, "Producer Price Index (PPI): Overview" (last modified Mar. 16, 2023), *https://www.bls.gov/ppi/overview.htm.*

[134] As a back-of-the-envelope denominator for 100,000 CPI observations, the Federal Reserve Bank of Atlanta's 2024 Survey and Diary of Consumer Payment Choice reports that U.S. consumers made 48 payments per consumer per month on average. Multiplying 267 million adults by 48 payments per month gives approximately 12.8 billion consumer payments per month. This is a conservative comparison for item-level CPI observations because a single consumer payment, such as a grocery receipt, may cover multiple items.

by a separate meta-analysis[135] and have resulted in sample sizes that show significant differences in acquisition costs between the two hospital categories.[136] While we applied data cleaning to exclude specific survey records with anomalous or implausible data, very few hospitals were excluded from our population: only 27 subunits that reported identical and duplicative data to their parent unit. Additionally, while we applied refinements to narrow the population of hospitals to only those who either responded to the survey or had OPPS claims for survey-relevant HCPCS codes, these refinements did not remove any hospital with relevant data from analysis. These efforts were undertaken to maintain the largest possible pool of hospitals and data to evaluate. It is our view based on efforts to sensitivity test the responses and reweight the findings that the conclusion of statistical difference in the average acquisition costs for 340B and non-340B hospitals would likely not change.

Comment: Multiple commenters concurred with CMS that the survey generated a statistically significant estimate. One commenter stated that:

> CMS opened the survey to all hospitals that received OPPS payments for outpatient drugs during the survey period. Because this survey was meant to determine hospital acquisition costs for outpatient drugs paid under OPPS, this is the correct universe. As explained in the survey, 3,147 entities were eligible to complete it. Of these, 1,343 (42.7%) submitted a response and 1,304 reported acquisitions of one of the surveyed drugs. While the statutory text "a large sample" has no objective meaning, nor does it have any statistical definition, expert judgment is called for to determine whether the CMS survey's sample would qualify. There are several reasons to believe it does. For one, this sample is larger than the original GAO survey conducted in 2005. In that survey, the original, official survey conducted as required by statute, only 1,157 hospitals responded. GAO determined that this sample was "reliable for estimating [Specified Covered Outpatient Drugs] prices." It went on to say that estimates of prices were more precise for drugs purchased by many hospitals. Further, the responding hospitals included hospitals across the relevant categories defined by GAO and frequently used in health care policy, such as teaching and non-teaching, urban and rural. Because each category was represented in the final sample, there was data CMS was able to use to transform the results such that they would match the population of hospitals, similar to how political polls feature weights such that they can reflect an entire voting population.

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[135] Vincent Maurice Meyer et al., "Global Overview of Response Rates in Patient and Health Care Professional Surveys in Surgery: A Systematic Review," Annuals of Surgery 275, no. 1 (January 2022): e75–e81, https://pubmed.ncbi.nlm.nih.gov/32649458/. The Meyer et al. meta-analysis found an average response rate of 53.3% (±24.5%) over 1,746 surveys of health care professionals.

[136] Vincent Maurice Meyer et al., "Global Overview of Response Rates in Patient and Health Care Professional Surveys in Surgery: A Systematic Review," *Annuals of Surgery* 275, no. 1 (January 2022): e75–e81, *https://pubmed.ncbi.nlm.nih.gov/32649458/.*

Another commenter stated that:

> CMS employed a census-based approach that sought information from all hospitals relevant to the proposed policy and ultimately obtained responses from a substantial number of hospitals, generating what [the commenter] understands to be the largest volume of acquisition cost data for hospital outpatient drugs ever collected in connection with the Medicare program. After applying appropriate data-cleaning and validation procedures, CMS used inverse probability weighting to account for differential response rates among hospital types and evaluated the resulting estimates using established statistical techniques. Importantly, the survey produced a narrow 95 percent confidence interval for the acquisition cost of 340B-acquired drugs, with estimates ranging only from ASP minus 32.3 percent to ASP minus 34.7 percent (a range of only 2.4 percentage points). CMS calculated these confidence intervals using 10,000 bootstrap replications, a sound and established statistical technique designed to assess the precision and reliability of survey estimates. The narrowness of this confidence interval confirms that the survey data are reliable and sufficiently precise for purposes of informing CMS's determination of the average acquisition cost of 340B-acquired drugs and implementing an acquisition-cost-based payment methodology. Moreover, CMS's approach to addressing nonrespondents likely results in a more conservative estimate of the discount associated with 340B-acquired drugs and therefore is favorable to 340B hospitals. CMS used inverse probability weighting to ensure that responding hospitals appropriately represented nonresponding hospitals in the overall population, a methodology that is widely accepted and that improved the representativeness of the final sample. To the extent that 340B hospitals with the lowest acquisition costs were less likely to respond, CMS's weighting methodology would tend to increase estimated acquisition costs for 340B-discounted drugs relative to the acquisition costs that might have been observed had all hospitals responded. Thus, if anything, the survey methodology is more likely to overstate average acquisition costs for 340B-acquired drugs than understate them. Taken together, the survey's large volume of data, rigorous weighting methodology, and narrow confidence intervals provide strong support for CMS's conclusion that the survey generated a statistically significant and reliable estimate of the average acquisition cost of 340B-acquired drugs.

Finally, a third commenter found the survey to be

> […]methodologically sound and has response rates that compare favorably to other drug cost surveys, such as the National Average Drug Acquisition Cost (NADAC) survey, which CMS has relied on for over a decade as the accepted benchmark for Medicaid fee-for-service pharmacy reimbursement. The ODACS identified 4,494 survey-eligible hospitals and all valid survey responses were used in the analysis. Of the initial population, 43.6 percent of hospitals submitted a response. This design and response profile appears robust when compared to NADAC. NADAC similarly collects voluntary, invoice-level net acquisition cost data from a random monthly sample of independent and chain retail community pharmacies but only 18-24 percent of surveyed pharmacies respond to the monthly survey request, a response rate below the 41.4 to 43.6 percent range achieved by the ODACS. The ODACS's methodology and point estimates provide compelling evidence for reducing 340B drug payment rates under OPPS.

Response: We thank commenters for their support. We concur with their assessment that our survey meets and exceeds the statutory standard.

Comment: Many commenters contended that CMS did not meet statutorily specified requirements to "conduct a survey . . . to determine the hospital acquisition cost for each specified covered outpatient drug" and raised concerns that the survey did not "have a large sample of hospitals that is sufficient to generate a statistically significant estimate of the average hospital acquisition cost for each specified covered outpatient drug." Commenters pointed to the fact that drugs for which fewer than 10 survey responses were received were dropped from the final margin calculations as evidence that CMS did not demonstrate that the survey sample was large enough to support statistically significant estimates of the average acquisition cost for each, individual outpatient drug.

Response: We disagree with the statement that the survey lacked adequate breadth and achieved an insufficient response rate to analyze the universe of specified covered outpatient drugs in a statistically significant manner. To the contrary, CMS fulfilled its statutory duties to request, collect, and analyze data for each specified covered outpatient drug. CMS gave nearly 4,500 hospitals the opportunity to submit their acquisition cost data for consideration. The survey included 1,843 NDCs for outpatient drugs and biological products, corresponding to 519 HCPCS codes. All but 10 drugs with nonzero outpatient claims utilization received at least one survey response. The drugs that received at least one survey response represent virtually all Medicare use and spending, comprising 99.9 percent of payment for survey-relevant outpatient drugs from July 1, 2024 to June 30, 2025. The fact that some low-volume drugs received fewer responses – consistent with their utilization patterns in practice – does not invalidate the data collected by the survey instrument or make it inapplicable for policymaking.

Commenters referenced the fact that outlier identification required the exclusion of drugs with fewer than 10 hospitals reporting acquisitions. While CMS excluded drugs that received fewer than 10 survey responses in the process of outlier identification, this enabled us to retain

the vast majority of HCPCS codes during this stage of analysis, particularly in the context of overall use and spending. Even with this restriction applied, we retained observations for drugs representing 93.8 percent of Medicare payment for survey-relevant outpatient drugs from July 1, 2024 to June 30, 2025. CMS also reiterates that outlier identification and trimming is only one aspect of the survey analysis process, and extensive analyses were performed upon the full population of data received.

Section 1833(t)(14)(D)(iii) of the Act requires that the survey have a "large sample of hospitals that is sufficient to generate a statistically significant estimate of the average hospital acquisition cost for each specified covered outpatient drug" but does not specify how this is to be determined. While GAO deemed a response rate of 1,000 out of 3,450 eligible hospitals would meet the requirement for a large sample when designing the initial surveys in 2004 and 2005, their assessment – specific to their survey design and constraints at the time – does not constitute a specific, authoritative response rate that all subsequent surveys must precisely meet. We reiterate that our survey design invited 100 percent of the 4,494 eligible hospitals to participate, and approximately 41 percent of the refined population of 3,147 hospitals reported acquiring surveyed drugs. Additionally, the volume of data collected overall through ODACS is substantially larger than what was collected in GAO's initial surveys: GAO only considered 53 non-radiopharmaceutical outpatient drug HCPCS codes in their surveys of hospitals' reported acquisition costs, a tenth of the number of Part B drug HCPCS codes that were analyzed through ODACS. As such, our survey greatly exceeds the comprehensiveness of GAO's survey in terms of included hospitals and drugs. Furthermore, as detailed in section V.B.8.b of this final rule, the data received in the CMS survey produced statistically significant results – particularly for 340B-acquired drugs – that are representative of the overall survey-eligible population as shown through the IPW and confidence interval analyses among other factors cited in this final rule. Detailed discussion of the statistical significance of the data collected through ODACS can be found in the ODACS Technical Report and elsewhere in this final rule.

2. Grouping Hospitals by 340B Covered Entity Status

Section 1833(t)(14)(A)(iii)(I) of the Act authorizes the Secretary to set the amount of payment for SCODs at an amount equal "to the average acquisition cost for the drug for that year (which, at the option of the Secretary, may vary by hospital group (as defined by the Secretary based on volume of covered OPD services or other relevant characteristics)), as determined by the Secretary taking into account the hospital acquisition cost survey data under subparagraph (D)."

In accordance with this authority, we proposed to vary the amount of payment for 340B-acquired drugs by the group of hospitals that are enrolled in the 340B Program as 340B covered entity hospitals because their drug acquisition costs vary significantly from those not enrolled in that program. The significant drug acquisition cost discounts that 340B covered entity hospitals receive for 340B-acquired drugs enable these hospitals to acquire drugs at much lower costs than non-340B hospitals incur for the same drugs. Accordingly, we proposed to use 340B covered entity status as a relevant characteristic to group hospitals for purposes of payment based on average acquisition cost under section 1833(t)(14)(A)(iii)(I) of the Act. Therefore, for 340B drugs acquired by 340B covered entity hospitals, we proposed changes to better align Medicare payment with average acquisition cost for the drug as specified in statute.

As discussed in more detail below, for drugs not acquired through the 340B Program, we proposed that 340B and non-340B hospitals would continue to receive payment at a payment rate that is generally ASP plus 6 percent.

We acknowledged (91 FR 41888) we could set a single payment rate for a drug for a hospital group (such as 340B hospitals) regardless of whether the drug was acquired through the 340B Program, but that does not align with our intent to more appropriately align payment with acquisition costs. As such, we are only applying the reduced payment rate to drugs acquired through the 340B Program by the hospital group defined as 340B hospitals, as this most appropriately aligns payment with acquisition cost of drugs of this hospital group. For non-340B

drugs acquired by 340B hospitals, we proposed that payment will not be adjusted. We sought comment on these proposals. Specifically, we sought comment on our proposal to use 340B covered entity status as a relevant characteristic to group hospitals for purposes of payment based on average acquisition cost under section 1833(t)(14)(A)(iii)(I) of the Act and our proposal to vary the amount of payment for 340B-acquired drugs by the group of hospitals that are enrolled in the 340B Program to more appropriately align payment with the average acquisition cost for the drug.

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: Many commenters supported our proposal to vary the amount of payment for 340B-acquired drugs by the group of hospitals that are enrolled in the 340B Program. These commenters stated that doing so would better align payment for these drugs with their acquisition cost, resulting in more accurate Medicare payment and reduced beneficiary copayment for these drugs.

Response: We thank the commenters for their support.

Comment: Many commenters stated that CMS lacks the authority under section 1833(t)(14)(A)(iii)(I) of the Act to vary payments by groups defined by 340B Program participation. These commenters characterized CMS' proposal to do so as arbitrary and capricious, contrary to the text of the Medicare statute, and not in accordance with 5 U.S.C. § 706(2)(A). These commenters recognized the Secretary's authority under section 1833(t)(14)(A)(iii)(I) to vary payment "by hospital group (as defined by the Secretary based on volume of covered OPD services or other relevant characteristics)" but stated that 340B status is not a relevant characteristic. They stated that 340B status is not a relevant characteristic because 340B Program participation designations are not CMS hospital groups, but rather determinations made by a separate agency unrelated to Medicare program considerations. They stated that the intent of Congress was never to include participation in the 340B Program, a Federal program

codified in another statute, the Public Health Service Act, as a characteristic that should be used to vary payment. One of these commenters stated that:

> If Congress intended 340B participation to be used as a factor to differentiate Medicare drug payment, it would have included it as one of the relevant characteristics in establishing the SCOD payment rate methodology, given that in passing the [Medicare Modernization Act] in 2003, the 340B program had already been in existence for over a decade. That is, Congress well knew that 340B hospitals had lower acquisition costs. Congress chose not to reference 340B in its SCOD reimbursement methodology but also took additional steps to ensure 340B prices do not affect Medicare reimbursement. It would be counterintuitive for Congress to enact a program that is intended to enable hospitals to purchase certain drugs at lower acquisition costs and realize savings through these discounts, only to completely eliminate the benefit of these discounts on Medicare drugs— a sizable portion of 340B hospitals' utilization—by allowing CMS to set their payment rate at 340B acquisition cost. In passing the 340B statute, Congress intended that the 340B program would function by allowing covered entities to purchase these drugs at lower costs and to retain the difference between reimbursement and the drug purchase price as a way to allow them to 'stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services.'

In support of their argument, the commenter pointed to the absence of 340B status on CMS enrollment forms, GAO reports from 2004 and 2005 in which the GAO did not include 340B participation as a relevant characteristic when examining differences in hospital acquisition costs, and Congress's exclusion of 340B prices from the calculation of ASP under section 1847A(c)(2)(A) of the Act.

Response: We do not agree that we lack the authority under section 1833(t)(14)(A)(iii)(I) of the Act to vary payments by groups defined by 340B Program participation. Section 1833(t)(14)(A)(iii)(I) of the Act authorizes the Secretary to establish appropriate Medicare OPPS payment rates for covered outpatient drugs equal to the average acquisition cost for the drug for that year (which, at the option of the Secretary, may vary by hospital group (as defined by the Secretary based on volume of covered OPD services or other relevant characteristics)), as determined by the Secretary taking into account the hospital acquisition cost survey data under subparagraph (D). As demonstrated by its plain language, the best reading of the statute is that it delegates significant discretionary authority to the Secretary. We do not see anything in the statute that would limit the Secretary's discretion in the manner described by commenters. The Secretary is generally empowered to define hospital groups "based on volume of covered OPD

services or other relevant characteristics" and there is nothing in section 1833(t)(14) of the Act or elsewhere to indicate the Secretary is foreclosed from defining a hospital group based on a hospital's voluntary participation in a program (the 340B Program) that has a direct and significant effect on the hospital's ability to acquire drugs at a substantial discount.

As described earlier in this section, we assessed a variety of hospital characteristics, such as hospital size, 340B participation status, ODACS drug purchase volume, outpatient drug claims billing volume, rurality, geographic location, GPO membership, GPO discount amount, and teaching status. Our detailed analysis found that 340B drug acquisition resulted in a nearly 40 percent differential from current Medicare payment, by far the most significant discrepancy between current Medicare payment and hospital acquisition cost, clearly making 340B status a relevant characteristic[] for purposes of varying OPPS payment.

After consideration of public comments we are finalizing our proposal to vary the amount of payment for 340B-acquired drugs by the group of hospitals that are enrolled in the 340B Program as 340B covered entity hospitals.

3. Applying a Single Reduction Percentage to ASP for 340B-Acquired Drugs

Section 1833(t)(14)(A)(iii)(I) of the Act provides that the payment amount for a SCOD for a year is equal to the average acquisition cost for the drug "as determined by the Secretary taking into account" the survey data collected under subparagraph (D). In accordance with this authority, we proposed to apply a single discount factor to ASP for drugs acquired by 340B hospitals in lieu of calculating individual acquisition cost amounts for 340B-acquired drugs. Applying a single discount factor to ASP creates a standardized payment reduction. Conversely, calculating individual acquisition costs links reimbursement directly to the exact, variable purchase prices hospitals pay for specific 340B drugs.

We considered calculating payment rates derived from individual acquisition cost amounts for 340B drugs; however, given the dynamic nature of drug pricing we concluded that it would be more appropriate to apply a single discount factor to ASP. We believe this is more

appropriate as ASP is also dynamic in nature. ASP changes over time (quarter to quarter), so tying the payment amount to an average discount of ASP results in a more accurate payment amount, by quarter, than if hospitals had to wait until the next survey cycle.

Each drug HCPCS code has its own specific payment rate calculated that is unique to the drug described by the applicable HCPCS code. We would apply an average discount, calculated as described previously under V.B.9.b. and V.B.9.c.(2). of this final rule with comment period, to the drug-specific ASP amount. This makes our proposed payment rate specific to the average acquisition cost for the drug. Applying the payment rate in this manner also allows for this average discount to apply to newly calculated ASPs as they are updated on a quarterly basis. It would not be practical to calculate a drug-specific payment rate for each NDC, and each HCPCS code, based on the survey data, as the survey-collected data is based on a snapshot in time and would not reflect future changes in average acquisition costs. Therefore, as drug prices change, we believe it is appropriate and reasonable to continue to update the calculated ASPs and then to reduce payments by an appropriate percentage of ASP to better align payment with the average cost of the drug.

As an alternative to establishing one aggregate discount amount based on survey data, we considered establishing one aggregate discount amount based on 340B ceiling prices from HRSA.[137] Under this alternative, we would use HRSA's 340B ceiling price data, rather than survey data, to calculate an average discount. As described previously, when assessing the 340B ceiling price, we calculated an analogous acquisition cost margin of ASP minus 28 percent for 340B drugs, which was calculated as the difference between the 340B ceiling price for each NDC in the survey and ASPs that were volume-weighted by 340B OPPS claims data utilization during the duration of the survey. We believed this could be a reasonable alternative to our

[137] HRSA calculates the ceiling price for each covered outpatient drug. The 340B ceiling price is the drug's average manufacturer price (AMP) minus the unit rebate amount (URA), which is a statutory formula that varies depending on whether the drug is an innovator single source drug (no generic available), an innovator multiple source drug (a brand drug with available generic(s)), or a non-innovator multiple source (generic) drug. The 340B ceiling price represents the maximum price a participating drug manufacturer can charge a covered entity for the drug.

proposal, as it is based on objective data, can be updated regularly (such as quarterly or annually) with the release of new ceiling prices and new claims utilization data, and significantly diminishes the discrepancy between Medicare payment and hospital acquisition costs for these drugs. We sought comment on this alternative to set OPPS payment for 340B acquired drugs at ASP minus 28.0 percent, per the methodology described to calculate this OPPS claims volume weighted mean margin of the 340B ceiling price from ASP. We note this figure is volume-weighted using OPPS claims data for the duration of the survey, but we also solicited comment on volume-weighting this average based on the claims data available for the applicable calendar year in which the policy would be effective. For example, for the CY 2027 rule, this would be volume-weighted based on claims data available for that year's rule, which would be claims data from CY 2025. At the end of this section in the proposed rule, we also provide estimated impacts of this alternative policy proposal of ASP minus 28 percent based on the 340B ceiling price data, so interested parties were aware of these impacts if CMS ultimately adopted this policy for CY 2027.

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: Multiple commenters supported our proposal to apply a uniform ASP adjustment rather than a drug-specific adjustment. A commenter stated that "to the extent CMS's proposed reimbursement rate accurately reflects surveyed acquisition costs, [the commenter] supports the proposed rate, whether CMS ultimately finalizes ASP minus 33.4 percent or another rate supported by the data, such as ASP minus 28 percent as discussed in the proposed rule. The proposal will reduce Medicare and beneficiary spending that exceeds hospitals' acquisition costs, advancing both program integrity and beneficiary affordability." Another commenter agreed with CMS that the proposed payment rate for 340B-acquired drugs "more accurately reflects the hospital acquisition cost, and we respectfully urge CMS to finalize this proposed payment change."

Response: We thank commenters for their support.

Comment: Many commenters opposed CMS's proposal to apply a uniform ASP adjustment rather than a drug-specific adjustment and stated that CMS lacks the statutory authority to uniformly reduce reimbursement for all 340B-eligible drugs paid under the OPPS. These commenters maintain that section 1833(t)(14) of the Act requires CMS to calculate and set payment rates for each specified covered outpatient drug. In other words, on a drug-by-drug basis.

Response: We disagree that section 1833(t)(14) of the Act requires CMS to calculate and set payment rates for each specified covered outpatient drug. While the statute indicates that data should be collected for specific drugs, it is not prescriptive regarding how that data should ultimately be used to set payment rates. Payment rates are already set on a drug-by-drug basis using the ASP methodology, and this will continue to be the manner in which payment rates for individual drugs are set. The percentage adjustment applied to the ASP (ASP plus six percent) has never been tailored to individual HCPCS codes; this policy mirrors that approach. Further, the proposed ASP percentage adjustment was volume-weighted to reflect the relative utilization and differing margins of individual drugs.

As stated in the proposed rule, it would not be practical to calculate a drug-specific payment rate for each NDC, and each HCPCS code, based on the survey data, as the survey-collected data is based on a snapshot in time and would not reflect future changes in average acquisition costs. Therefore, as drug prices change, we believe it is appropriate and reasonable to continue to update the calculated ASPs and then to reduce payments by an appropriate percentage of ASP to better align payment with the average cost of the drug.

Comment: Some commenters supported our alternative proposal to set OPPS payment for 340B-acquired drugs at ASP minus 28.0 percent based on 340B ceiling price data. Most of these commenters indicated that they supported neither alternative but that if CMS nonetheless proceeded with a payment adjustment that they preferred ASP minus 28 percent because an

approach grounded in objective, regularly updated ceiling price data would be less disruptive than the survey-based methodology. Another commenter stated that this approach would be better because it relies on a more complete, independently maintained data source. Several commenters suggested that if we proceeded with the ASP minus 28 percent approach that we should weight it using Medicare claims volume for the applicable calendar year. A commenter urged CMS to more fully evaluate this alternative, which they contended avoided many of the response-rate and representativeness concerns expressed by commenters.

Response: We agree with commenters that our alternative approach would have several advantages compared to our proposed survey-data-based approach. A payment rate based on ceiling price data would be objective and could be updated annually with far less burden to hospitals and CMS than an annual survey. We also think that this approach is appropriate based on the survey results, which, as we noted previously, found that hospitals' survey-reported 340B acquisition costs were at least 28.9 percent below the mean ASP for drugs in all high-spending therapeutic classes (that is, those with more than $100 million in reported acquisition costs).

We thank the commenters for their comments regarding updating the ceiling price payment rate weighted by claims volume for the applicable calendar year, in this case 2025 claims for CY 2027 rulemaking, rather than claims data from the duration of the survey. CMS will consider this for future rulemaking, but for CY 2027 will calculate the 340B ceiling price data using claims data mirroring the survey timeframe.

Comment: A few commenters recommending the ASP minus 28 percent alternative suggested that we phase it in gradually over several years, which would provide us with the opportunity to provide additional drug-level information, evaluate actual claims experience, establish an appropriate payment for pharmacy and clinical infrastructure, and create hospital groupings that recognize safety-net, teaching, trauma, pediatric, and rural responsibilities. One of these commenters stated that such an approach would recognize CMS' legitimate interest in better aligning payment with acquisition cost without immediately adopting the largest reduction

supported by an aggregate survey whose 340B hospital response rate and drug-level representativeness remain contested.

Response: We appreciate the commenters' suggestions to phase-in in our policy; however. as we stated previously, we believe that the payment misalignment that our proposed policy would address has been in effect for many years and it is important to implement this policy without delay now that we have conducted the required survey and have data clearly demonstrating that the existing payment rate for 340B-acquired drugs is so far out of line as a representative proxy for the cost of their acquisition.

Comment: Several commenters opposed our alternative proposal to set OPPS payment for 340B-acquired drugs at ASP minus 28.0 percent based on 340B ceiling price data. One of these commenters expressed confusion as to what feedback CMS might be requesting since, in their view, the Supreme Court's decision in *AHA v. Becerra* forecloses HHS from setting payment for 340B drugs based on "subjective measures." In this commenter's view, under the statute, CMS can only vary payment by hospital group when it is using the survey data to set payment rates: "In *AHA v. Becerra*, the Supreme Court held that if HHS collects hospital acquisition cost survey data from hospitals, then HHS may use the data to set reimbursement rates equal to the average acquisition cost for the drug. . . . Importantly, in that circumstance, HHS may vary reimbursement rates by hospital group. While CMS conducted a survey for 2027, it is not proposing to use that survey data to set acquisition costs by hospital group; instead, it is using the survey as attempted cover to rely on what would otherwise be an improper source of data on which to base payment adjustments by hospital group." (Internal quotation marks omitted.) Additionally, several commenters stated that ASP minus 28 percent was not an acceptable substitute because a ceiling price is a statutory maximum, the highest price a manufacturer may charge a covered entity, not a measure of what hospitals actually pay or what it costs them to dispense a drug. One of these commenters opined that setting payment by reference to ceiling prices would convert a price cap into a presumed actual acquisition cost,

which is not the "average acquisition cost for the drug" the statute directs CMS to determine. One commenter urged CMS not to adopt the alternative rate of ASP minus 28 percent because the proposed 33.4 percent reduction is derived from valid, newly collected hospital acquisition data and represents the most accurate market reality.

Response: We disagree that the statute or the Supreme Court's decision in *AHA v. Becerra* requires us to set payment rates using the hospital acquisition cost survey data as a precondition to vary payment by hospital group. Section 1833(t)(14)(A)(iii)(I) of the Act requires the Secretary to "take into account" the hospital acquisition cost survey data. It does not require the Secretary to apply the actual data from the survey to set payment rates. We have taken into account the hospital acquisition cost survey data; indeed, it is our thorough analysis of that data that demonstrates (1) the clear and substantial discrepancy between current payment for 340B-acquired drugs and acquisition cost for 340B drugs that requires a prompt and reasonable solution, and (2) that a payment rate of ASP minus 28 percent would reflect a reasonable and conservative estimate of the average acquisition costs for 340B drugs for 340B hospitals given the survey results shows an average acquisition cost of ASP minus 33.4 percent. This is consistent with the approach we adopted in response to the GAO's survey in 2006. When the GAO conducted their survey and released their report, CMS did not use the survey data to directly set drug payment rates prospectively. Rather, CMS used that information to validate the appropriateness of ASP plus 6 percent as the Medicare payment rate. In its report, the GAO stated that "[t]o ensure that Medicare payments for SCOD products are based on sufficiently accurate data, we recommend that the Secretary . . . validate, on an occasional basis, manufacturers' reported drug ASPs as a measure of hospitals' acquisition costs using a survey of hospitals or other method that CMS determines to be similarly accurate and efficient."[138] CMS conducted the survey and the survey demonstrated that (1) current Medicare payment for 340B-acquired drugs is not based on sufficiently accurate data, as evidenced by the nearly 40-percent

[138] *https://www.gao.gov/assets/gao-06-372.pdf.*

discrepancy between average acquisition cost and Medicare payment; and (2) that ASP minus 28 percent would reflect a reasonable and conservative estimate of the discounts 340B hospitals receive on 340B drugs.

We acknowledge that 340B ceiling prices are the maximum prices that pharmaceutical manufacturers can charge hospitals participating in the 340B Program. However, we do not agree that renders them unsuitable to inform Medicare payment rates.

Comment: A few commenters stated that the existence of the two alternatives suggests that neither should be adopted. According to these commenters, the two alternatives constitute "materially different estimates" from Federal data sources, which underscore both the uncertainty surrounding the underlying analysis and the limitations of using a single national average discount assumption to establish payment rates for a highly diverse set of drugs and providers.

Response: We do not agree with commenters' assessment of the two alternatives. We acknowledge their differing natures; however, we do not believe that they signify uncertainty in our analysis or limitations in using a single national average discount to establish payment rates for 340B-acquired drugs. In fact, we believe that the relative uniformity of these two estimates of ASP minus 28.0 percent and ASP minus 33.4 percent augers for the validity and accuracy of these two estimates, with the ASP minus 28.0 percent estimate naturally and predictably reflecting a slightly more conservative estimate of the discounts 340B hospitals receive on 340B-acquired drugs.

Comment: A commenter preferred the proposed ASP minus 33.4 percent methodology over the alternative ASP minus 28 percent approach because it is grounded directly in observed hospital acquisition costs. The commenter observed that while an ASP minus 28 percent methodology might slightly lessen the fiscal impact of the revised policy, the acquisition-cost survey provides a more direct empirical foundation than an alternative derived from estimates of statutory ceiling prices.

Response: We agree with the commenter that the proposed ASP minus 33.4 percent methodology has several advantages in comparison to the ASP minus 28 percent alternative in that it is based on real world acquisition cost data and would more fully capture the discount hospitals are receiving. However, as previously discussed, we believe ceiling price payment methodology volume-weighted by OPPS claims data is a reasonable alternative, as it is based on objective data, can be updated regularly (at least annually, and perhaps quarterly in the future as we gain more experience with this process) with the release of new ceiling prices and new claims utilization data, and significantly diminishes the discrepancy between Medicare payment and hospital acquisition costs for these drugs. It is a reasonable, empirically based payment methodology and the accuracy of our estimate is reinforced by the survey finding similar, but slightly larger, average discounts for 340B drugs acquired by 340B hospitals.

After consideration of public comments received and after taking into account the hospital acquisition cost survey data, we are finalizing our alternative proposal to set OPPS payment for 340B-acquired drugs at ASP minus 28 percent based on 340B ceiling price data and we are revising 42 CFR 419.41(d) and adding a new paragraph (k) to implement this payment change. While we believe both alternatives to be excellent proxies for hospitals' acquisition costs for 340B-acquired drugs, we think that the virtues of setting the payment rate for 340B drugs acquired by 340B hospitals at ASP minus 28 percent based on the 340B ceiling data as validated by the ODACS outweigh the advantages of using the ASP minus 33.4 percent payment rate based on the survey data alone. ASP minus 28 percent is based on objective data, is a reasonable and conservative estimate of hospital 340B drug acquisition costs as validated by the ODACS, and is responsive to commenters' concerns that a payment rate of ASP minus 33.4 percent would result in too significant of a payment reduction and would inhibit beneficiary access to these drugs. ASP minus 28 percent is also in line with the minimum discount by major therapeutic class CMS found from the ODACS, where the acquisition costs varied from a high of ASP minus 28.8 percent to a low of ASP minus 71.4 percent. Additionally, our 95 percent

confidence interval analyses of the survey data determined that acquisition costs fell between ASP minus 34.7 percent and ASP minus 32.3 percent. When including the IPW analysis, this 95 percent confidence interval became ASP minus 34.3 to minus 32.1 percent. It additionally is in line with the average acquisition costs stratified by various hospital characteristics as shown in Table 70. Specifically, and as previously discussed, we assessed the survey data by drug acquisition volume, OPPS drug billing volume, hospital size (number of beds), geographic rurality, census region, teaching status, share of Medicare patients, disproportionate share percent, and hospital type. Through all of these different hospital characteristics, assessing both the mean and median results, the margin drops as low as ASP minus 39.7 percent, and as high as ASP minus 30.3 percent. Through these 96 permutations of the data, these tight ranges not only support the integrity of the survey results but also make the ceiling price alternative that we are adopting reasonable and should help alleviate any commenter concerns that the payment rate based on the survey data is inappropriate.

We note that in the event that our authority under section 1833(t)(14) of the Act was determined to not provide sufficient flexibility to utilize the 340B ceiling price data as validated by the ODACS to set a payment rate of ASP minus 28 percent for 340B-acquired drugs for CY 2027, we believe the payment rate of ASP minus 33.4 percent – as determined by the average 340B drug acquisition cost in the ODACS – to be a better, more accurate determination of such hospital acquisitions costs than our prior policy of ASP plus 6 percent.

4. Add-on Payment for 340B Drugs

Under the OPPS, Medicare pays separately payable drugs at rates that approximate their acquisition costs, such as at ASP or WAC. These drugs may also receive an add-on payment. Under the OPPS, section 1833(t)(14)(E) of the Act authorizes, but does not require, the Secretary to make an adjustment to payment rates for SCODs to take into account overhead and related expenses, such as pharmacy services and handling costs. Because we took a prudent approach in estimating the average acquisition costs for 340B-acquired drugs, we did not believe that it was

necessary to establish an add-on for overhead and handling as we believed that a conservative estimate may already account for the costs of overhead. We also believed that hospitals would likely negotiate additional discounts that will render an additional add-on payment unnecessary. This approach also aligned with the requirement under section 1833(t)(14)(A)(iii) of the Act to pay at the average acquisition cost. Therefore, for CY 2027 and subsequent years, we proposed to pay for 340B drugs acquired under the 340B Program by 340B hospitals at ASP minus 33.4 percent with no add-on payment. We sought comment on our proposal to not include an add-on payment.

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: A commenter supported our proposal not to provide an add-on. This commenter cautioned CMS about layering additional payments onto the survey-derived amount without clear evidence that they represent costs not already captured in the methodology. The commenter found our proposal reasonable "insofar as the underlying acquisition-cost estimate already provides an appropriate approximation of hospitals' costs associated with obtaining these drugs. A separate adjustment should require evidence of a distinct and material expense rather than become another mechanism through which the gap between Medicare reimbursement and acquisition cost gradually reemerges."

Response: We thank the commenter for their support.

Comment: Many commenters objected to our proposal not to include an add-on payment for overhead and handling and faulted our proposed payment methodology for failing to capture all of the costs associated with furnishing a drug and complying with the 340B Program. Commenters listed many of these expenses, including acquiring, storing, preparing, administering, and monitoring medications, implementing software, hiring additional staff, inventory management, infusion center infrastructure and clinical staffing, medication safety and quality programs, information technology and electronic health record infrastructure, regulatory

and compliance requirements, sterile compounding facilities, USP compliance, hazardous drug protections, medication-use technology, waste handling and disposal, shortage mitigation efforts, diversion prevention programs, audit readiness activities, 24/7 clinical support, cybersecurity protections, accreditation standards, emergency preparedness capabilities, dedicated 340B pharmacy staff, split-billing software, annual licensing fees, daily reconciliation of 340B and non-340B inventory to prevent diversion, preparation for HRSA audits and responses to manufacturer audits, with associated legal and compliance costs, as well as ongoing regulatory monitoring, cold-chain management, nuclear medicine technologists, nurses, and multidisciplinary care coordination, hot lab, infusion, dedicated bathroom infrastructure, dose calibration, decay correction, and radiation safety oversight. A commenter emphasized the importance of the add-on payment for hospitals dispensing high-cost cellular and gene therapy products, including CAR-T therapies, that require specialized apheresis and cell-processing capacity; chain-of-custody and chain-of-identity protocols; and compliance with many additional requirements.

Many commenters disagreed with our rationale for not establishing an add-on. In the proposed rule we stated that an add-on was unnecessary because (1) we took a prudent approach in estimating the average acquisition costs for 340B-acquired drugs and we believe that that prudent estimate of acquisition cost may already account for overhead and (2) we believe that hospitals will likely negotiate additional discounts. A commenter characterized the decision as arbitrary and capricious, stating that CMS provides no justification for the exclusion and "merely states that its cost estimate may already account for the costs of overhead, a weak statement that undermines confidence in the adequacy of the resulting payment rate." Several commenters shared their view that CMS' assumption that hospitals will likely negotiate additional discounts was inconsistent with market realities. A commenter indicated that in their experience, voluntary discounts for high-cost drugs were rare, particularly those for which a limited number of manufacturers dominate the market. A few commenters alleged that CMS's assumption is

internally inconsistent with the underlying premise of the proposed payment methodology. These commenters stated that we propose to establish a payment rate based on survey data that we describe as representative and sufficiently reliable to estimate average acquisition cost. These commenters then ask, if the survey is statistically valid and accurately measures acquisition costs, how can CMS simultaneously justify the absence of an overhead add-on by speculating that hospitals may receive undocumented and unmeasured discounts beyond those reflected in the survey? "Either the Survey accurately captures acquisition costs or it does not," a commenter stated. A few commenters alleged that, in setting the payment rate, CMS failed to account for how cost structures vary dramatically across different types of hospitals.

Many commenters emphasized that acquisition costs and overhead costs are two separate measures and that in setting the payment rate CMS conflated the reported acquisition costs with overhead costs. A commenter pointed out that the current payment rate of ASP plus 6 percent contains the average sales price (a proxy for acquisition cost) plus a 6 percent add-on for overhead costs and that in the survey, CMS collected only a hospital's total net acquisition cost for a drug defined as "the total amount paid by the hospital inclusive of all discounts, rebates, and price concessions applicable at the NDC level." The commenter stated that hospitals were not instructed to report any additional costs that they incurred to administer the drugs, such as overhead, pharmacy services, and handling costs.

Many commenters alleged that not including a 6 percent add-on for 340B drugs would arbitrarily create a payment differential for overhead costs compared to non-340B drugs that is not supported by the survey or other analysis. Another commenter stated that the proposal is flawed because the agency is proposing to continue providing an add-on payment to hospitals exempt from its proposed payment policy, but not for hospitals subject to its proposed policy. In doing so, the commenter states, the agency recognizes that overhead costs are real and legitimate components of Medicare payment policy for some hospitals, but not for others. "CMS provides no rationale for why the same overhead, pharmacy operations, drug handling, storage, inventory

management, compliance, billing, and patient care costs disappear when the same drug is acquired by a 340B hospital subject to its proposed payment policy. Excluding any add-on payment from the proposed 340B payment rate therefore creates an arbitrary and internally inconsistent payment policy that recognizes overhead costs for some hospitals and some drugs, while ignoring those same costs for others." Another commenter alleged that the proposed policy creates a logical disconnect between reimbursement for drugs at 340B and non-340B sites. "Payment policy for the former would reject the need for an add-on that covers overhead costs, and the latter would recognize the need to reimburse these costs. At no point does CMS make a case for this distinction." Another commenter requested CMS to explain why comparable operational costs are recognized for non-340B drugs but not for 340B-acquired drugs and radiopharmaceuticals.

Response: We acknowledge the many costs that are associated with the delivery of a drug; however, as we have explained, we believe that, due to our prudent approach in determining an average acquisition cost, our proposed payment amount for 340B-acquired drugs does not support CMS exercising its discretion to include an add-on or adjustment in payment for overhead costs. Many of the costs mentioned by commenters are standard operating costs of hospitals and healthcare facilities and are not necessarily related to the cost of the drug. Additionally, as we are finalizing the alternative ASP minus 28 percent payment rate, a significantly conservative average acquisition cost, it is not necessary to provide an add-on. Finally, an add-on percentage, such as a 6 percent add-on to ASP, can create incentives for some providers to choose higher-priced products over lower-priced products even when the two products are clinically equivalent.

After consideration of public comments, we are finalizing our proposal to not include an add-on payment for 340B-acquired drugs.

5. 340B Payment Policy for Drugs for Which ASP Is Unavailable

Section 1847A of the Act establishes the average sales price (ASP) methodology, which provides the amount payable for drugs and biologicals described in section 1842(o)(1)(C) of the Act furnished on or after January 1, 2005. Based on this, our historic policy has been to pay for most drugs at ASP plus 6 percent. There are some situations, however, where it is not possible to pay ASP because, for example, a drug is sufficiently new so there is no sales data available upon which to derive an average. In these situations, our historic policy has been to pay for the drug according to the following hierarchy: In general, if ASP information is not available, payment is based on the WAC with WAC plus 6 percent. If WAC information also is not available, then payment is based on AWP with 95 percent of AWP being paid. If AWP is not available, then payment is based on Mean Unit Cost (MUC). And if MUC is not available, then payment is based on the invoice price.

Consistent with this policy, starting in CY 2027, we proposed that payment for 340B drugs when ASP is unavailable mirrors CMS's historic payment policies for drugs paid under OPPS. If ASP information is not available, payment is based on the WAC, with WAC minus 33.4 percent. If WAC information also is not available, we proposed a payment rate of 59.69[139] percent of AWP. This percent was calculated by first reducing the original 95 percent of AWP price by 6 percent to generate a value that is similar to WAC with no percentage markup. Then we applied the 33.4 percent reduction WAC-similar AWP value to obtain the 59.69 percent of AWP, which is similar to either ASP minus 33.4 percent or WAC minus 33.4 percent. For 340B drugs paid based on MUC, we proposed to continue to pay them at 100 percent of MUC. These MUC-based payments are calculated based on hospital claims data, which already account for hospital acquisition costs and do not need to be discounted further. Similarly, we proposed to continue to pay for invoice priced 340B drugs at the invoice amount as the invoice price amount should already reflect the 340B discount. We sought comment on this proposal.

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[139] Except for new drugs and biologicals that have not been assigned a HCPCS code. Under section 1833(t)(15) of the Act, these drugs and biologicals are required to be paid at 95 percent of AWP.

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: One commenter requested clarification as to whether we are proposing to pay MUC only for 340B drugs for which ASP is unavailable or are we also proposing to pay for 340B drugs for which ASP is available but is paid under the MUC under non-340B settings. Another commenter noted that while ASP minus 33.4 percent appears to be higher than most proposed MUC-based rates for CY 2027, applying different reimbursement methodologies to 340B-acquired drugs, biologics, and diagnostic radiopharmaceuticals without pass-through status that are subject to MUC-based payment may create additional confusion for hospitals. The commenter requested that CMS provide additional clarification, as needed, in the CY 2027 OPPS Final Rule.

Response: If ASP information is not available, payment is based on the WAC. If WAC information also is not available, payment is based on AWP. If AWP is not available, then payment is based on arithmetic MUC. If MUC is not available, then payment is based on invoice pricing. However, certain products, such as nonpass-through diagnostic radiopharmaceuticals with claims data, will continue to be paid based on arithmetic MUC as discussed in this final rule with comment period. MUC-based payments are calculated based on hospital claims data, including 340B and non-340B drugs, which already account for hospital acquisition costs and do not need to be discounted further. If we were to discount this payment rate, then we would be accounting for 340B discounts twice.

After consideration of these public comments, we are finalizing our payment hierarchy for when ASP is not available as proposed: If ASP information is not available, payment will be based on the WAC; if WAC information is not available, payment will be based on AWP; if AWP is not available, payment will be based on MUC; and if MUC is not available, payment will be based on the invoice price. However, given our adoption of the proposed alternative of ASP minus 28 percent, we are not finalizing the reduction amounts that we proposed for WAC

and AWP. Consistent with the reduction amount we are adopting, we are finalizing WAC minus 28 percent and 64.53 percent of AWP. We are finalizing our proposal to pay 100 percent of MUC for 340B drugs paid based on MUC and the invoice amount for invoiced priced 340B drugs as proposed.

6. Applicability

We proposed to apply our proposed policy to pay for drugs acquired under the 340B Program at ASP minus 33.4 percent to all separately payable drugs, biologicals, biosimilars and radiopharmaceuticals acquired under the 340B Program. This approach would establish a uniform payment policy consistent with our historic OPPS payment policy of paying the same payment rate for SCODs and non-SCODs. We noted our proposal to apply this policy to separately payable drugs and biologicals that are not SCODs was a policy proposal rather than a statutory requirement. We note that the survey included both SCODs and drugs and biologicals that we have historically treated as SCODs for payment purposes. We have treated non-SCOD drugs as SCODs for payment purposes since CY 2006. We sought comment on this proposal.

The payment policy would not apply to vaccines, as they are excluded from the 340B Program; drugs with transitional pass-through payment status, which are paid under section 1833(t)(6)(D) of the Act; and non-opioid pain management drugs as defined under section 1833(t)(16)(G) of the Act, as we believe reducing payment for those drugs would be inconsistent with statutory instructions on payment amount for those qualifying products. As previously described in the information collection request approved by OMB under the PRA, CMS may continue to validate the results of this survey on a periodic basis; for example, perhaps as often as every 4 years. We sought comment on this proposal. Specifically, we sought comment on the proposal that the policy to pay for drugs acquired under the 340B Program at ASP minus 33.4 percent would apply to all separately payable drugs, biologicals, biosimilars and radiopharmaceuticals acquired under the 340B Program, and would not apply to vaccines, drugs with transitional pass-through payment status and non-opioid pain management drugs.

Additionally, as we proposed to apply a single discount factor to the ASP for 340B-acquired drugs in lieu of calculating individual acquisition cost amounts for 340B-acquired drugs, we believed it was appropriate to apply this payment adjustment using the single discount factor to existing and new drugs that are paid under the OPPS.

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: Several commenters stated that CMS lacks the statutory authority to apply a 340B-differentiated rate to drugs that are not SCODs. These commenters point to section 1833(t)(14)(B) of the Act which defines a SCOD as "a covered outpatient drug (as defined in section 1927(k)(2)) for which a separate ambulatory payment classification group (APC) has been established and that is (I) a radiopharmaceutical agent; or (II) a drug or biological for which payment was made [on a pass-through basis] on or before December 31, 2002" and excludes drugs that first received pass-through payment on or after January 1, 2003. These commenters state that if CMS wants to apply the ASP minus 33.4 percent rate to separately payable drugs not meeting this definition (i.e., drugs CMS has historically treated as SCODs), then CMS must identify, drug by drug or class by class, the statutory authority on which that differential rests. A commenter requested that CMS enumerate in the final rule which HCPCS codes CMS treats as SCODs and state the authority applied to each separately payable drug outside that definition.

Response: We disagree that we lack the statutory authority to apply our proposed payment policy to drugs that we have historically treated as SCODs. We note that in the event that our authority under section 1833(t) of the Act was determined not to be sufficient to adjust payment for 340B-acquired SCODs to ASP minus 28 percent, we would continue to apply an adjusted payment rate for 340B-acquirednon-SCODs. Similarly, we note that in the event that our authority under the Act was determined not to be sufficient to adjust payment for 340B-acquired non-SCODs, we would continue to apply an adjusted payment rate for 340B-acquired SCODs.

Comment: Most commenters who commented on our proposal not to apply the payment adjustment to vaccines, drugs with transitional pass-through payment status, and qualifying non-opioid pain management drugs under section 1833(t)(16)(G) of the Act supported it. One commenter thanked CMS for recognizing that failing to exempt NOPAIN Act-qualifying drugs would undercut – or severely limit – the underlying policy goal of increasing use of and access to non-addictive pain management approaches. Similarly, another commenter expressed strong support for our proposal not to apply the payment adjustment to qualifying non-opioid pain management drugs under section 1833(t)(16)(G) of the Act because applying an additional 340B payment adjustment to these products would be inconsistent with the statutory framework governing payment for eligible non-opioid treatments. The commenter stated that finalizing the exclusion would help preserve the integrity of the separate payment policy established by Congress, ensure that qualifying non-opioid products continue to be reimbursed in a manner consistent with the statutory methodology applicable to them and help ensure Medicare beneficiaries retain access to clinically appropriate alternatives to opioids.

Response: We thank commenters for their support.

Comment: A commenter requested that CMS confirm that the proposed policy does not apply to 340B-acquired diagnostic radiopharmaceuticals with pass-through status.

Response: Please see section V.A. of this final rule with comment period for discussion of pass-through payment for drugs, biologicals, biosimilars, and radiopharmaceuticals. As previously discussed, the payment policy would not apply to drugs with transitional pass-through payment status, which are paid under section 1833(t)(6)(D) of the Act, as we believe reducing payment for those drugs would be inconsistent with statutory instructions on payment amount for those qualifying products. However, we will continue to monitor the effects of this policy and will consider changes as appropriate.

Comment: A commenter requested clarification as to how drugs will be treated during the calendar year in which their temporary pass-through status expires. Will the drug remain

excluded for the remainder of that year or become subject to the reduced payment rate upon expiration? A few commenters expressed concern that drugs graduating from pass-through status would be underpaid due to such drugs accruing little or no inflation penalty and having a ceiling price of 23.1 percent upon expiration. A commenter recommended establishing a smaller reimbursement reduction for drugs leaving temporary pass-through status. Another suggested a minimum three-year delay of application of the reduction to drugs graduating from pass-through status.

Response: CMS operationalizes pass-through expiration on a quarterly basis as discussed in section V.A. of this final rule with comment period. Once pass-through expires, the applicable payment rate would be effective the following quarter.

Comment: One commenter expressed concern about the proposal to exclude drugs with transitional pass-through status from the proposed payment adjustment for 340B-acquired drugs. This commenter requested that CMS acknowledge that the exclusion could result in significant payment differentials among therapies treating the same condition where some drugs qualify for transitional pass-through status and others do not. The commenter referenced studies demonstrating that payment differentials among clinically competing products can significantly affect product utilization at 340B covered entities during periods of differential reimbursement. The commenter suggested that CMS consider available authorities, including its equitable adjustment authority under section 1833(t)(2)(E) of the Act, to mitigate these disparities and promote a more uniform payment policy by January 1, 2027. The commenter additionally requested that CMS acknowledge that covered entities maintain flexibility and may purchase outside of the 340B Program on a drug-by-drug basis at prices above the 340B ceiling price and code those claims accordingly, which would trigger reimbursement at the standard OPPS rate.

Response: We thank the commenter for bringing this matter to our attention and we acknowledge the potential for the payment disparities they have identified. We anticipate examining this issue in annual rulemaking in the near future and we welcome engagement from

interested parties as to how we might do so. If hospitals follow all required guidance and regulations, they may purchase outside of the 340B program as necessary. Readers should follow the finalized billing modifier requirements as discussed later in this section and comply with all relevant requirements to ensure proper payment. We remind readers that dispensing or furnishing drugs solely to take advantage of differences in reimbursement structures, rather than based on the patient's medical needs, may raise concerns under applicable federal fraud and abuse laws. Such conduct may also implicate section 1156(a)(1) of the Act, which states that items and services provided by a hospital for which payment may be sought under Medicare "will be provided economically and only when, and to the extent, medically necessary."

Comment: Multiple commenters suggested additional drugs for CMS to consider excluding from the proposed payment policy. Several commenters suggested that biosimilars should be excluded. These commenters contended that biosimilars are fundamentally different from both single-source drugs and innovator biologics and should not be subject to a payment adjustment derived from a survey methodology that does not adequately account for their unique market characteristics. A commenter suggested that, if not exempted, the payment adjustment should be reduced for biosimilars because reimbursing biosimilars at the same reduced rate as their reference or originator products would eliminate an important financial incentive for covered entities to preferentially use lower-cost biosimilars over more expensive originator products. A few commenters expressed concern that applying the reduction to biosimilars would be inconsistent with requirements of the Inflation Reduction Act (IRA), which directs CMS to provide a payment rate of ASP plus 8 percent. A few commenters suggested that radiopharmaceuticals be excluded. A of these commenters recommended that CMS exempt therapeutic radiopharmaceuticals pending a targeted analysis of radiopharmaceutical therapy (RPT)-specific costs. One commenter recommended that CMS exclude plasma protein therapies from the payment adjustment given the unique facets of plasma protein therapies and the dependence of Medicare beneficiaries on them. The commenter alleges that both Congress and

CMS have previously recognized the unique aspects of plasma protein therapies by excluding them from previous reimbursement initiatives. The commenter cited as examples CMS's implementation of the competitive acquisition program, in which it excluded certain plasma protein therapies (e.g., blood clotting factors and immune globulin products), and the statutory exclusion from the Medicare drug pricing negotiation program for products derived from human whole blood or plasma. A commenter suggested oncology drugs. Another commenter suggested cell and gene therapies. This commenter stated that cell and gene therapies are materially different from the mature, higher-volume drugs that likely drive the aggregate 340B acquisition-cost estimate. These therapies are newly launched, patient-specific or otherwise operationally complex, used in very small populations, and frequently supported by too few survey observations to establish a reliable product-level acquisition cost. Other commenters did not recommend a specific class of drug be excluded but rather drugs in shortage or with documented supply vulnerabilities or drugs with limited manufacturer competition where reimbursement reductions could threaten market sustainability. Another commenter suggested exempting drugs whose Medicare spending per beneficiary exceeds $100,000 annually. In the commenter's view this exemption would protect beneficiary access to therapies that cost more than $100,000 annually, such as advanced oncology, immunotherapy, rare disease, and specialty biologic treatments. The commenter stated that applying the proposed payment adjustment to these high-cost drugs would make it very difficult for hospitals to acquire them, particularly given the continued price increases from pharmaceutical companies. Using an annual treatment-cost threshold would provide a transparent, objective, and administratively feasible approach that relies on data already available to CMS while protecting access to the therapies most critical to vulnerable Medicare beneficiaries.

Response: We thank commenters for their feedback and analysis of our proposed policy. While we understand drug payment and pricing is a dynamic issue, we believe the most ideal policy is one that is consistent and universal to the extent possible.

Comment: Two commenters suggested that Drugs Covered as Preventive Services (DCAPS), which include HIV PrEP medicines, be excluded because they are covered and reimbursed under a separate statutory framework from traditional Medicare Part B drugs.

Response: We thank the commenters for their suggestion. While the OPPS payment for DCAPS mirrors the amounts set forth in the fee schedule established under section 1833(a)(1)(W)(ii) of the Act, DCAPS furnished in HOPDs are paid under section 1833(t) of the Act, not section 1833(a)(1) of the Act. Section 1833(a)(1) of the Act sets forth payment amounts for services described in section 1832(a)(1) of the Act, which excludes medical and other health services (including additional preventive services) furnished by a provider of services (including a hospital). Rather, DCAPS furnished in HOPDs are described in section 1832(a)(2)(B) of the Act—medical and other health services furnished by providers of services. Section 1833(a)(2)(B)(iii) of the Act provides that services described in 1832(a)(2) of the Act (with exceptions not relevant here) are paid an amount determined under section 1833(t) of the Act—that is, the OPPS. In the CY 2025 OPPS/ASC final rule (89 FR 94295 to 94304), we finalized an OPPS payment amount for DCAPS, codified at § 419.41(j), that was consistent with the fee schedule established under section 1833(a)(1)(W)(ii) of the Act; we did not, however, establish a policy to pay for DCAPS under the section 1833(a)(1)(W)(ii) fee schedule itself. DCAPS furnished in a HOPD are thus paid under the OPPS, and not under section 1833(a)(1)(W)(ii) of the Act.

However, the OPPS DCAPS payment framework is separate and distinct from the payment methodologies set forth at section 1833(t)(14)(A)(iii)(I) and (II) of the Act. We did not propose to revise the OPPS payment methodology applicable to DCAPS. As such, DCAPS are not subject to our finalized 340B payment adjustment made pursuant to our authority at 1833(t)(14)(A)(iii)(I) of the Act at this time. We may consider revisions to the OPPS DCAPS payment methodology in future rulemaking.

Comment: We received a few comments relating to periodic revalidation of the survey.

All commenters supported CMS periodically revalidating the survey. A commenter said CMS should periodically repeat or otherwise validate the survey so that the adjustment reflects changes in purchasing patterns, discounts, and the composition of the 340B market rather than allowing a one-time estimate to become a permanent payment convention. Most commenters requested that CMS conduct the survey more frequently than every 4 years, and most commenters requested that CMS conduct the survey on an annual basis. In the commenters' view, conducting an annual survey would be more appropriate because acquisition costs, drug mix and 340B enrollment are not static. One commenter stated that an annual series produces trend data that can inform purchasing patterns and impact on beneficiary access. Another commenter, noting CMS's reporting that it had received a number of responses, many of which appeared to be coordinated form letters declining to provide their acquisition data, stated that an annual survey would diminish the leverage of a single year's non-response. Another commenter pointed out that an annual survey cadence would create a more durable evidentiary record for future OPPS rulemaking and would help ensure that payment policy remains responsive to changes in drug pricing, utilization, and provider purchasing behavior. Finally, one commenter acknowledged the administrative burden of an annual survey on hospitals and CMS but noted that the survey infrastructure now exists, and the marginal burden of a repeat administration is materially lower than the burden of conducting the survey the first time. One commenter encouraged CMS to continue refining its data collection and analysis methods in future rulemaking cycles, including by addressing potential non-response when CMS next validates the acquisition cost survey.

Response: We appreciate the commenters' suggestions and will take them into account for future rulemaking. We acknowledge the administrative burden of an annual survey on hospitals but agree, as commenters noted, that the survey infrastructure now exists, and the marginal burden of a repeat administration is materially lower than the burden of conducting the survey the first time.

Comment: A few commenters stated that the survey window was too short.

Response: We disagree with commenters that the survey window was too short. It ran for fourteen weeks (January 1, 2026 through April 7, 2026), was supported by two pre-survey training webinars, a dedicated phone line and email address for technical support, a dedicated web page featuring multiple guidance documents (FAQs, user guides, fact sheets, etc.) and featured a survey instrument designed to minimize, to the extent reasonably possible, the amount of effort necessary for hospitals to collect and report the required information to CMS. Hospitals were put on notice as early as April 2025 with the President's Executive Order that a survey was coming, nearly a year prior to the survey close date, with the majority of the survey requirements being available with the CY 2026 OPPS/ASC proposed rule with comment period published in July 2025.

After consideration of public comments, we are finalizing our proposal to apply our payment proposal to all separately payable drugs, biologicals, biosimilars and radiopharmaceuticals acquired under the 340B Program as proposed, with exceptions as discussed. We are also finalizing our proposal to not apply the payment proposal to vaccines, drugs with transitional pass-through payment status and non-opioid pain management drugs as proposed.

7. Beneficiary Copayments

An important consequence of our final policy is that it will reduce Medicare beneficiaries' copayments for Medicare Part B drugs. Medicare beneficiaries are liable for a copayment that is typically equal to 20 percent of the OPPS payment rate, which is currently generally ASP plus 6 percent (regardless of the 340B purchase price for the drug). As the survey demonstrates, in some cases, beneficiary coinsurance alone exceeds the amount the hospital paid to acquire the drug under the 340B Program. For example, Lupron Depot (NDC 00074-3663-03) had a mean adjusted ASP of $4,690.08 compared to an average 340B acquisition cost of $667.94, excluding outliers and responses above the 340B ceiling price, yielding an absolute

margin of –$4,022.14 and a percent margin of –85.8 percent. As the drug is paid at ASP plus 6 percent, the payment rate for one package of the NDC averaged $4,971.49, of which a beneficiary would pay 20 percent, or $994.30. Therefore, a beneficiary's copay would be over $300 above the average hospital's 340B acquisition cost. During the ODACS study period, 3,544 beneficiaries had an OPPS claim for Lupron Depot, meaning that a sizeable beneficiary population is affected by these high coinsurance amounts. This is also not a small sample size aberration: 137 hospitals reported purchasing this drug through the 340B Program (after excluding outliers and responses above the 340B ceiling price).

Additionally, sections 11101 and 11102 of the Inflation Reduction Act of 2022 (IRA) (Pub. L. 117-169, enacted August 16, 2022) established requirements under which drug manufacturers must pay inflation rebates if they raise their prices for certain drugs payable under Part B and/or covered under Part D faster than the rate of inflation. Specifically, section 11101 of the IRA amended section 1847A (i) of the Act, which establishes a requirement for drug manufacturers to pay rebates into the Federal Supplementary Medical Insurance Trust Fund for Part B rebatable drugs for each calendar quarter beginning on or after January 1, 2023, if the specified amount, as determined under section 1847A(i)(3)(A)(ii) of the Act, exceeds the inflation-adjusted payment amount, which is calculated as set forth in section 1847A(i)(3)(C) of the Act. Pursuant to section 1847A(i)(5) of the Act, the IRA also provides for an adjustment to the beneficiary coinsurance amount in cases where the price of a Part B rebatable drug increases faster than the rate of inflation such that the beneficiary coinsurance is calculated based on the lower inflation-adjusted payment amount instead of the applicable payment amount.

Section 11101(b) of the IRA amended section 1833(t)(8) of the Act by adding a new subparagraph (F) to modify OPPS copayments for Part B rebatable drugs. In the CY 2024 OPPS/ASC final rule with comment period, we codified the OPPS program payment and cost sharing amounts for Part B rebatable drugs as required by section 1833(t)(8)(F) of the Act by adding a new paragraph (e) to § 419.41, which states in the case of a rebatable drug (as defined

in section 1847A(i)(2)(A) of the Act), except if such drug does not have a copayment amount as a result of application of section 1833(t)(8)(E) of the Act, for which payment is not packaged into payment for a covered OPD service (or group of services) furnished on or after April 1, 2023, and the payment for such drug under the outpatient prospective payment system is the same as the amount for a calendar quarter under section 1847A(i)(3)(A)(ii)(I) of the Act, in lieu of the calculation of the copayment amount and the Medicare program payment amount otherwise applicable under § 419.41(d) (other than application of the limitation described in paragraph § 419.41(c)(4)(i)), the copayment and Medicare program payment amounts determined under §§ 410.152(m) and 489.30(b)(6) of this chapter shall apply. In the CY 2025 PFS final rule, we codified policies regarding the computation of the inflation-adjusted beneficiary coinsurance, including § 427.201, which specifies that the methodology set forth in § 427.201(b) will be used to calculate the inflation-adjusted beneficiary coinsurance and associated Medicare payment percentage for Part B rebatable drugs as set forth in §§ 410.152(m), 419.41(e), and 489.30(b)(6). The methodology at § 427.201(b) ensures that coinsurance adjustments are not applied in a manner that would increase beneficiary coinsurance. For additional details on this coinsurance policy, we refer readers to the full discussion at 89 FR 98237 and 98238.

Under section 1833(t)(8)(F) of the Act and current OPPS regulations at § 419.41(e), beneficiary coinsurance is adjusted for Part B rebatable drugs paid under the OPPS only where a Part B rebatable drug is paid the same as the amount for a calendar quarter under section 1847A(i)(3)(A)(ii)(I) of the Act—that is, for single source drugs and biologicals, paid 106 percent of the lesser of ASP or WAC, and for biosimilar biological products, paid the amount determined under section 1847A(b)(8) of the Act. Because, as proposed, separately payable, nonpass-through, 340B-acquired drugs would be paid an amount other than the amount under section 1847A(i)(3)(A)(ii)(I) of the Act, the coinsurance adjustment provisions of the Medicare Part B Inflation Rebate Program would not apply to separately payable, nonpass-through, 340B-

acquired drugs under the proposed payment policy. We believed this was appropriate and consistent with the statutory intent of the Medicare Part B Inflation Rebate Program, as the coinsurance adjustment at section 1847A(i)(5) of the Act is intended to reduce the coinsurance amount to equal that of 20 percent of the inflation-adjusted payment amount described at section 1847A(i)(3)(C) of the Act, and we expected that the applicable coinsurance under the payment proposal for 340B-acquired drugs would likely be lower than 20 percent of such inflation-adjusted payment amount. We sought comment on the interaction between coinsurance adjustments under section 1847A(i)(5) of the Act and the proposed policy to pay for drugs acquired under the 340B Program at ASP minus 33.4 percent.

We anticipated that our proposed policy to pay for separately paid drugs acquired under the 340B Program at ASP minus 33.4 percent would collectively reduce beneficiary copayments by an estimated $1.15 billion for CY 2027.

We received public comments. The following is a summary of the comments we received and our responses.

Comment: Many commenters appreciated the effect of the proposed policy on reducing beneficiary copayments.

Response: We thank commenters for their support.

Comment: Many commenters challenged our statement that the proposed payment adjustment would reduce copayments for Medicare beneficiaries. In their view we failed to disclose that due to budget neutrality Medicare beneficiaries will pay higher copayments for all non-drug Part B items and services by roughly the same amount. Consequently, in these commenters' view, the out-of-pocket burden on patients is redistributed, not decreased, by the proposed policy. One of these commenters recommended that CMS calculate and report the net impact on beneficiary spending across the complete episode of care, rather than presenting the drug-specific reduction as though it were a direct reduction in total patient expense. A few commenters found fault with the example we cited of a drug, Lupron Depot, for which the

beneficiary copayment exceeded the 340B price paid by the hospital. A commenter stated that this one illustration was insufficient data to draw any conclusions about the reliability of CMS' estimation of beneficiary savings. Another commenter stated that the observation that beneficiary cost-sharing sometimes exceeded a hospital's 340B purchase price describes the intended design of the 340B statute, in which the differential between acquisition cost and payer reimbursement is the mechanism by which Congress chose to fund safety-net care.

Response: We thank the commenters for expressing their concerns. As we acknowledged throughout the proposed rule and this final rule, including the regulatory impact section, this policy will largely be implemented in a budget neutral manner. From an individual beneficiary experience, their reduced payment for 340B drugs will be substantial and noticeable. We also emphasize that our proposal to apply this reduction to non-excepted, off-campus PBDs will not be budget neutralized and therefore will generate savings for beneficiaries.

Comment: Some commenters expressed concern that the proposed payment adjustment would arbitrarily create cost-sharing disparities between Medicare beneficiaries. These commenters pointed out that while a beneficiary who receives a Part B drug at a 340B hospital will see reduced coinsurance liability for that drug, a beneficiary receiving the identical drug at a non-340B hospital will face higher coinsurance despite having the same coverage via Medicare. Some of these commenters said that this disparity could result in a distortion of the beneficiary experience. Since beneficiary out-of-pocket liability would vary significantly by facility status, patients would be steered toward specific health systems based on financial incentives rather than quality, provider access, or clinical outcomes. Similarly, these commenters contend, this payment structure would place a disproportionate burden on beneficiaries whose care needs are driven by procedures, diagnostic scans, or emergency visits rather than specialty Part B drugs.

Response: The intent of our proposed policy is to better align payment for 340B-acquired drugs with their acquisition costs as demonstrated by the ODACS. A consequence of that increased accuracy is that beneficiaries will pay more accurate copayments. We do not think that

it would be appropriate to continue to pay what we now know to be less accurate rates for drugs, and make beneficiaries pay higher copays for those drugs, simply to maintain parity in beneficiaries' copayment experience between 340B and non-340B hospitals. With respect to the proposed reduction having a disproportionate effect on beneficiaries whose care needs are driven by non-drug items and services, we reiterate our response to the previous comment. We note that the 340B program in general is outside the scope of this final rule with comment period.

Comment: One commenter stated that because the large majority of Part B coinsurance is paid not by beneficiaries out of pocket but by supplemental coverage, including Medigap, employer wrap plans, and Medicaid, realized out-of-pocket savings to beneficiaries are a fraction of the amount cited by CMS. The commenter additionally noted that budget neutrality requires an increase of approximately 8.44 percent in the conversion factor for non-drug services, which raises beneficiary coinsurance on every non-drug outpatient service at every OPPS hospital and that the proposed rule nowhere nets this offsetting increase against the claimed drug savings.

Response: We note that, even though many beneficiaries have supplemental coverage, beneficiaries often pay a premium for such supplemental coverage and those plans make coinsurance payments for the beneficiary. Thus, to the extent Medicare would be lessening the coinsurance amount such supplemental plans would have to make, we would expect the price of such plans to decrease or otherwise reflect these lower costs in the future, thereby lowering the amount that beneficiaries pay for supplemental plan coverage. Further, for the millions of Medicare beneficiaries who do not have supplemental coverage at all or who have a supplemental plan that does not cover all of a beneficiary's cost-sharing obligation, the proposed policy would directly lower out-of-pocket spending for 340B-acquired drugs for those beneficiaries. We also note that the budget neutral nature of this policy is required by statute.

We thank commenters for their input. As we indicated above, we are revising 42 CFR 419.41(d) and adding a new paragraph (k) to implement our finalized policy to pay ASP minus 28 percent for all separately payable drugs, biologicals, biosimilars and radiopharmaceuticals

acquired under the 340B Program . We anticipate that this policy will collectively reduce beneficiary copayments for drugs by an estimated $1.1 billion for CY 2027.

8. 340B Payment Policy Exemptions

We proposed to exempt children's hospitals and PPS-exempt cancer hospitals from our proposed policy to adjust OPPS payments for drugs acquired under the 340B Program. In accordance with section 1833(t)(7)(D)(ii) of the Act, we make transitional outpatient payments (TOPs) to both children's and PPS-exempt cancer hospitals. This means that these hospitals are permanently held harmless to their "pre-BBA amount," and they receive hold harmless payments to ensure that they do not receive a payment that is lower in amount under the OPPS than the payment amount they would have received before implementation of the OPPS. Accordingly, if we were to reduce drug payments to these hospitals on a per claim basis, it is very likely that the reduction in payment would be paid back to these hospitals at cost report settlement, given the TOPs structure. Consequently, we believe it is appropriate to exempt children's and PPS-exempt cancer hospitals from the alternative 340B drug payment methodology.

In addition to the children's and PPS-exempt cancer hospitals, Medicare has long recognized the particularly unique needs of rural communities and the financial challenges rural hospital providers face. Across the various Medicare payment systems, CMS has established a number of special payment provisions for rural providers to maintain access to care and to deliver high quality care to beneficiaries in rural areas. With respect to the OPPS, section 1833(t)(13) of the Act provided the Secretary with the authority to make an adjustment to OPPS payments for rural hospitals, effective January 1, 2006, if justified by a study of the difference in costs by APC between hospitals in rural areas and hospitals in urban areas. Our analysis showed a difference in costs for rural SCHs. Therefore, for the CY 2006 OPPS, we finalized a payment adjustment for rural SCHs of 7.1 percent for all services and procedures paid under the OPPS, excluding separately payable drugs and biologicals, brachytherapy sources, and devices paid

under the pass-through payment policy, in accordance with section 1833(t)(13)(B) of the Act. We have continued this 7.1 percent payment adjustment since 2006.

For CY 2027 and subsequent years, we proposed that rural sole community hospitals (as described under the regulations at 42 CFR 412.92 and designated as rural for Medicare purposes), children's hospitals, and PPS-exempt cancer hospitals would be exempted from the 340B payment adjustment and that these hospitals would continue to generally be paid ASP plus 6 percent for drugs. We stated that we may revisit our policy to exempt rural SCHs, as well as other hospital designations for exemption from the 340B drug payment adjustment, in future rulemaking.

We noted that hospitals listed under 42 CFR 419.20(b),[140] such as Critical Access Hospitals (CAHs) and Rural Emergency Hospitals (REHs), would not be subject to our proposed payment adjustment for 340B-acquired drugs.

We sought comment on our proposal to exempt children's hospitals, PPS-exempt cancer hospitals and rural SCHs from the 340B drug payment adjustment.

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: All commenters that commented on our proposed exemption for rural SCHs supported the exemption. These commenters emphasized that rural SCHs already operate on thin margins and are frequently the only source of hospital-based and emergency care across large, sparsely populated service areas. They appreciated CMS' recognition of the unique role they play in ensuring access to care and supporting the health of rural populations and the unique financial challenges they face.

Response: We thank the commenters for their support.

Comment: Nearly all commenters that commented on our proposed exemption for PPS-exempt cancer hospitals supported the exemption. These commenters appreciated CMS's

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[140] *https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-419/subpart-B/section-419.20.*

acknowledgement that PPS-exempt cancer centers necessitate unique reimbursement structures and indicated that a cancer-specialty hospital's portfolio of 340B drugs is focused upon high-complexity, high-cost anti-cancer therapeutics, that cancer-specialty hospitals are already subject to a highly restrictive version of the 340B Program rules that include the GPO prohibition and orphan drug exclusion, and that the exception would ensure that they would be able to continue to provide high complexity care to socioeconomically vulnerable populations.

Response: We thank the commenters for their support.

Comment: A commenter opposed the proposed exemption for PPS-exempt cancer hospitals from the 340B payment adjustment. The commenter disagreed with our rationale for excluding them, that PPS-exempt cancer hospitals receive transitional outpatient payments under section 1833(t)(7)(D) of the Act and that a reduction in claim-level drug payment could therefore be offset, in whole or in part, through the hospital's subsequent hold-harmless payment at cost-report settlement. The commenter stated that that interaction, by itself, should not justify maintaining ASP plus six percent payment for 340B-acquired drugs at these hospitals. Instead, the commenter recommended that CMS determine whether the transitional outpatient payment methodology can be administered, consistent with the statute, so that it does not negate an otherwise applicable acquisition-cost-based payment adjustment for 340B-acquired drugs. The commenter also expressed concern that exempting PPS-exempt cancer hospitals would perpetuate different Medicare payment for the same 340B-acquired drug based solely on the institutional status of the hospital furnishing it. It would allow qualifying cancer hospitals to continue receiving ASP plus six percent even when the hospital's acquisition cost is substantially below ASP, while other 340B hospitals would receive payment based on the survey-derived acquisition-cost relationship. Such a distinction would undermine CMS's objectives of aligning payment with acquisition cost, reducing inappropriate payment differentials, and reducing beneficiary cost sharing. If CMS nonetheless proceeds with exempting PPS-exempt hospitals, the commenter requested that CMS explain the statutory constraint in detail, quantify the

resulting payment and beneficiary cost-sharing effects, and consider any available mechanisms to prevent the hold-harmless methodology from restoring 340B drug payments that exceed acquisition costs.

Response: We appreciate the commenter's input; however, we do not think that the qualified exemption for PPS-exempt cancer hospitals suggested by the commenter would be administratively feasible. As previously described, by statute, these hospitals are permanently held harmless to their "pre-BBA amount," and they receive hold-harmless payments to ensure that they do not receive a payment that is lower in amount under the OPPS than the payment amount they would have received before implementation of the OPPS. Accordingly, if we were to reduce drug payments to these hospitals on a per claim basis, it is very likely that the reduction in payment would be paid back to these hospitals at cost report settlement, given the TOPs structure.

Comment: All commenters that commented on our proposed exemption for children's hospitals supported the exemption. These commenters stressed that children's hospitals serve a uniquely vulnerable patient population and rely on 340B savings to help offset systemic underpayments and sustain access to specialized pediatric services.

Response: We thank the commenters for their support.

Comment: Several commenters requested that we make our exemptions for rural SCHs, PPS-exempt cancer hospitals and children's hospitals permanent.

Response: As noted in the proposed rule, we are proposing the exemptions for rural SCHs, PPS-exempt cancer hospitals and children's hospitals for CY 2027 *and subsequent years*; however, we may revisit these exemptions in future rulemaking.

Comment: A commenter cautioned that, to the extent CMS retains exemptions, they should be justified narrowly by identifiable statutory, payment system, or access considerations.

Response: We agree with the commenter that we should employ a careful and considered approach in determining whether to continue or discontinue an exemption.

Comment: One commenter requested that the final rule and implementation guidance confirm that the term "rural sole community hospitals" includes an SCH reclassified as rural under 42 CFR 412.103.

Response: Hospitals must (1) either be a sole community hospital, as set forth in the regulations at 42 CFR 412.92, or be an essential access community hospitals, which is considered to be an SCH under section 1886(d)(5)(D)(iii)(III) of the Act, that is (2) located in a rural area, as defined in § 412.64(b), or is treated as being located in a rural area under § 412.103.

Comment: Many commenters requested CMS to provide exemptions for additional hospital types and services. Multiple commenters stated that the proposed exemptions do not capture the universe of disadvantaged rural safety-net providers and requested that other rural hospitals, including SCHs, MDHs, and LVHs be exempted. Some of these commenters requested that all rural hospitals be exempted. These commenters stated that these hospitals serve the same populations as rural SCHs and depend on 340B savings for the same reasons. Others maintained that rural SCHs were exempted from the 340B payment adjustment primarily because these hospitals are in a more vulnerable financial position and already receive a special payment adjustment under OPPS and, given that reasoning, CMS should extend the exemption to the additional rural hospital designations as well. Others suggested that all DSHs or DSH safety-net hospitals operating oncology programs serving high Medicaid, uninsured, and medically vulnerable populations be exempted. Others suggested rural referral centers and academic medical centers. Other commenters requested more general exemptions for "hospitals serving high proportions of Medicaid, uninsured, and low-income patients and hospitals located in or primarily serving health professional shortage areas and medically underserved areas," and "hospitals with substantial federal engagement and funding that serve very large rural regions." Other commenters invited CMS to use its equitable adjustment authority to exempt hospitals with significant safety-net responsibilities that would be disproportionately affected by the proposed payment adjustment. These commenters offered various criteria for CMS to use to

define these hospitals along with names to identify them: “essential health systems,” “qualifying disadvantaged hospitals,” “frontline hospitals,” and “hospitals with extraordinary safety-net responsibilities.” One commenter stated that an exemption limited to IPPS-exempt children’s hospitals would not fully protect the pediatric delivery system and requested that all children’s hospitals, including freestanding children’s hospitals, children’s hospitals within larger systems, and pediatric service lines be exempted. Finally, a few commenters suggested more targeted exemptions such as qualifying sites that administer complex cell and gene therapies or cancer and infusion services.

Response: We understand commenters’ concerns; however, we emphasize that the exemptions we are proposing are justified by the very specific circumstances of the hospital types we propose to exempt. As explained in the proposed rule, we proposed to exempt rural SCHs based on our historical analysis of the costs between hospitals in rural areas and urban hospitals, which revealed a difference in costs for rural SCHs. We also proposed to exempt PPS-exempt cancer hospitals and children’s hospitals due to their unique payment structure. We decline at this time to exempt hospitals not falling into either of these two categories; however, we may revisit our policy to exempt other hospital designations from the 340B drug payment adjustment in future rulemaking.

Comment: One commenter requested clarification as to whether the proposed payment adjustment would apply to hemophilia treatment centers.

Response: Hospitals paid under the OPPS, including excepted and non-excepted provider-based departments of the hospital, are subject to this policy. To the extent that entities are paid under OPPS and participate in the 340B Program, they are subject to the payment policy unless otherwise exempted.

After consideration of public comments, we are finalizing our proposal to exempt rural SCHs, children’s hospitals and PPS-exempt cancer hospitals from our proposed policy to adjust OPPS payments for drugs acquired under the 340B Program as proposed for CY 2027 and

subsequent years.

9. 340B Payment Policy for Drugs Furnished by Nonexcepted Off-Campus Departments of a Hospital

In the CY 2017 OPPS/ASC final rule with comment period (81 FR 79699), we discussed implementation of section 603 of the Bipartisan Budget Act of 2015 (Pub. L. 114-74), enacted on November 2, 2015, which amended section 1833(t) of the Act. Specifically, this provision amended section 1833(t) of the Act by amending paragraph (1)(B) and adding a new paragraph (21). As a general matter, under sections 1833(t)(1)(B)(v) and (t)(21) of the Act, applicable items and services furnished by certain off-campus outpatient departments of a provider on or after January 1, 2017, are not considered covered OPD services as defined under section 1833(t)(1)(B) of the Act for purposes of payment under the OPPS and will instead be paid "under the applicable payment system" under Medicare Part B if the requirements for such payment are otherwise met. We indicated that, in order to be considered part of a hospital, an off-campus department of a hospital must meet the provider-based criteria established under 42 CFR 413.65. Accordingly, we refer to an "off-campus outpatient department of a provider," which is the term used in section 603 of the Bipartisan Budget Act of 2015, as an "off-campus outpatient provider-based department" or an "off-campus PBD." For a detailed discussion of the legislative history and statutory authority related to payments under section 603 of the Bipartisan Budget Act of 2015, we refer readers to the CY 2017 OPPS/ASC final rule with comment period (81 FR 79699 through 79719) and interim final rule with comment period (81 FR 79720 through 79729).

To implement the amendments made by section 603 of Pub. L. 114-74, we issued an interim final rule with comment period (81 FR 79720), which accompanied the CY 2017 OPPS/ASC final rule with comment period to establish the PFS as the "applicable payment system" that applies in most cases, and we established payment rates under the PFS for those nonexcepted items and services furnished by nonexcepted off-campus PBDs. Specifically, we

established a PFS relativity adjuster that is applied to the OPPS rate for the billed nonexcepted items and services furnished in a nonexcepted off-campus PBD to calculate payment rates under the PFS. The PFS relativity adjuster reflects the estimated overall difference between the payment that would otherwise be made to a hospital under the OPPS for the nonexcepted items and services furnished in nonexcepted off-campus PBDs and the resource-based payment under the PFS for the technical aspect of those services with reference to the difference between the facility and nonfacility (office) rates and policies under the PFS. The current PFS relativity adjuster is set at 40 percent of the amount that would have been paid under the OPPS (90 FR 53770). These PFS rates include the same packaging rules that are unique to the hospital outpatient setting under the OPPS, including the packaging of drugs that are unconditionally packaged under the OPPS. This includes packaging certain drugs and biologicals that would ordinarily be separately payable under the PFS when furnished in the physician office setting. For a full discussion of our initial implementation of section 603, we refer readers to the CY 2017 OPPS/ASC final rule with comment period (81 FR 79699 through 79719) and the interim final rule with comment period (79720 through 79729). For a detailed discussion of the current PFS relativity adjuster related to payments under section 603, we refer readers to the CY 2018 OPPS/ASC final rule with comment period (82 FR 52356 through 52637) and the CY 2019 PFS final rule with comment period (82 FR 59505 through 59513).

We note that, ordinarily, Medicare pays for drugs and biologicals furnished in the physician's office setting at ASP plus 6 percent. This is because section 1842(o)(1)(A) of the Act provides that if a physician's, supplier's, or any other person's bill or request for payment for services includes a charge for a drug or biological for which payment may be made under Medicare Part B and the drug or biological is not paid on a cost or prospective payment basis as otherwise provided in this part, the amount for the drug or biological is equal to the following: The amount provided under section 1847, section 1847A, section 1847B, or section 1881(b)(13) of the Act, as the case may be for the drug or biological.

Generally, in the hospital outpatient department setting, low-cost drugs and biologicals are packaged into the payment for other services billed under the OPPS. Separately payable drugs (1) have pass-through payment status, (2) have a cost per day exceeding a threshold, or (3) are not policy-packaged or packaged in a C-APC. As described in sections V.A. and V.B. of this final rule with comment period, section 1847A of the Act establishes the ASP methodology, which is used for payment for drugs and biologicals described in section 1842(o)(1)(C) of the Act furnished on or after January 1, 2005. The ASP methodology, as applied under the OPPS, uses several sources of data as a basis for payment, including the ASP, the WAC, and the AWP (90 FR 53682). As noted in section V.B. of this final rule with comment period, since CY 2013, our policy has been to pay for separately payable drugs and biologicals at ASP plus 6 percent in accordance with section 1833(t)(14)(A)(iii)(II) of the Act (the statutory default) (90 FR 53702). Consequently, in the case of services furnished in a hospital outpatient department, Medicare has historically paid ASP plus 6 percent for separately payable Part B drugs and biologicals. For a detailed discussion of our current OPPS drug payment policies, we refer readers to the CY 2026 OPPS/ASC final rule with comment period (90 FR 53697 through 53766).

As a general matter, in the nonexcepted off-campus PBD setting, we pay hospitals under the PFS for all drugs and biologicals that are packaged under the OPPS based on a percentage of the OPPS payment rate, which is determined using the PFS relativity adjuster. Because OPPS packaging rules apply to the PFS payments to nonexcepted off-campus PBDs, the PFS payment for some nonexcepted items and services that are packaged includes payment for some drugs and biologicals that would be separately billable under the PFS if a similar service had been furnished in the office-based setting. As we noted in the CY 2017 final rule with comment period, in analyzing the term "applicable payment system," we considered whether and how the requirements for payment could be met under alternative payment systems in order to pay for nonexcepted items and services, and considered several payment systems under which payment is made for similar items and services (81 FR 79712). Because the PFS relativity adjuster that is

applied to calculate payment to hospitals for nonexcepted items and services furnished in nonexcepted off-campus PBDs is based on a percentage (40 percent) of the amount determined under the OPPS for a particular item or service, and the OPPS is a prospective payment system, we believed that items and services furnished by nonexcepted off-campus PBDs paid under the PFS were payable on a prospective payment basis. Therefore, we believed we had flexibility to pay for separately payable drugs and biologicals furnished in nonexcepted off-campus PBDs at an amount other than the amount dictated by sections 1842(o)(1)(C) and 1847A of the Act.

As discussed previously, our proposal to adjust the payment rate for separately payable drugs and biologicals (other than vaccines, drugs on pass-through payment status and non-opioid pain management drugs) acquired under the 340B Program from ASP plus 6 percent to ASP minus 33.4 percent would apply to separately payable drugs and biologicals paid under the OPPS. Under sections 1833(t)(1)(B)(v) and (t)(21) of the Act, however, nonexcepted items and services furnished by nonexcepted off-campus PBDs are not covered outpatient department services and, therefore, are not payable under the OPPS. This means that, absent our inclusion of them in our proposed policy, nonexcepted off-campus PBDs would not be subject to the payment changes we proposed. Because hospitals can, in some cases, acquire drugs and biologicals under the 340B Program for use in nonexcepted off-campus PBDs, we believe that not adjusting payment for these departments would present a significant incongruity between the payment amounts for these drugs depending upon where (for example, excepted or nonexcepted PBD) they are furnished. This incongruity would distort the relative accuracy of the resource-based payment amounts under the site-specific PFS rates and could result in significant perverse incentives for hospitals to acquire drugs, biologicals, biosimilars, and radiopharmaceuticals under the 340B Program and avoid Medicare payment adjustments that account for the discount by providing these drugs to patients predominantly in nonexcepted off-campus PBDs. It would also undermine our goals of reducing beneficiary cost-sharing for these drugs and biologicals and moving towards site neutrality through the section 603 amendments to section 1833(t) of the

Act. To avoid such perverse incentives and the resulting distortions, we proposed for CY 2027 and subsequent years, to pay an amount equal to ASP minus 33.4 percent, or equivalent, for drugs, biologicals, biosimilars, and radiopharmaceuticals acquired under the 340B Program that are furnished by nonexcepted off-campus PBDs.

Consistent with the approach to budget neutrality we adopted when we previously implemented a reduction for 340B-acquired drugs furnished by nonexcepted off-campus PBDs (83 FR 59021) and our approach to budget neutrality for items and services provided by nonexcepted off-campus PBDs generally (83 FR 58832), these adjusted payments would not be budget neutralized.

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: A few commenters supported our proposal to apply the proposed 340B payment adjustment to drugs furnished in nonexcepted off-campus PBDs. A commenter stated that consistent payment treatment for 340B-acquired drugs would help ensure that the site at which a drug is administered is not selected merely because of a payment differential. Another commenter stated that they "particularly support[ed] applying the proposed 340B payment adjustment to drugs furnished in nonexcepted off-campus PBDs." The commenter explained that "[t]hese departments remain hospital-owned and may have access to 340B acquisition discounts even though Medicare generally pays for their services under a methodology intended to approximate payment in the physician office setting. Leaving 340B-acquired drugs furnished in these departments at ASP plus six percent would preserve a substantial payment advantage based solely on hospital ownership, and undermine the purpose of moving toward site neutral payment." The commenter agreed with CMS that failing to apply the adjustment would create distorted incentives for hospitals to furnish 340B drugs through these departments and encouraged CMS to continue examining Medicare payment policies that create different financial incentives for the same service based primarily on site of care or ownership. "Payment

differentials can influence organizational decisions about where services are furnished and contribute to consolidation without improving the care patients receive." The commenter concluded by encouraging CMS to consider the proposed 340B payment adjustment "as part of its broader efforts to reduce unnecessary site-of-service payment disparities while ensuring that savings attributable to these reforms benefit patients and the Medicare program."

Response: We thank commenters for their support.

Comment: Several commenters referenced previous comments they or others made to the CY 2019 final rule alleging that CMS lacks the authority under 1833(t)(21)(C) of the Act to adjust drug payments to nonexcepted off-campus PBDs or to do so in a non-budget neutral manner.

Response: We direct readers to our responses to those comments in the CY 2019 final rule at 83 FR 59020 through 59022.

Comment: Several commenters alleged that CMS's proposal is arbitrary and capricious because it undermines Congress's intent under the 340B statute.

Response: We have explained earlier in this rule why we do not believe that our proposed policy undermines Congress's intent under the 340B statute. The purpose of this policy is to align Medicare payment with average acquisition costs as required by statute.

Comment: A commenter stated that we lack a sound rationale for applying the proposed reduction to nonexcepted off-campus PBDs. The commenter contends that we provide no empirical evidence for our conclusion that not applying the reduction to nonexcepted off-campus PBDs could result in significant perverse incentives for hospitals to acquire drugs under the 340B Program and avoid Medicare payment adjustments. The commenter requests that CMS publish the data and methodological information necessary to independently verify the accuracy of the agency's estimates, including which 340B providers CMS used to estimate its payment impact, whether the agency applied any exclusion criteria, and how CMS accounted for hospitals that are not included in the OPPS impact file but would be subject to the agency's proposed

340B payment adjustment policy.

Response: We disagree that we lack a sound rationale for applying the proposed reduction to nonexcepted off-campus PBDs. We do not think that it is unreasonable to assume that if an entity can furnish a drug in one setting and receive significantly more (nearly 40 percent) payment for the drug then it would receive furnishing the same drug in a different setting, that there exists an incentive for the entity to provide the drug in the setting in which they would receive the higher payment.

After consideration of public comments, we are finalizing our proposal to apply our payment policy to 340B-acquired drugs furnished in nonexcepted off-campus PBDs as proposed.

We expect that for CY 2027 this will result in savings of approximately $640 million to the Medicare Part B Trust Fund and would collectively reduce beneficiary copayments by an estimated $160 million. These beneficiary savings are included in the $1.1 billion figure for reduced beneficiary copayments for drugs in section 7. Beneficiary Copayments.

10. Billing Modifiers

To effectuate the payment adjustment for 340B-acquired drugs, we proposed that, beginning January 1, 2027, providers who are not exempted from the 340B payment adjustment would report modifier "JG" (Drug or biological acquired with 340B Drug Pricing Program Discount) to identify if a drug was acquired under the 340B Program. The phrase "acquired under the 340B Program" would include all drugs acquired under the 340B Program or Prime Vendor Program, regardless of the level of discount applied to the drug. Drugs that were not acquired under the 340B Program would not be reported with the modifier "JG." For separately payable drugs (status indicator "K"), application of modifier "JG" would trigger a payment adjustment such that the 340B-acquired drug is paid at ASP minus 33.4 percent.

We additionally proposed that, beginning January 1, 2027, for drugs or providers that are exempted from the 340B drug payment policy for CY 2027, which include pass-through drugs (status indicator "G"), non-opioid treatment for pain relief drugs authorized under section 4135

of the CAA, 2023 (status indicator "K1"), rural SCHs, children's hospitals, and PPS-exempt cancer hospitals, should not report modifier "JG." Instead, these exempted providers should report the informational modifier "TB" (Drug or Biological Acquired With 340B Drug Pricing Program Discount, Reported for Informational Purposes) to identify OPPS separately payable drugs purchased with a 340B discount. The informational modifier "TB" will facilitate the collection and tracking of 340B claims data for OPPS providers that are exempted from the payment adjustment in CY 2027. However, use of modifier "TB" will not trigger a payment adjustment, and these providers will generally receive ASP plus 6 percent for separately payable drugs furnished in CY 2027, even if such drugs were acquired under the 340B Program.

We also proposed that, beginning January 1, 2027, all providers report a distinct modifier to identify drugs and biologicals that were not acquired under the 340B Program. Specifically, we proposed to establish a new modifier, designated in the proposed rule with the placeholder modifier code "XX" (Drug or biological not acquired under the 340B Drug Pricing Program), which would be required to be reported for all separately payable drugs that were purchased outside of the 340B Program.

The requirement to use modifier "XX" would apply to all providers paid under the OPPS, including excepted and nonexcepted off-campus PBDs. Reporting the modifiers "XX," "JG," or "TB" for applicable drugs would ensure that all drug claims are consistently categorized as either 340B-acquired or non-340B-acquired. We believe that requiring the use of modifier "XX" for non-340B drugs will improve the completeness and consistency of claims data, facilitate program integrity and oversight, and enhance our ability to monitor acquisition patterns across providers. The use of modifier "XX" would not trigger a payment adjustment and such drugs would continue to be paid at the applicable OPPS rate (generally ASP plus 6 percent for separately payable drugs) consistent with existing policy. In summary, we proposed all separately paid drug claims reported under the OPPS would be reported with a modifier of either

"JG," "TB," or "XX" (Table 75). We solicited comment on our proposal to require all separately paid drug claims to be reported with a modifier of either "JG," "TB," or "XX."

As stated in the CY 2027 OPPS/ASC proposed rule, we believe the addition of this new modifier is consistent with the decisions that hospitals are already making (is the drug a 340B-acquired drug or a non-340B-acquired drug) when billing for these drugs. As previously mentioned, we believe requiring the use of modifier "XX" for non-340B drugs will improve the completeness and consistency of claims data – this requirement could even decrease burden on hospitals as it may improve the accuracy of billing, thus decreasing the need for hospitals to reprocess claims that were billed incorrectly. We requested comment as to whether the addition of modifier "XX" would create unnecessary, undue burden for hospitals.

TABLE 75: PROPOSED DRUG CLAIM MODIFIERS FOR ENTITIES PAID UNDER THE OPPS

Hospital Type	Pass-through Drug (SI "G")	Separately Payable Drug (SI "K")	Non-Opioid Treatment for Pain Relief Drug (SI "K1")	Packaged Drug (SI "N")
340B Drugs				
340B Hospitals	TB	JG	TB	TB
Children's Hospitals	TB	TB	TB	TB
PPS-Exempt Cancer Hospitals	TB	TB	TB	TB
Rural Sole Community Hospitals	TB	TB	TB	TB
Non-340B Drugs				
All OPPS Hospitals	XX			XX Optional

Additionally, we acknowledged this billing modifier proposal would have implications for how we identify billing units of drugs acquired through the 340B Program under the Medicare Part B Drug Inflation Rebate Program. In the CY 2025 Physician Fee Schedule (PFS)

final rule (89 FR 98583), we codified at § 427.303(b)(1)(iv) that we will exclude from Part B rebate calculations separately payable billing units in claim lines for institutional claims that are billed with the "TB" modifier for claims with dates of service on or after January 1, 2025. As we stated in the proposed rule, establishing a requirement to use the "JG" modifier, in addition to the requirement to use the "TB" modifier would necessitate changes to how we identify 340B units to exclude from Part B rebate calculations.

Consequently, we proposed a conforming change at § 427.303(b)(1)(iv) to reflect proposed changes to the requirements to use billing modifiers for 340B-acquired drugs as described in section V.B.10. of this final rule with comment period. Specifically, to account for these billing modifier proposals, at § 427.303(b)(1)(iv), we proposed to add "or successor billing modifiers to identify 340B units." This means, for the purposes of Part B inflation rebate calculations, we would exclude billing units acquired under the 340B Program as identified through separately payable units in claim lines billed with the "TB" modifier, or successor billing modifiers to identify 340B units for 340B-acquired drugs, for claims with dates of service on or after January 1, 2025. Therefore, as a matter of operations, effective January 1, 2027, CMS would identify separately payable billing units in claim lines billed with the "TB" modifier and proposed "JG" modifier. We recognized that policy amendments for the Medicare Prescription Drug Inflation Rebate Program are typically proposed in the PFS; however, we believed it was appropriate to propose an amendment to § 427.303(b)(1)(iv) in the OPPS/ASC proposed rule due to timing differences in the publication of the CY 2027 PFS proposed rule relative to the OPPS/ASC proposed rule and to ensure we are able to appropriately exclude 340B units from Part B rebate calculations starting January 1, 2027.

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: Some commenters unreservedly supported our proposals relating to modifiers. One commenter stated that, "taken together, these three modifiers would, for the first time,

categorize every separately payable drug claim under the OPPS as either 340B-acquired or non-340B-acquired. That completeness will further make the data usable and meaningful." Another commenter praised the proposal as a step toward greater transparency in the 340B Program. A third commenter called the modifier "long awaited" and stated that it would help ensure Medicare has reliable claims-level data to distinguish drugs that should be subject to the 340B payment adjustment from those that should not, helping prevent inaccurate payments before they are made. Another commenter stated that ensuring every separately paid drug claim is consistently categorized as either 340B or non-340B will improve the completeness and consistency of claims data, facilitate program integrity oversight, and enhance CMS's ability to monitor acquisition patterns.

Response: We thank commenters for their support.

Comment: Several commenters provided suggestions for the use of the modifiers beyond what we proposed. One commenter suggested that we use the claims modifiers to annually recalculate the budget-neutrality adjustment factor to ensure that the 340B payment policy is being implemented in a consistently budget-neutral manner. Another commenter urged CMS to expand the application of the XX claims modifier and require all Medicare claims, including under Part D and Medicare Advantage, to have the appropriate modifier within 10 days of dispense. A third commenter recommended that CMS consider the following implementation refinements to ensure consistent administration and compliance with the Inflation Reduction Act (IRA): (1) extend this requirement beyond drugs paid for under the OPPS to all Part B claims that report a drug; and (2) extend the XX modifier requirement to all non-340B drugs, not just those that are separately payable.

Response: We thank commenters for their suggestions and will potentially consider them for future rulemaking where appropriate.

Comment: A commenter supported the use of modifiers but requested that we limit their application to separately payable drugs furnished by 340B hospitals.

Response: We thank the commenter for their suggestion; however, for the reasons discussed in the proposed rule, it is necessary to apply the proposed modifier requirement to 340B and non-340B hospitals to effectively implement our 340B Payment Policy.

Comment: Many commenters opposed the proposal as being administratively burdensome. These commenters expressed concern with the costs associated with implementing the modifiers such as adapting their electronic health record and billing systems and training their staff. A commenter noted the immense technical complexity of adopting the new modifier, requiring extensive reconfigurations across electronic health records (EHRs), pharmacy management systems, charge description masters, and revenue cycle platforms systemwide. Another commenter stated that "because 340B drugs are generally managed through a replenishment model, the purchasing information necessary to identify how a drug is ultimately replenished may not be available at the same point in time that the claim is submitted. This may require hospitals to develop additional processes to reconcile pharmacy purchasing information with claims data." The commenter encouraged CMS to ensure that any modifier requirements account for the operational realities of the 340B replenishment process and do not add administrative burden. Many commenters claimed that it would not be feasible to implement the proposed changes by January 1, 2027, and requested a delayed or phased-in implementation start date coupled with robust implementation guidance. These commenters stated that hospitals would need to modify their systems, interfaces, edits, training, quality controls, reconfigure charge description masters, pharmacy inventory systems, split billing software, claim scrubbers, and revenue cycle logic, and retrain pharmacy and billing staff between publication of a final rule around November 1 and an effective date of January 1. Commenters suggested various alternative timeframes for making the modifier changes effective as well as requesting that CMS issue sub-regulatory billing guidance by a date certain, provide claim edit testing, and refrain from denials or recoupments for good-faith modifier errors during a defined transition period.

Many commenters stated that the scope and complexity of implementing the new

modifier would greatly increase the risk of errors. A commenter stated that it would be difficult to identify every non-340B claim accurately and that that would create a high volume of potential billing mistakes, which could lead to rejected claims or compliance audits. Another commenter cautioned that minor misconfigurations or data mapping errors could trigger widespread claim rejections and payment denials. A third commenter found the XX modifier to be especially concerning because non-340B status may depend on purchasing, replenishment, mixed-use inventory, patient eligibility, accumulator logic, wholesaler data, and retrospective claim information and a missing or incorrect modifier could result in denials, underpayment, reprocessing, audits, and compliance exposure.

Many commenters also allege that new modifier XX is unnecessary and duplicative. These commenters state that the new modifier is not needed because CMS would be able to identify 340B drugs with the TB and JG modifiers. A commenter stated that "[a]ny drugs that do not have either of those modifiers appended would be a non-340B drug, so the 'XX' modifier is unnecessary." Another commenter alleges that "[a]ny claim line without either modifier is, by definition, already identifiable as a non-340B drug. The XX-placeholder modifier is therefore redundant: requiring hospitals to affirmatively identify what is already the logical default would add a data field without providing new information."

A commenter urged CMS to consider other, less-burdensome options, such as creating a neutral clearinghouse for 340B claims.

Response: We recognize that implementation of the new XX modifier may be the source of some amount of administrative burden for some hospitals. However, the XX modifier is a necessary component of our proposal, and we do not believe that its implementation would be unduly burdensome or warrant a delay or phased-in approach. This modifier does not require the provider to obtain any additional information to use as it only requires information that the provider already has: whether the drug was acquired under the 340B Program.

The addition of this new modifier is consistent with the decisions that hospitals are

already making (is the drug a 340B-acquired drug or a non-340B-acquired drug) when billing for these drugs. As previously mentioned, we believe requiring the use of modifier "XX" for non-340B drugs will improve the completeness and consistency of claims data – this requirement could even decrease burden on hospitals as it may improve the accuracy of billing, thus decreasing the need for hospitals to reprocess claims that were billed incorrectly.

We question those commenters who stated they would be unable to identify the non-340B claims as the provenance of the drug is something that the entities should know.

With respect to comments about timing to operationalize the new modifier, we note that hospitals have been on notice since the proposed rule went on display at the Office of the Federal Register on July 7, 2026 that CMS was considering establishing a new modifier for non-340B drugs, if finalized. In addition, the new modifier will not be required until January 1, 2027, which after display of this final rule with comment period will give hospitals two additional months to operationalize the modifier. Under section 1835(a) of the Act, providers have 12 months after the date of service to timely file a claim for payment. Therefore, for those hospitals that may need more time to ensure that they are in compliance with the modifier requirements, they have 12 months from the date of service to do so.

Comment: A few commenters commented on our proposed conforming amendment to 42 CFR 427.303(b)(1)(iv) to account for successor billing modifiers used to identify 340B units. All commenters supported our proposal. One commenter suggested additional textual revisions. Specifically, the commenter recommended that CMS conform the regulatory text to the preamble by using disjunctive rather than conjunctive phrasing: "The preamble proposes to add 'or successor billing modifiers to identify 340B units,' but the proposed regulatory text reads 'billed with the 'TB' modifier and successor billing modifiers to identify 340B units.' Read literally, the codified text's conjunctive phrasing would require both modifiers on the same claim line. Because TB and JG are mutually exclusive in CMS's own design, that reading would exclude far fewer 340B units than CMS intends and would increase manufacturers' rebatable billing units

correspondingly. CMS should revise the codified text to reflect the disjunctive phrasing in the preamble."

Response: We appreciate the feedback from the commenter and, after reviewing the proposed regulation at § 427.303(b)(1)(iv), we agree that this appears to be an unintended technical error. We are therefore finalizing a modification to the text at § 427.303(b)(1)(iv) to replace "and" with "or" so that it reads: "Separately payable billing units in claim lines billed with the 'TB' modifier or successor billing modifiers to identify 340B units, for claims with dates of service on or after January 1, 2025."

After consideration of public comments, we are finalizing our proposal to require all separately paid drug claims to be reported with a modifier of either "JG," "TB," or "XX" as proposed. We note placeholder "XX" is being replaced with permanent modifier "ND" as reflected in the final table below. We are also finalizing with modification our proposal for a conforming amendment to 42 CFR 427.303(b)(1)(iv) to account for successor billing modifiers used to identify 340B units.

TABLE 76: FINAL DRUG CLAIM MODIFIERS

Hospital Type	Pass-through Drug (SI "G")	Separately Payable Drug (SI "K")	Non-Opioid Treatment for Pain Relief Drug (SI "K1")	Packaged Drug (SI "N")
340B Drugs				
340B Hospitals, non-excepted and excepted Off Campus PBDs	TB	JG	TB	TB
Children's Hospitals	TB	TB	TB	TB
PPS-Exempt Cancer Hospitals	TB	TB	TB	TB
Rural Sole Community Hospitals	TB	TB	TB	TB
Non-340B Drugs				

Hospital Type	Pass-through Drug (SI "G")	Separately Payable Drug (SI "K")	Non-Opioid Treatment for Pain Relief Drug (SI "K1")	Packaged Drug (SI "N")
340B Drugs				
All OPPS Hospitals, non-excepted and excepted Off Campus PBDs	ND			ND Optional

D. CY 2027 OPPS Payment Methodology for Non-340B-Acquired Drugs Based on ODACS

CMS analyzed acquisition cost data collected through the ODACS for drugs acquired outside the 340B Program and evaluated several methodologies for estimating the relationship between hospitals' acquisition costs and ASP-based payment amounts as previously discussed in this section.

Using our preferred proposed methodology, which calculates acquisition cost margins using the geometric mean of survey-reported acquisition costs, we estimate that hospitals' acquisition costs for non-340B drugs were approximately 2.7 percent above ASP during the survey period. However, we recognize that acquisition costs reported through the survey may not fully reflect all manufacturer rebates, chargebacks, administrative fees, or other post-purchase price concessions received by hospitals, as we have not included GPO discounts into the ASP plus 2.7 percent figure. Therefore, even ASP plus 2.7 percent, the reported acquisition costs, may overstate hospitals' net acquisition costs. As a result, the estimated margin of ASP plus 2.7 percent may, in part, reflect differences in how manufacturer rebates and other retrospective discounts were reported rather than solely the underlying acquisition costs of the drugs.

The survey results for non-340B drugs exhibit greater variation than the survey results for 340B-acquired drugs. As a result, the confidence intervals for the estimated non-340B acquisition cost margins span a slightly wider range of potential values. We believe this finding is expected given the diversity of purchasing arrangements, contracting structures, and acquisition channels available to hospitals when acquiring drugs outside the 340B Program. The broader distribution of survey-reported acquisition costs suggests greater uncertainty regarding

the precise average acquisition cost margin for non-340B drugs relative to the margin observed for 340B-acquired drugs.

Although the survey data suggest that hospitals' acquisition costs for non-340B drugs may be lower on average from the current payment rate of ASP plus 6 percent, the survey results are subject to slightly greater variability and may be affected by differences in the reporting of manufacturer rebates and other price concessions. Consequently, we believe the survey data should be interpreted further as we assess the need for a payment rate change for non-340B drugs.

Given the need to further consider the non-340B survey results for the reasons mentioned, including the range of reasonable acquisition cost estimates supported by the data, we did not propose to establish a survey-based payment rate for non-340B drugs. Rather, for CY 2027, after taking into account the survey results, we proposed to continue paying separately payable non-340B drugs, biologicals, biosimilars, and radiopharmaceuticals as we do in CY 2026, which is generally at a rate of ASP plus 6 percent. We believe this approach appropriately considers the survey findings, including the uncertainty associated with manufacturer rebate reporting and the broader distribution of acquisition cost estimates, while maintaining stability in payment rates and allowing CMS to continue evaluating acquisition cost information obtained through its survey authority under section 1833(t)(14)(D)(ii) of the Act.

Under the same survey-based methodology proposed for determining payment for 340B-acquired drugs, such an approach for non-340B drugs would be based on the geometric mean acquisition cost estimate derived from the survey data, resulting in a payment rate of approximately ASP plus 2.7 percent. In the case of the 340B-acquired drugs, the discrepancy between acquisition cost and Medicare payment is substantial and obviously apparent; however, the discrepancy between acquisition cost and Medicare payment for non-340B acquired drugs is much less significant. Therefore, we proposed to continue paying for non-340B acquired drugs at a rate of ASP plus 6 percent. We also intended to continue evaluating the acquisition cost

survey data for non-340B-acquired drugs and noted we may consider the results of this analysis in future rulemaking.

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: Several commenters supported our proposal to maintain the current payment rate for CY 2027 for separately payable drugs and biologicals without pass-through payment status that are not acquired under the 340B Program. These commenters stated that this method of payment makes hospital reimbursement predictable, accurate, and maintains parity with the physician office setting. One of these commenters stated that applying a payment change to non-340B drugs on the strength of data that is more widely dispersed than the data for 340B drugs would introduce risk for products that are dispensed infrequently as compared to non-orphan drugs. Several of these commenters cautioned CMS against future reductions to non-340B drugs. A commenter opined that applying any reimbursement reductions for drug purchases would be particularly difficult to justify because non-340B hospitals generally acquire drugs without the substantial discounts available through the 340B Program. Multiple commenters observed that since survey reported acquisition costs were only 2.7 percent above the mean ASP and 2.8 percent above the median ASP, that this means that for any given non-340B drug, it is likely that ASP will be roughly the same as the non-340B purchase price.

Response: We thank commenters for their support. With respect to future payment adjustments to non-340B drugs, as we indicated in the proposed rule, we are continuing to evaluate the survey data.

Comment: Several commenters expressed concern with the asymmetry of applying survey findings to reduce OPPS payment for 340B drugs but not to adjust payment for non-340B drugs. One commenter alleged that this demonstrates that CMS is "applying the survey aggressively when it produces savings but disregards it where application would reduce payment to non-340B hospitals." The commenter contends that this inconsistency undermines our

rationale that payments should reflect actual acquisition cost. The commenter also pointed out that the failure to reduce OPPS payments for non-340B drugs will create a situation where non-340B hospitals will see their total OPPS reimbursements increase due to budget neutrality. The commenter finds this outcome to be unfair and discriminatory based on 340B status. The commenter contends that the proposed payment rate will result in an underpayment for some 340B drugs since the 340B discount can range from 23.1 percent to 100 percent depending on manufacturers' actions. CMS' proposal to apply a single ASP percentage reduction of 33.4 percent to all drugs supposedly will underpay hospitals for 340B drugs subject to any discount above 33.4 percent. The commenter says that based on this underpayment of some 340B drugs, they will choose to not dispense a 340B drug to patients where the 340B payment would result in an underpayment. Instead, the commenter will purchase those drugs at the list price (wholesale acquisition cost), submit the claim without a 340B modifier, and receive the ASP plus 6 percent payment. It is the commenter's belief that other hospitals and health systems will do the same thing, which will significantly impact CMS proposed budget savings of $5.7 billion from this proposed payment adjustment.

Response: We acknowledge that we are proposing to adjust payment for 340B-acquired drugs but not for non-340B-acquired drugs in CY 2027. However, this asymmetry is simply the result of our analysis of the survey data in conjunction with ceiling prices required under the 340B Program for which there is no corollary outside of that program. As we explained in the proposed rule, based on the respective confidence intervals for 340B and non-340B drugs, we believe it is appropriate to move forward with an adjustment for 340B-acquired drugs in CY 2027 but to continue to study the data with respect to non-340B-acquired drugs. We disagree with the commenter that we are discriminating against 340B hospitals in doing so. We are better aligning our payment for 340B-acquired drugs with the cost of their acquisition, as demonstrated by the survey and supported by ceiling-price data, in compliance with section 1833(t)(14) of the Act and we are budget neutralizing that payment adjustment in compliance with our statutory

budget neutrality obligations. The nearly 40 percent discrepancy for 340B-acquired drugs is so drastic and obvious it needs to be addressed immediately; however, the preliminary non-340B average acquisition cost is only a few percentage points away from the current payment rate and warrants additional consideration before proposing changes, especially considering there is no non-340B corollary to 340B ceiling prices.

Comment: One commenter suggested that, based on the confidence interval spread for 340B drugs, CMS should conclude that the current payment rate for non-340B drugs is in fact the current payment rate for non-340B drugs (ASP plus 6 percent). Alternatively, the commenter indicated that they also supported our determination in the proposed rule that hospital acquisition data is not currently available for non-340B drugs such that payment under section 1833(t)(14)(A)(iii)(II) (i.e., ASP plus 6 percent) continues to be appropriate.

Response: We thank the commenter for their suggestion and for their support of our proposal to pay ASP plus 6 percent for non-340B-acquired drugs for CY 2027. As we indicated in the proposed rule, we continue to evaluate acquisition cost information obtained through CMS's survey authority under section 1833(t)(14)(D)(ii) of the Act.

After consideration of public comments, we are finalizing our proposal to continue paying for non-340B-acquired drugs at a rate of ASP plus 6 percent for CY 2027.

E. Summary

In summary, after consideration of public comments received, for the reasons discussed above, we are not finalizing our proposal for CY 2027 and subsequent years to pay for drugs acquired under the 340B Program at ASP minus 33.4 percent. Instead, we are finalizing our alternative proposal for CY 2027 and subsequent years to pay for drugs acquired under the 340B Program at ASP minus 28 percent and are revising 42 CFR 419.41(d) and adding a new paragraph (k) to implement this payment change. We are finalizing our proposal to pay for drugs acquired outside of the 340B Program at ASP plus 6 percent. We are also finalizing our proposal to exempt rural SCHs, PPS-exempt cancer hospitals and children's hospitals from the 340B

Payment Policy for CY 2027 and subsequent years. We are also finalizing our proposal that hospitals paid under the OPPS, other than a type of hospital excluded from the OPPS (such as CAHs or REHs) or exempted from the 340B drug payment policy for CY 2027, are required to report modifier "JG" on the same claim line as the drug HCPCS code to identify a 340B-acquired drug; the modifier "TB" for all pass-through drugs, non-opioid treatment for pain relief drugs, and 340B-acquired drugs reported by rural SCHs, children's hospitals and PPS-exempt cancer hospitals for informational purposes; and the modifier "XX" (finalized as "ND") for all drugs that were not acquired through the 340B Program. We note these payment policies apply to both excepted and non-excepted provider-based departments of a hospital. Finally, we are finalizing our proposal with modification to make a conforming change to § 427.303(b)(1)(iv) to ensure our process to identify 340B units for purposes of Part B inflation rebate calculations aligns with our proposed 340B modifier billing requirements. All of these finalized proposals are effective January 1, 2027.

F. Budget Neutrality

As we proposed the previously defined payment adjustments through our authority under section 1833(t)(14)(A)(iii)(I) of the Act, we also proposed making this adjustment in a budget neutral manner. To maintain budget neutrality within the OPPS, we estimated that OPPS payment for 340B-acquired drugs would be reduced by approximately $4.85 billion in CY 2027; however, these payments would be redistributed in an equal offsetting amount to all hospitals paid under the OPPS through increased payment rates for non-drug items and services furnished by all hospitals paid under the OPPS. Specifically, the redistributed dollars would increase the conversion factor for OPPS non-drug items and services by 8.44 percent for CY 2027.

We also estimated the alternative methodology previously described to pay 340B-acquired drugs at ASP minus 28 percent, which is the average acquisition cost calculated from the 340B ceiling prices and volume weighted by OPPS utilization data. Through this method, we estimated that OPPS payment for 340B-acquired drugs would be reduced by approximately

$4.68 billion in CY 2027. Specifically, the redistributed dollars would increase the conversion factor for OPPS non-drug items and services by 8.14 percent for CY 2027.

For additional details on our proposed budget neutral implementation of this policy, please see section II.B. of this final rule with comment period.

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: Several commenters acknowledged our statutory obligation to budget neutralize our proposed payment adjustment. One commenter stated that "this adjustment is both appropriate and required."

Response: We thank commenters for recognizing our statutory obligation to budget neutralize our proposed payment adjustment.

Comment: Several commenters supported budget neutralizing our proposed payment adjustment due to the benefit the budget-neutral redistribution would provide to many hospitals, including those serving rural and underserved communities. One of these commenters expressed disappointment that physician practices would not receive the corresponding increase in OPPS payment for non-drug items and services. The commenter opined that payment under the Medicare PFS continues to lag OPPS payment for many comparable services and stated that this distributional effect underscores the need for CMS, through PFS rulemaking, to ensure that payment to independent physician practices reflects the realistic cost of furnishing high-quality care and supports continued beneficiary access.

Response: We thank commenters for their support. With respect to the commenter's suggestion that we address differences in payment between the PFS and the OPPS, as acknowledged by the commenter this issue is outside the scope of this rulemaking.

Comment: Several commenters, including MedPAC, supported reducing payment for 340B-acquired drugs generally but lamented our statutory obligation to budget neutralize those reductions. These commenters disliked its effect of increasing beneficiary copayments for non-

drug items and services and contributing to greater differences in Medicare's payment rates for those services delivered in both the hospital and office settings. These commenters urged us to work with Congress to enable us to implement the payment adjustment in a non-budget neutral manner.

Response: We thank MedPAC and the other commenters for their feedback and will take their suggestion under consideration for future rulemaking, if applicable.

Comment: Many commenters requested that CMS recalculate the budget-neutrality adjustment on an annual basis, using OPPS claims data from the prior year to ensure the policy is implemented in a fully budget neutral manner. These commenters pointed to the implementation of our previous 340B payment policy and stated that because we did not recalculate the budget neutrality adjustment to account for volume changes in drug claims and non-drug claims over the duration of that policy, the original adjustment did not reflect actual claims.

Response: We are fully implementing budget neutrality for CY 2027. We will consider recalculating the budget-neutrality adjustment on an annual basis for future rulemaking.

Comment: Many commenters claimed that budget neutrality does not require a uniform redistribution across hospitals and that CMS should prioritize "essential hospitals," "true safety-net hospitals," teaching hospitals, non-exempted children's hospitals, "hospitals that demonstrably serve the greatest numbers of Medicare beneficiaries, Medicaid beneficiaries, dual-eligible individuals, and low-income patients," and "hospitals whose operations and missions are consistent with the intent of the 340B Program, particularly nonprofit hospitals with a demonstrated commitment to providing charity care and serving underserved populations" in the budget neutral redistribution.

Response: While we recognize the commenters' concerns regarding the effect of budget neutrality on the hospital types they list, we note that the purpose of the 340B Payment Policy is not to replace the 340B Program. We have attempted to address some of these concerns through the finalized exemptions for rural sole community hospitals, PPS-exempt cancer hospitals, and

children's hospitals.

Comment: Many commenters observed that the 8.44 percent increase to payment for non-drug items and services would not make all hospitals whole. The commenters state that hospitals with substantial 340B drug volume would experience a drug payment reduction, while hospitals with comparatively little or no 340B exposure would receive the benefit of the increased payments for non-drug services. A commenter stated "[t]here is no assurance that the hospital will recover what it loses." Another commenter observed that "[a] hospital that experiences a substantial reduction in drug payments will not necessarily receive sufficient additional reimbursement through non-drug services to offset its actual losses. CMS should therefore evaluate budget neutrality at the hospital level and by hospital type rather than relying solely upon aggregate OPPS neutrality."

Response: We acknowledge that some hospitals will potentially experience greater reductions to drug payments than increases to non-drug items and services as a consequence of our policy. However, that does not change our statutory obligation under section 1833(t)(14) of the Act to conduct a survey of drug acquisition costs and adjust payment rates taking those costs into account.

Comment: A commenter expressed concern about APC calibration. The commenter stated that "[w]hile CMS anticipates that reductions in 340B drug reimbursement will be offset through corresponding increases in payment for non-drug OPPS services, hospitals must have confidence that the APC recalibration accurately and fully reflects the funds removed from 340B drug reimbursement. However, CMS has not demonstrated that the resulting redistribution appropriately reflects the hospitals, service lines, and patient populations most affected by the proposed drug payment reductions. Because reductions in drug reimbursement and increases in APC payments are not distributed uniformly across providers and service lines, the effects of the proposal are likely to vary considerably across hospitals and clinical programs. Therefore, CMS should provide greater transparency regarding both the calculation of the budget neutrality

adjustment and the distributional impact of the proposal to ensure that hospitals can appropriately evaluate its effects."

Response: We agree that it is important to provide transparency in calculating budget neutrality for this finalized payment adjustment. For this reason, we have provided discussion throughout the proposed and final rules regarding the calculations and impact involved. We further note that we provide a separate column describing the impacts of the budget neutral distribution for this adjustment for various categories of OPPS providers in section XXVII of this final rule.

Comment: Many commenters requested that we conduct additional analyses and release additional information relating to budget neutrality before finalizing our proposal. Multiple commenters requested CMS conduct and publish a detailed analysis of the proposal's impact on 340B hospitals, safety-net providers, access to care, and essential outpatient services before finalizing the policy. A commenter suggested that CMS publish hospital-specific net-impact estimates before finalizing the policy and establish protections for hospitals facing material losses. The commenter additionally requested that CMS evaluate whether the redistribution changes incentives to furnish complex outpatient therapies or affects access in communities already experiencing hospital financial stress. Another commenter requested that CMS publish a combined beneficiary cost-sharing analysis that nets the claimed drug coinsurance savings against the coinsurance increases produced by the budget-neutral conversion factor adjustment.

Another commenter alleged that CMS provided no explanation of its methodology for calculating the impact of the payment reductions and included no accompanying data files providing the data that went into its calculation of the aggregate impact. The commenter stated that "[i]t is imperative that prior to implementing a policy of such magnitude, CMS be transparent in its methodology for modeling the cut and the corresponding budget neutrality adjustment, so that interested parties can replicate these models and verify CMS' calculations. CMS should publish its methodology for modeling the impact, which would include how CMS

identified 340B hospitals and 340B drugs, including which data sources it used. CMS should also publish a hospital-level impact file with the results of the payment cut."

Response: We thank commenters for their many suggestions for information for us to release and analyses for us to conduct prior to finalizing our proposal. As we have noted previously; however, we believe that the payment misalignment that our policy will address has been in effect for many years and it is important to implement this policy without delay now that we have conducted the required survey and have data clearly demonstrating that the existing payment rate for 340B-acquired drugs is not even close to a representative proxy for the cost of their acquisition. With respect to the commenter's suggestion to establish protections for hospitals facing material losses, as we discussed in our earlier response to a commenter, we have attempted to address some of these concerns through the finalized exemptions for rural sole community hospitals, PPS-exempt cancer hospitals, and children's hospitals. We also note that with respect to potential future impacts, our budget neutrality calculations are based on what exists in the claims data and the direct changes associated with policy. We do not predict behavioral changes or hospital decisions as a result of those policies. With respect to beneficiary cost savings, these savings are likely to stay flat or increase, saving beneficiaries more as a result. As is true of any update, there will be some redistribution of copayments because the 20 percent beneficiary cost sharing for drugs gets "transferred" over as 20 percent into the broader OPPS through the conversion factor budget neutrality adjustment for the 340B policy. That budget neutrality adjustment will make many of the overall OPPS payment rates and their associated copayments higher. OPPS cost-sharing for a service is capped at the applicable Part A hospital inpatient deductible amount for that year for each service. That means that when OPPS payments and therefore their associated copayments, increase relative to that fixed amount, more services are likely to get capped at the inpatient deductible amount. Finally, we note that the impact file includes all proposed/final budget neutrality adjustments and updates, as well as the 340B remedy where applicable. The impact analysis looks at the existing claims, applies the

proposed/finalized policies but not does not consider behavioral changes or provider decision making.

We thank commenters for their input. We estimate that OPPS payment for 340B-acquired drugs will be reduced by approximately $4.65 billion in CY 2027 as a result of our adoption of this policy. When factoring in our finalized policy for 340B drug payment in non-excepted PBDs, our total estimated reduction in 340B drug spending is $5.45 billion for CY 2027, which includes both Medicare and beneficiary payments.

G. Final Payment Rates for Skin Substitute APCs

In the CY 2026 OPPS/ASC final rule with comment period, we finalized a policy to separately pay for skin substitute products as incident-to supplies in the physician office, hospital outpatient, and ambulatory surgical center settings effective January 1, 2026 (90 FR 53729 through 53748). We excluded skin substitutes approved as biological products under section 351 of the PHS Act, which would continue to be paid consistent with section 1847A of the Act, from our policy to pay for skin substitute products as incident-to-supplies. As part of this final policy, we assigned sheet-form skin substitute products to one of three clinical APCs we created on "FDA regulatory categories":[141] APC 6000 (PMA Skin Substitute Products), APC 6001 (510(k) Skin Substitute Products), and APC 6002 (361 HCT/P Skin Substitute Products). For CY 2026, we set an initial payment rate of $127.14/cm^2 for APCs 6000 (PMA Skin Substitute Products), 6001 (510(k) Skin Substitute Products), and 6002 (361 HCT/P Skin Substitute Products). We stated we would update the payment rates for skin substitute categories annually through rulemaking using the most recently available calendar quarter of ASP data, when available, to set

[141] The use of the term "FDA regulatory categories" in this final rule refers to those described in the CY 2026 PFS and OPPS/ASC PPS final rules and is not intended to reflect or imply that such products under CMS's payment policy are characterized as such or grouped together by FDA. Specifically, CMS clarified that "use of short descriptors and associated FDA regulatory categories may reflect current FDA regulation but are not intended to imply that FDA has determined that a product meets any specific FDA statutory or regulatory requirements. FDA's statutory and regulatory framework, including, for example, FDA's findings that a product is 'safe and effective,' is not controlling of Medicare's determination under its own authorities of whether a product is 'reasonable and necessary' for a Medicare beneficiary and meets all preconditions for Medicare coverage and payment. FDA does not make Medicare coverage or payment determinations, nor do FDA statutes and regulations govern Medicare coverage or payment determinations." (90 Fed. Reg. 53,448 at 53,725).

the rates. In the event ASP data was not available for a particular product, we stated we would use the outpatient hospital MUC data. If MUC was not available, we stated we would use the product's WAC or 89.6 percent of AWP if WAC was also unavailable. We finalized a policy to include all skin substitute products used across both settings as well as the combined product utilization patterns and, as soon as data was available that reflects the results of this policy, to determine a weighted average per-unit cost by group to set the payment rates for each of the three categories.

As stated in the proposed rule, at this time, we do not believe we have sufficient data upon which to propose a revised payment rate for all three skin substitute product APCs. We also believe that updating the payment rates for CY 2027, before the impacts of the payment policy are reflected in the CY 2026 claims that will be used for CY 2028 OPPS/ASC and PFS rulemakings, could result in payment disruptions or introduce unnecessary volatility. Because updated use patterns reflecting the CY 2026 policy changes are not yet available, we proposed for CY 2027 to continue the policy finalized for CY 2026 in its entirety, which includes maintaining the payment rate of $127.14/cm^2 for APCs 6000 (PMA Skin Substitute Products), 6001 (510(k) Skin Substitute Products), and 6002 (361 HCT/P Skin Substitute Products).

We note that, effective April 1, 2026, CMS created new HCPCS Level II codes to describe the application of non-sheet form skin substitute products HCPCS codes G0681 through G0684:

- G0681 - *Application of a premarket approval (pma), 510(k), 361 human cells, tissues or cellular and tissue-based products (hct/p) non-sheet form skin substitute for a wound surface area up to 100 sq cm; first 25 sq cm or less of wound surface area.*
- G0682 - *Application of a premarket approval (pma), 510(k), 361 human cells, tissues or cellular and tissue-based products (hct/p) non-sheet form skin substitute for a wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (list*

separately in addition to code for primary procedure).

- G0683 - *Application of a premarket approval (pma), 510(k), 361 human cells, tissues or cellular and tissue-based products (hct/p) non-sheet form skin substitute graft for a wound surface greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1 percent of body area of infants and children.*

- G0684 - *Application of a premarket approval (pma), 510(k), 361 human cells, tissues or cellular and tissue-based products (hct/p) non-sheet form skin substitute graft for a wound surface greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area or part thereof, or each additional 1 percent of body area of infants and children, or part thereof (list separately in addition to code for primary procedure).*

As explained in the CY 2026 OPPS/ASC Final Rule, we did not finalize changes to the payment arrangement under the OPPS for products that are not in sheet form and explained that we would continue to explore the issue for future rulemaking (90 FR 53739). Accordingly, we assigned the new non-sheet form application codes a status indicator of "N" to indicate that payment for the application is packaged effective April 1, 2026.

For CY 2027, we proposed to maintain the payment arrangement for non-sheet form skin substitute products under the OPPS; we proposed to assign status indicator "N" to both the non-sheet form application codes (G0681 through G0684) and the non-sheet form skin substitute products, themselves. Therefore, for CY 2027, we proposed to continue to package both the non-sheet form products and the application codes used to apply them.

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: Commenters generally supported finalizing a single blended payment rate for CY 2027. Commenters supported a period of stable payment to ensure beneficiary access to skin substitute products.

Response: We thank the commenters for their support.

Comment: Some commenters did not support continuing to pay for sheet-form skin substitute products at the $127.14/cm^2 payment rate for CY 2027 as proposed. Some commenters believed that the proposed payment rate is punitive and overcorrects for abuses seen in the skin substitute space. Commenters suggested that targeted program integrity tools directed at improper billing patterns rather than an across-the-board payment reduction that applies to both compliant and noncompliant providers would more precisely address CMS's concerns without impacting access to medically necessary care. Several commenters requested that CMS finalize a payment rate that is more reflective of the costs and utilization volume for skin substitute products. Some commenters recommended that we finalize a revised payment rate between $478/cm^2 and $715.45/cm^2. Several commenters did not recommend a new specific payment rate and instead proposed alternative methodologies for calculating a new payment rate for skin substitute products. For example, several commenters requested that we reconsider using OPPS utilization data to determine the payment rate for skin substitute products in the HOPD and physician office setting, with some explaining that the quantity of a skin substitute purchased or utilized is not a measure of its clinical value. A few commenters suggested that we revise the payment methodology finalized in the CY 2026 OPPS/ASC final rule to instead utilize providers' acquisition costs up to a CMS-established payment ceiling, at the lower of an invoice or a cap. These commenters believed a cap would minimize payment-driven selection of products, support clinically appropriate utilization, and ensure providers are compensated for the resources required to deliver high-quality patient care. Other commenters recommended that, if utilization data were to be used, CMS adopt a volume-weighted geometric mean instead of a volume-weighted arithmetic average to determine the payment rate.

Response: We thank the commenters for their input regarding the proposed CY 2027 payment rate of $127.14/cm^2 for sheet-form skin substitute products and for their suggestions on alternative payment methodologies to calculate a new payment rate. We note that several of the comments were extremely similar to those provided to CMS in response to the proposed

payment methodology for skin substitute products in the CY 2026 OPPS/ASC proposed rule. As we explained in the CY 2026 OPPS/ASC final rule, we calculated a single rate for each FDA regulatory category by taking the volume-weighted average ASP for skin substitute products in each FDA regulatory category from Q4 2024, using hospital outpatient utilization to weight each category, and applied the highest of the three resulting rates uniformly across all three categories for CY 2026. We used the highest average for the three FDA regulatory categories to ensure we would not underestimate the resources involved with furnishing these services. We refer readers to the discussion in the CY 2026 OPPS/ASC final rule for a summary of the comments and detailed responses regarding the payment methodology that was finalized for CY 2026 (90 FR 53728 through 53748).

We continue to believe that it is premature to adjust the payment rate for skin substitute products because updated use patterns reflecting the CY 2026 policy changes are not yet available. Therefore, we are finalizing our proposal to maintain the $127.14/cm^2 payment rate for sheet-form skin substitute products paid under the OPPS.

Comment: Several commenters requested CMS evaluate utilization patterns following the implementation of the revised $127.14/cm^2 rate and to monitor beneficiary access and distinguish reductions in inappropriate utilization from reductions in clinically appropriate utilization. Commenters requested that we review the available 2026 claims data to assess changes in several measures, including utilization rates of skin substitute products by site of service; clinical outcomes for patients with chronic, non-healing wounds, and utilization rates of medical visits.

Response: We thank the commenters for their suggestions. CMS is generally interested in better understanding the effects of all of our payment policies, including potential impacts to beneficiary access and clinically appropriate utilization. We do not yet have a sufficient volume of claims data reflecting the revised payment rate to draw reliable conclusions regarding several of the measures requested by the commenter as the policy was only implemented in CY 2026.

We intend to continue monitoring relevant claims data as it becomes available.

Comment: Several commenters requested that CMS update the payment rate for skin substitute products using a defined inflation index, such as the Consumer Price Index for All Urban Consumers (CPI-U) or the Medicare Economic Index, rather than recalculating them based on new ASP data. Commenters thought updating the payment rate annually for inflation would keep reimbursement aligned with rising costs and help ensure continued beneficiary access to advanced wound care technologies.

Response: We appreciate the commenters for their input. We believe that, over time, the ASP data we are collecting will more accurately reflect the market impacts of our policy to treat skin substitute products as incident-to supplies. By relying on ASP, payment updates will be responsive to changes in the actual cost of skin substitute products as a result of market pressures, whereas an index like the CPI-U is a general inflation measure that does not account for pricing dynamics. Therefore, we believe that updating the payment rates, based on ASP data will more likely result in payment rates that reflect the changing dynamics of the market rather than anchoring the cost to the initial payment rate for CY 2026, and finalized payment rate for CY 2027, based on data collected prior to the implementation of this policy. We do understand the merits of the commenters' suggestion and will keep it under consideration for future policy development as this policy evolves.

Comment: We received two comments regarding the payment methodology for skin substitute products licensed as biological products under section 351 of the PHS Act, meaning those that have gone through the FDA BLA process. A commenter supported continuing this approach because it recognizes their distinct regulatory status. Another commenter did not support continuing to pay for 351s under the ASP plus 6 percent methodology arguing that evidentiary standards for 351s are likely being lowered due to external pressure to reduce the barrier-to-entry for approval.

Response: We thank the commenters for their input and perspective on this issue. We

note that the evidentiary standards for biological products under section 351 of the PHS Act are out of scope for CMS rulemaking. We are not finalizing changes to the ASP methodology for biological products licensed under section 351 of the PHS Act at this time.

Comment: We received comments regarding our proposal to continue to categorize skin substitute products by FDA regulatory pathway, as finalized in the CY 2026 OPPS/ASC final rule. While one commenter supported implementing a three-tiered approach with differing payment rates per FDA regulatory category, most commenters urged CMS not to pursue payment differentiation or categorize skin substitute products by FDA regulatory category. A commenter noted that because FDA regulatory requirements and pathways evolve over time, using regulatory history as a permanent basis for payment differentiation would also create arbitrary disparities among products that serve the same clinical purpose today, based solely on when and how each product entered the market. The commenter recommended that CMS should base any future payment distinctions on demonstrated clinical performance and resource costs, not regulatory classification. Similarly, another commenter requested that CMS clarify that FDA regulatory pathway by itself will not establish clinical superiority or therapeutic hierarchy among skin substitute products. A commenter explained that products previously subject to more burdensome PMA requirements would today likely enter the market under a 510(k) pathway, so relying on FDA regulatory history as a proxy for payment differentiation risks entrenching outdated distinctions that no longer reflect current practice. One commenter further supported maintaining a single payment rate for all three categories because they believed the waste, fraud, and abuse observed in the skin substitute market is the result of certain 361 HCT/P manufacturers taking advantage of easy market entry to manipulate reimbursement, and that by differentiating payment by FDA approval, CMS risks enabling further price manipulation from some 361 HCT/Ps without the moderating impact of PMA and 510(k) product prices.

Response: We thank the commenters for their input. We continue to believe that categorizing skin substitute products by FDA regulatory pathway remains appropriate at this

time. We note, however, that under the finalized policy, for CY 2027, all sheet-form skin substitute products would be paid at the same $127.14/cm^2 rate. We continue to believe that it is premature to adjust the payment rate for skin substitute products because updated use patterns reflecting the CY 2026 policy changes are not yet available. We will continue to analyze claims data as it becomes available and will propose any changes in payment through the rulemaking process.

Comment: We received several comments requesting that we align payment for non-sheet form skin substitutes with payment for sheet-form skin substitute products. Specifically, commenters requested that CMS change the status indicator of the non-sheet application codes (HCPCS codes G0681-G0684) from "N" to "T" to allow for payment, and assign the non-sheet application codes to the same APCs as the sheet-form application codes (CPT codes 15271-15278). Specifically, commenters requested that CMS assign HCPCS code G0681 to APC 5053 (Level 3 Skin Procedures) and HCPCS code G0683 to APC 5054 (Level 4 Skin Procedures). HCPCS codes G0682 and G0684, which describe add-on codes, should be treated the same as the sheet-form application add-on codes (CPT codes 15272, 15274, 15276, and 15278) and be assigned to status indicator "N," per the commenters. In addition, commenters requested that CMS pay separately for non-sheet skin substitute products to align with payment for sheet-form skin substitute products. Commenters believed that non-sheet products service similar clinical purposes as sheet products, and, therefore, aligning for non-sheet forms and sheet-forms recognizes the clinical non-sheet forms offer, preserves physician flexibility to select the best product for each patient, supports innovation, ensures skin substitute products are evaluated on therapeutic value rather than disadvantaged by coding or reimbursement policy, and maintains site neutrality with products applied in the physician office setting.

Response: We thank the commenters for their input. Payment for application of non-sheet skin substitute products could benefit from parity with payment for the application of sheet form skin substitute products, and not doing so could fail to appropriately recognize the resource

costs expended when applying non-sheet products. Accordingly, we are not finalizing our proposal to maintain the status indicator of "N" for HCPCS codes G0681 and G0683. For CY 2027, we are finalizing to change the status indicator for HCPCS codes G0681 and G0683 from "N" to "T" and assign G0681 to APC 5053 (Level 3 Skin Procedures) and G0683 to APC 5054 (Level 4 Skin Procedures), consistent with the APC assignments for the analogous sheet form application codes (CPT codes 15271 through 15278). We are finalizing assignment of status indicator "N" to add-on codes G0682 and G0684, consistent with the treatment of the sheet form application add-on codes (CPT codes 15272, 15274, 15276, and 15278), as proposed. The final CY 2027 payment rates can be found in Addendum B to this final rule with comment via the internet on the CMS website. In addition, we refer readers to Addendum D1 of this final rule with comment period for the status indicator definitions for all codes reported under the OPPS. Addendum D1 can also be found via the internet on the CMS website. As previously discussed, we will continue to monitor the effects of this policy in general, including this newly finalized aspect.

We are not finalizing separate payment for non-sheet skin substitute products at this time. Non-sheet products are not manufactured, applied, or measured in the same standardized manner as sheet form products, which are billed in per cm^2 units. Because of these differences, we believe it is more appropriate to continue packaging payment for non-sheet form products under the OPPS. We recognize the interest commenters have expressed in separate payment for non-sheet form skin substitute products, and we will continue to consider the issue of separate payment for non-sheet products moving forward .

Comment: We received a comment requesting that CMS provide a clear, operational definition of a non-sheet skin substitute product.

Response: We thank the commenter for this suggestion and will take it into consideration. One difficulty with the commenter's request is that non-sheet products cover a wide range of physical forms and may not share a common structure the way sheet-form skin

substitute products do. We note that we have described the form of some non-sheet skin substitute products in the CY 2026 OPPS/ASC Final Rule as gels, powders, liquids, injectables, 3D-printed constructs, etc. (90 FR 53739) that have units that are difficult to standardize for payment purposes. We will consider providing additional clarifications in future rulemaking.

Comment: We received a comment from a manufacturer requesting separate payment for Omeza Complete Matrix, a non-sheet skin substitute product described by HCPCS code A2014 (Omeza collagen matrix, per 100 mg). The commenter stated that separate payment is appropriate for this product because, in the commenter's view, a product's starting form as a non-sheet product should not determine its payment category so long as the product forms a sheet-like scaffolding once applied.

Response: We appreciate the commenter's request. We believe it is necessary to apply a consistent payment methodology across non-sheet form skin substitute products for CY 2027. Consistent with the approach finalized in this final rule, application of Omeza Complete Matrix, as described by HCPCS codes G0681 and G0683, will be paid separately, while the product itself will be packaged for CY 2027. We do not believe it is appropriate to except this product from the non-sheet product payment methodology based on its post-application form, given that the product is supplied in mg and applied in non-sheet form. As stated earlier, we will continue to consider the issue of separate payment for non-sheet products more broadly.

Comment: We received requests for billing guidance pertaining to our skin substitute payment policies. Several commenters requested that CMS provide guidance clarifying that providers may bill for the total amount of skin substitute product clinically necessary to treat a wound, rather than only the two-dimensional surface area of the wound bed. Commenters explained that, especially for deep wounds, the amount of product needed to treat the wound often exceeds the cm^2 surface area. Commenters requested CMS provide billing instructions that would allow providers to calculate the relevant surface area for the application codes based on the interior surface area of the wound plus an appropriate margin for graft fixation. A

commenter recommended a specific formula for providers to use to calculate the total therapeutic area. Commenters requested that CMS provide guidance that states that providers can bill for the total amount of skin substitute product needed to treat the entire wound area, for sheet form and non-sheet form products, to enable providers to bill accurately for the services they furnish and to give MACs a consistent framework for adjudication.

Response: We appreciate the input from the commenters. We do not believe it is necessary at this time to issue additional guidance on how providers should bill for the total amount of skin substitute product used to treat a wound. The application codes that would be used to bill for the application of the products, namely CPT codes 15271 through 15278 for sheet form products and HCPCS codes G0681 through G0684 for non-sheet products, already specify defined wound surface area amounts for purposes of reporting the applicable code. Providers are expected to select the appropriate application code and report the units of product that correspond to the total wound surface area treated. We note that this same coding structure, and the same expectation that providers report the total wound surface area treated using these application codes, were in place prior to the CY 2026 OPPS/ASC skin substitute policy was in effect, even when the products were packaged into the application payment at that time. We do not believe the manner in which the application codes describe and are used to report wound surface area has changed in a way that necessitates new guidance at this time. However, we will continue to consider whether such guidance is necessary going forward.

Comment: We received a comment from Kerecis, a skin substitute product manufacturer, explaining that two of their products have different code coding classifications. Specifically, the manufacturer stated that one product is described by a Q-code and another is described by an A-code. Per the manufacturer, the coding classification distinction creates administrative burden due to the confusion it causes for both physicians and MACs. The commenter requested that CMS address this issue to ensure there are no inappropriate burdens or barriers to accessing clinically appropriate skin substitute products.

Response: We appreciate the commenter for sharing their concern regarding the current bifurcated system. We will take comments about the coding differences between the products into consideration for future rulemaking.

In summary, for CY 2027, we are finalizing the $127.14/cm^2 payment rate for all sheet form skin substitute products as proposed. We are also finalizing our proposals regarding payment for non-sheet skin substitute application codes and non-sheet products with modifications. Specifically, we are finalizing to assign HCPCS code G0681 to APC 5053 (Level 3 Skin Procedures) with status indicator "T" and G0683 to APC 5054 (Level 4 Skin Procedures APC) with status indicator "T." We are finalizing to continue to assign HCPCS codes G0682 and G0684 to status indicator "N," as proposed. Finally, we are not finalizing changes to the current payment arrangement under the OPPS for products that are not in sheet form at this time and, therefore, non-sheet skin substitute products will remain assigned to status indicator "N." We refer readers to Addendum B for the final CY 2027 APC and status indicator assignments for skin substitute products. The final CY 2027 payment rates can be found in Addendum B to this final rule with comment via the internet on the CMS website. In addition, we refer readers to Addendum D1 of this final rule with comment period for the status indicator definitions for all codes reported under the OPPS. Addendum D1 can also be found via the internet on the CMS website.

H. *Add-on Payment for Technetium-99m (Tc-99m) Derived from Domestically Produced Molybdenum-99 (Mo-99)*

As discussed in prior rulemaking, in collaboration with the Department of Energy, National Nuclear Security Administration (DOE/NNSA), CMS provided an additional payment of $10 for the marginal cost for Tc-99m produced by non-Highly Enriched Uranium (HEU) sources in an effort to support access to Technetium-99m (Tc-99m), a critical radioisotope used in the majority of diagnostic imaging services, and produced through the radioactive decay of molybdenum-99 (Mo-99) from CY 2013 to CY 2025. We stated that we believe such an

adjustment would ensure equitable payments in light of market influences, cost differentials, and cost variations and their potential to create significant payment inequities among hospitals (77 FR 68323). Accordingly, we established HCPCS code Q9969 (Tc-99m from non-highly enriched uranium source, full cost recovery add-on per study dose) to describe the Tc-99m radioisotope produced by non-HEU methods and used in a diagnostic procedure.

In January 2022, the Secretary of Energy issued a certification that stated that there is a sufficient global supply of non-HEU-sourced Mo-99 to meet the needs of patients in the United States (86 FR 73270). Additionally, in March 2023, the last major global producer of Mo-99 converted from HEU to low-enriched uranium (LEU) targets, and all Mo-99 used in the United States is now produced without HEU. As such, in the CY 2024 OPPS final rule with comment period (88 FR 81803), we adopted a policy to end the additional $10 add-on payment described by HCPCS code Q9969 for non-HEU-sourced Tc-99m at the end of CY 2025. We explained that given that all Mo-99 used in the U.S. is now produced without HEU, we believe that starting in CY 2026 the Medicare claims data utilized to set payment rates would only include claims for diagnostic radiopharmaceuticals that utilized non-HEU-sourced Tc-99m, meaning the data would reflect the full cost of the Tc-99m diagnostic radiopharmaceuticals that providers would use in CY 2026. That being the case, we believe there would no longer be a need for the additional $10 add-on payment for non-HEU-sourced Tc-99m for CY 2026 or future years.

In the CY 2025 OPPS/ASC proposed rule with comment period (89 FR 59377 through 59378), we shared that the Department of Energy and other interested parties raised another issue affecting the domestic supply chain for Mo-99 and Tc-99 that, left unaddressed, could also cause payment inequity among outpatient hospital providers. We noted that foreign Mo-99 production has historically been subsidized by foreign governments, resulting in prices below the true cost of production. These artificially low, foreign government-subsidized prices have created a disincentive for domestic investments in Mo-99 production infrastructure and a barrier to entry for new producers, including U.S. companies, which in turn has resulted in unreliable production

and periodic shortages. Subsequently, using our equitable adjustment authority under section 1833(t)(2)(E) of the Act, we proposed and finalized a policy to address the payment inequity resulting from the higher cost of Tc-99m derived from domestically produced Mo-99 by establishing a new add-on payment of $10 per dose for radiopharmaceuticals that use Tc-99m derived from domestically produced Mo-99 starting on January 1, 2026. Furthermore, we stated that the Department of Energy, National Nuclear Security Administration (DOE/NNSA) would establish the criteria to certify whether the Tc-99m radiopharmaceutical dose is derived from domestically produced Mo-99 and eligible for the add-on payment, which would be included in the CY 2026 OPPS/ASC proposed rule with comment period. We also stated that we would continue to develop the technical implementation of this additional payment after a definition for domestically produced Tc-99m radiopharmaceutical was established, including any requirements for providers to document that the Tc-99m radiopharmaceutical used in a procedure was domestically produced and could qualify to receive the add-on payment. Additionally, we stated that our intent was to have the regulatory framework for this policy in place prior to the domestic production of Mo-99 and Tc-99m, to increase provider awareness of the availability of additional payments for domestically sourced Tc-99m radiopharmaceuticals. Likewise, producers of domestic Mo-99 would have certainty that the Medicare OPPS payment policy takes into account the additional costs of Tc-99m derived from domestically produced Mo-99.

a. Criteria for Classifying a Tc-99m Radiopharmaceutical Dose as Domestically Produced

In the CY 2026 OPPS/ASC final rule with comment period (90 FR 53751-53755), for purposes of the add-on payment for radiopharmaceuticals that use Tc-99m derived from domestically produced Mo-99, we finalized our definition of a domestically produced dose of Tc-99m as a dose of Tc-99m generated from domestically produced Mo-99. We also finalized the following definitions:

- Domestically produced dose of Tc-99m: A dose of Tc-99m generated from

domestically produced Mo-99;

- Domestically produced Mo-99: Mo-99 that was both irradiated and processed in the U.S.;
- Irradiated: The process of bombarding a uranium or molybdenum target with radiation in order to produce Mo-99, and to specify that irradiation is typically performed with a nuclear reactor or particle accelerator;
- Processed: In this context, processed refers to the purification of Mo-99 from irradiated material.

Additionally, we finalized a policy that a dose of Tc-99m generated from Mo-99 that was irradiated or processed outside the U.S. would not qualify for this add-on payment, even if the Mo-99 was loaded into a Tc-99m generator in the U.S. or if the Tc-99m was eluted at a radiopharmacy in the U.S. We also finalized the codification of the aforementioned definitions and references for domestically produced Mo-99 to § 419.49 to specify when a dose of Tc-99m generated from domestically produced Mo-99 could be eligible for the add-on payment.

b. Coding and Documentation for the Add-on Payment for Tc-99m Derived from Domestically Produced Mo-99

In the CY 2026 OPPS/ASC final rule with comment period (90 FR 53751-53755), we also finalized the establishment of HCPCS C-code C9176 (Tc-99m from domestically produced non-HEU Mo-99, [minimum 50 percent], full cost recovery add-on, per study dose), effective January 1, 2026. Hospitals may report HCPCS code C9176 once per dose, along with any diagnostic scan or scans furnished using Tc-99m derived from domestically produced Mo-99, if they can certify that at least 50 percent of the Mo-99 in the Tc-99m generator used to produce the Tc-99m was domestically produced Mo-99. We also finalized the implementation plan, including the $10 per-dose add-on payment and the certification and tracking approach described in the CY 2026 rulemaking.

For CY 2027, we did not propose any changes to the add-on payment policy for

radiopharmaceuticals that use Tc-99m derived from domestically produced Mo-99. We received public comments regarding this policy, which we summarize and respond to below.

Comment: Although we did not propose any changes to the add-on payment for radiopharmaceuticals that use Tc-99m derived from domestically produced Mo-99 for CY 2027, we received comments regarding the policy. One commenter supported continuation of the $10 per-dose add-on payment and HCPCS code C9176, stating that the policy helps account for the higher costs associated with domestic production and supports investment in a more secure and resilient domestic Mo-99 supply chain. The commenter also encouraged CMS to continue monitoring whether the $10 add-on payment remains sufficient over time in light of production, compliance, transportation, and supply-chain costs.

Another commenter opposed continuation of the add-on payment and urged CMS to discontinue the policy for CY 2027. The commenter stated that the add-on payment does not effectively incentivize domestic Mo-99 production because payments are made to hospitals rather than directly to domestic producers and expressed concern that hospitals may have difficulty identifying when a dose qualifies for the add-on payment. The commenter also stated that the policy could disrupt existing Tc-99m supply and distribution arrangements, including generator contracting, and potentially affect patient access, particularly in rural communities.

Response: We thank the commenters for their feedback. As discussed in the CY 2025 OPPS/ASC final rule with comment period, we established the $10 per-dose add-on payment using our equitable adjustment authority under section 1833(t)(2)(E) of the Act to address the payment inequity resulting from the higher cost of Tc-99m derived from domestically produced Mo-99. In the CY 2026 OPPS/ASC final rule with comment period, we finalized the implementation framework for this policy, including the criteria for a domestically produced dose of Tc-99m, the 50-percent threshold for domestically produced Mo-99, and HCPCS code C9176.

We continue to believe that the add-on payment appropriately accounts for the additional

costs to hospital outpatient departments associated with utilizing Tc-99m derived from domestically produced Mo-99. As we explained in prior rulemaking, establishing the payment framework in advance of domestic production provides hospitals with information regarding the availability of additional payment for qualifying doses and provides domestic producers with greater certainty that Medicare OPPS payment policy takes into account the additional costs associated with domestic production. After a consideration of the comments received, noting we did not propose changes to this policy for CY 2027, we are continuing the existing policy without modification.

We appreciate commenters' perspectives regarding the amount of the add-on payment, implementation of the policy, and potential effects on the Mo-99 and Tc-99m supply chain. We will continue to monitor relevant information regarding the implementation of the policy, including information regarding the costs associated with domestically produced Mo-99 and the availability of Tc-99m, and may consider whether future refinements are warranted.

VI. Estimate of OPPS Transitional Pass-Through Spending for Drugs, Biologicals, Radiopharmaceuticals, and Devices

A. Amount of Additional Payment and Limit on Aggregate Annual Adjustment

Section 1833(t)(6)(E) of the Act limits the total projected amount of transitional pass-through payment for drugs, biologicals, and categories of devices for a given year to an "applicable percentage," currently not to exceed 2.0 percent of total program payments estimated to be made for all covered services under the OPPS furnished for that year. If we estimate before the beginning of the calendar year that the total amount of pass-through payments in that year would exceed the applicable percentage, section 1833(t)(6)(E)(iii) of the Act requires a uniform prospective reduction in the amount of each of the transitional pass-through payments made in that year to ensure that the limit is not exceeded. We estimate the pass-through spending to determine whether payments exceed the applicable percentage and the appropriate pro rata reduction to the conversion factor for the projected level of pass-through spending in the following year to ensure that total estimated pass-through spending for the prospective payment year is budget neutral, as required by section 1833(t)(6)(E) of the Act.

For devices, developing a proposed estimate of pass-through spending in CY 2027 entails estimating spending for two groups of items. The first group of items consists of device categories that are currently eligible for pass-through payment and that will continue to be eligible for pass-through payment in CY 2027. The CY 2008 OPPS/ASC final rule with comment period (72 FR 66778) describes the methodology we have used in previous years to develop the pass-through spending estimate for known device categories continuing into the applicable update year. The second group of items consists of devices that we know are newly eligible, or project may be newly eligible, for device pass-through payment in the remaining quarters of CY 2026 or beginning in CY 2027. The sum of the proposed CY 2027 pass-through spending estimates for these two groups of device categories equals the proposed total CY 2027 pass-through spending estimate for device categories with pass-through payment status. We

determined the device pass-through estimated payments for each device category based on the amount of payment as required by section 1833(t)(6)(D)(ii) of the Act, and as outlined in previous rules, including the CY 2026 OPPS/ASC final rule with comment period (90 FR 53766 through 53769). We noted that, beginning in CY 2010, the pass-through evaluation process and pass-through payment methodology for implantable biologicals newly approved for pass-through payment beginning on or after January 1, 2010, that are surgically inserted or implanted (through a surgical incision or a natural orifice) use the device pass-through process and payment methodology (74 FR 60476). As has been our past practice (76 FR 74335), we include an estimate of any implantable biologicals eligible for pass-through payment in our estimate of pass-through spending for devices. Similarly, we finalized a policy in CY 2015 that applications for pass-through payment for skin substitutes and similar products be evaluated using the medical device pass-through process and payment methodology (79 FR 66885 through 66888). In CY 2026, we finalized a policy to consider skin substitutes with an approved Biologics License Application (BLA) under transitional drug pass-through payment status, while skin substitutes with FDA Premarket Approval or FDA 510(k) clearance continue to be evaluated under transitional device pass-through payment status (90 FR 53636). Therefore, for CY 2027, we also proposed to include an estimate of any skin substitutes and similar products with FDA Premarket Approval or FDA 510(k) clearance in our estimate of pass-through spending for devices and skin substitutes with an approved BLA under transitional drug pass-through spending for drugs and biologicals.

For drugs and biologicals eligible for pass-through payment, section 1833(t)(6)(D)(i) of the Act establishes the pass-through payment amount as the amount by which the amount authorized under section 1842(o) of the Act (or, if the drug or biological is covered under a competitive acquisition contract under section 1847B of the Act, an amount determined by the Secretary equal to the average price for the drug or biological for all competitive acquisition areas and year established under such section as calculated and adjusted by the Secretary)

exceeds the portion of the otherwise applicable fee schedule amount that the Secretary determines is associated with the drug or biological. Consistent with current policy, we proposed to apply a rate of ASP plus 6 percent to most drugs and biologicals for CY 2027, and therefore our estimate of drug and biological pass-through payment for CY 2027 for this group of items was $12.2 million.

Payment for certain drugs,[142] specifically contrast agents without pass-through payment status, is packaged into payment for the associated procedures, and these products are not separately paid. In addition, we policy-package non-pass-through drugs and biologicals that function as supplies when used in a diagnostic test or procedure unless a high-cost diagnostic radiopharmaceutical with a per-day cost greater than the finalized per-day cost threshold referenced in section II.A.3.c. of this final rule with comment period is used for the diagnostic test or procedure. We policy-package all drugs and biologicals that function as supplies when used in a surgical procedure or for anesthesia, and other categories of drugs and biologicals, as discussed in section V.B.1.c. of this final rule with comment period. Consistent with current policy, for CY 2027, we proposed that policy-packaged drugs and biologicals with pass-through payment status will be paid at ASP plus 6 percent, like other pass-through drugs and biologicals less the policy-packaged drug APC offset amount described later in this section of the preamble. Our estimate of pass-through payment for policy-packaged drugs and biologicals with pass-through payment status approved prior to CY 2027 is not $0. This is because the pass-through payment amount and the fee schedule amount associated with the drug or biological will not be the same, unlike for separately payable drugs and biologicals. In the CY 2024 OPPS/ASC final rule with comment period (88 FR 81774 through 81776), we discussed our policy to determine if the costs of certain policy-packaged drugs or biologicals are already packaged into the existing APC structure. If we determine that a policy-packaged drug or biological approved for pass-

[142] In the CY 2025 OPPS/ASC final rule with comment period, we finalized the high-cost diagnostic radiopharmaceuticals policy to separately pay those products when the per-day costs are greater than a threshold. Please refer to section II.A.3.c. of this final rule with comment period for more information regarding this policy.

through payment resembles predecessor drugs or biologicals already included in the costs of the APCs that are associated with the drug receiving pass-through payment, we offset the amount of pass-through payment for the policy-packaged drug or biological. For these drugs or biologicals, the APC offset amount is the portion of the APC payment for the specific procedure performed with the pass-through drug or biological, which we refer to as the policy-packaged drug APC offset amount. Consistent with current policy described in section V.A.5. of this final rule with comment period, if we determine that an offset is appropriate for a specific policy-packaged drug or biological receiving pass-through payment, we proposed to reduce our estimate of pass-through payments for these drugs or biologicals by the APC offset amount.

Similar to pass-through spending estimates for devices, the first group of drugs and biologicals requiring a pass-through payment estimate consists of those products that were recently made eligible for pass-through payment and that will continue to be eligible for pass-through payment in CY 2027. The second group contains drugs and biologicals that we know are newly eligible, or project will be newly eligible, in CY 2027. The sum of the CY 2027 pass-through spending estimates for these two groups of drugs and biologicals equals the total CY 2027 pass-through spending estimate for drugs and biologicals with pass-through payment status.

We did not receive public comments on this provision, and therefore, we are finalizing as proposed.

B. Final Estimate of Pass-Through Spending for CY 2027

For CY 2027, we proposed to set the applicable pass-through payment percentage limit at 2.0 percent of the total projected OPPS payments for CY 2027, consistent with section 1833(t)(6)(E)(ii)(II) of the Act and our OPPS policy from CY 2004 through CY 2026 (90 FR 53767). The pass-through payment percentage limit is calculated using pass-through spending estimates for devices and for drugs and biologicals.

The first group of devices consists of device categories that are currently eligible for pass-through payment and will continue to be eligible for pass-through payment in CY 2027. We stated in the CY 2027 OPPS/ASC proposed rule, there would be 15 active categories for CY 2027, described by HCPCS codes C1605, C1606, C8000, C1735, C1736, C1737, C1738, C1739, C9610, C1740, C1741, C1742, C1607, C1608, and C1743. Based on CY 2025 Medicare hospital outpatient claims data available by the time of the proposed rule and information from the device manufacturers provided in their respective pass-through applications regarding the device cost and the projected CY 2027 OPPS utilization, we estimated the CY 2027 pass-through expenditures for each of the 15 device categories and proposed an estimate for the first group of devices of $177.6 million in the CY 2027 OPPS/ASC proposed rule (91 FR 41897 through 41898).

We did not receive any public comments on our proposed estimate. Based on updated CY 2025 Medicare hospital outpatient claims data available by the time of this final rule with comment period and information from the device manufacturers provided in their respective pass-through applications regarding the device cost and the projected CY 2027 OPPS utilization, we estimated the CY 2027 pass-through expenditures for each of the 15 device categories in Table 77.[143] Therefore, we have finalized the CY 2027 spending estimate for the first group of devices of approximately $180.3 million.

TABLE 77: ESTIMATED PASS-THROUGH EXPENDITURES FOR DEVICE CATEGORIES THAT ARE CURRENTLY ELIGIBLE AND WILL CONTINUE TO BE ELIGIBLE FOR PASS-THROUGH PAYMENT IN CY 2027

HCPCS Code	Effective Date	Pass-through Expiration Date	Estimated Pass-through Expenditures in CY 2027

[143] Estimated costs are updated to reflect the Medicare hospital outpatient claims data for each HCPCS code as such data becomes available. Prior to the availability of Medicare hospital outpatient claims data, estimated costs are based on the device cost and projected CY OPPS utilization provided by the device manufacturer in the device pass-through application. As such, in the CY 2027 OPPS/ASC final rule with comment period, the estimated pass-through costs for HCPCS codes C1605, C1606, C8000, C1735, C1736, C1737, C1738, C1739, and C9610 are based on CY 2025 Medicare hospital outpatient claims data available for the CY 2027 OPPS/ASC final rule with comment period. The estimated pass-through costs for HCPCS codes C1740, C1741, C1742, C1607, C1608, and C1743 are based on information provided by the device manufacturers in the respective device pass-through applications regarding the device cost and the projected CY 2027 OPPS utilization.

HCPCS Code	Effective Date	Pass-through Expiration Date	Estimated Pass-through Expenditures in CY 2027
C1605	07/01/2024	06/30/2027	$8.6 million
C1606	07/01/2024	06/30/2027	$0.3 thousand
C8000	10/01/2024	09/30/2027	$0.9 million
C1735	01/01/2025	12/31/2027	$7.5 million
C1736	01/01/2025	12/31/2027	$4.0 million
C1737	01/01/2025	12/31/2027	$1.4 million
C1738	01/01/2025	12/31/2027	$0.1 million
C1739	01/01/2025	12/31/2027	$0.9 million
C9610	01/01/2025	12/31/2027	$37.3 million
C1740	10/01/2025	09/30/2028	$31.7 million
C1741	10/01/2025	09/30/2028	$7.5 million
C1742	10/01/2025	09/30/2028	$0.7 million
C1607	01/01/2026	12/31/2028	$12.5 million
C1608	01/01/2026	12/31/2028	$22.4 million
C1743	04/01/2026	03/31/2029	$44.9 million

In estimating our proposed CY 2027 pass-through spending for device categories in the second group, we included the following: (1) device categories that we assumed at the time of the development of the proposed rule would be newly eligible for pass-through payment in CY 2027; (2) additional device categories that we estimated could be approved for pass-through status after the development of the CY 2027 OPPS/ASC proposed rule and before January 1, 2027; and (3) contingent projections for new device categories established in the second through fourth quarters of CY 2027. For CY 2027, we proposed to use the general methodology described in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66778), while also taking into account recent OPPS experience in approving new pass-through device categories. In the CY 2027 OPPS/ASC proposed rule, we proposed to continue device pass-through payment status for seven device pass-through applications that were granted conditional approval in CY 2027, and we proposed to deny six CY 2027 device pass-through applications. The proposed estimate of CY 2027 pass-through spending for this second group of device categories was $5.6 million (91 FR 41898).

We did not receive any public comments on this proposed estimate. As stated earlier in section IV.A.2. of this final rule with comment period, we are finalizing pass-through payment

status for all seven device pass-through applications that were granted conditional approval in CY 2027, including the MY01 Continuous Compartmental Pressure Monitor, RemeOs™ Screw LAG Solid, WiSE® CRT System, SetPoint System, TOUCH® CMC 1 Prosthesis, Esprit™ BTK Everolimus Eluting Resorbable Scaffold System, and TOPS™ System.[144] We are also approving two additional device pass-through applications for Altius® Direct Electrical Nerve Stimulation System and TIDAL™ Fusion Cage System (Ossera™ AFX). For this final rule with comment period, based on information from the device manufactures provided in their respective pass-through applications regarding the projected CY 2027 OPPS utilization, we estimate the amount of spending for the second group of devices would be approximately $5.6 million for TOPS™ System; $58.1 million for Altius® Direct Electrical Nerve Stimulation System; and $4.0 million TIDAL™ Fusion Cage System (Ossera™ AFX). Therefore, we are finalizing an estimate of $67.7 million for this second group of devices for CY 2027.

To estimate proposed CY 2027 pass-through spending for drugs and biologicals in the first group, specifically those drugs and biologicals recently made eligible for pass-through payment and continuing on pass-through payment status for at least one quarter in CY 2027, we proposed to use the CY 2025 Medicare hospital outpatient claims data regarding their utilization, information provided in their respective pass-through applications, other historical hospital claims data, pharmaceutical industry information, and clinical information regarding these drugs and biologicals to project the CY 2027 OPPS utilization of the products.

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[144] As discussed in section IV.A.2.b.(1) of this final rule with comment period: the pass-through applications for MY01 Continuous Compartmental Pressure Monitor, RemeOs™ Screw LAG Solid, and WiSE® (Wireless Stimulation of the Endocardium Technology) CRT System were approved for transitional pass-through payment under the alternative pathway effective October 1, 2025; the pass-through applications for SetPoint System and TOUCH® CMC 1 Prosthesis were approved for transitional pass-through payment under the alternative pathway effective January 1, 2026; the pass-through application for Esprit™ BTK Everolimus Eluting Resorbable Scaffold System was approved for transitional pass-through payment under the alternative pathway effective April 1, 2026; and the pass-through application for TOPS™ System was approved for transitional pass-through payment under the alternative pathway effective July 1, 2026. Due to the timing of the preliminary approvals, the CY 2027 spending estimate for MY01 Continuous Compartmental Pressure Monitor, RemeOs™ Screw LAG Solid, WiSE®, SetPoint System, TOUCH® CMC 1 Prosthesis, and Esprit™ BTK Everolimus Eluting Resorbable Scaffold System is included in the CY 2027 spending estimate for the first group of devices, and the CY 2027 spending estimate for the TOPS™ System is included in the CY 2027 spending estimate for the second group of devices.

For the known drugs and biologicals (excluding policy-packaged contrast agents, drugs, biologicals, radiopharmaceuticals with per-day costs at or below the packaging threshold that function as supplies when used in a diagnostic test or procedure, and drugs and biologicals that function as supplies when used in a surgical procedure) that will be continuing on pass-through payment status in CY 2027, we estimated the pass-through payment amount as the difference between the general payment rate of ASP plus 6 percent and the payment rate for non-pass-through drugs and biologicals that would be separately paid. Because we proposed to utilize a payment rate of ASP plus 6 percent for most separately payable drugs and biologicals in the proposed rule, the proposed payment rate difference between the pass-through payment amount and the non-pass-through payment amount was $0 for this group of drugs.

Because payment for policy-packaged drugs and biologicals is packaged if the product is not paid separately due to its pass-through payment status, we proposed to include in the CY 2027 pass-through estimate the difference between payment for the policy-packaged drug or biological at ASP plus 6 percent (or wholesale acquisition cost (WAC) plus 3 or 6 percent according to the policy in section V.B.2.a. of this final rule with comment period, or 95 percent of average wholesale price (AWP), if ASP or WAC information is not available) and the policy-packaged drug APC offset amount, if we determine that the policy-packaged drug or biological approved for pass-through payment resembles a predecessor drug or biological already included in the costs of the APCs that are associated with the drug receiving pass-through payment. Diagnostic radiopharmaceuticals that currently have pass-through status, but would likely be paid separately because of the policy initially established in the CY 2025 OPPS/ASC final rule with comment period (89 FR 93953) to separately pay for high-cost diagnostic radiopharmaceuticals with per-day costs greater than the proposed per-day cost threshold and which we proposed to continue as discussed in section II.A.3.c. of this final rule with comment period, are not considered to be policy-packaged and therefore are not included in this group.

For this first group of policy-packaged drugs and biologicals, we estimated pass-through spending for CY 2027 of $2.2 million.

We did not receive any public comments on our proposed estimate. Using our methodology for this final rule with comment period, we are finalizing the CY 2027 spending estimate for this first group of drugs and biologicals to be $2.4 million based on additional data available at the time of this final rule with comment period.

To estimate proposed CY 2027 pass-through spending for drugs and biologicals in the second group (that is, drugs and biologicals that we knew at the time of development of the proposed rule were newly eligible or recently became eligible for pass-through payment in CY 2026, additional drugs and biologicals that we estimated could be approved for pass-through status subsequent to the development of the proposed rule and before January 1, 2027, and projections for new drugs and biologicals that could be initially eligible for pass-through payment in the second through fourth quarters of CY 2027), we proposed to use utilization estimates from pass-through applicants, pharmaceutical industry data, clinical information, recent trends in the per unit ASPs of hospital outpatient drugs, and projected annual changes in service volume and intensity as our basis for making the CY 2027 pass-through payment estimate. We also proposed to consider the most recent OPPS experience in approving new pass-through drugs and biologicals. Using our proposed methodology for estimating CY 2027 pass-through payments for this second group of drugs, we calculated a proposed spending estimate for this second group of drugs and biologicals of approximately $10 million.

We did not receive any public comments on our proposed estimate. Using our methodology for this final rule with comment period, we are finalizing our estimate of pass-through spending for the second group of drugs and biologicals to be $10 million.

We estimated for the CY 2027 OPPS/ASC proposed rule (91 FR 41899) that the amount of pass-through spending for the device categories and the drugs and biologicals that are continuing to receive pass-through payment in CY 2027 and the amount of pass-through

spending for those device categories, drugs, and biologicals that first become eligible for pass-through payment during CY 2027 would be approximately $195.3 million (approximately $183.1 million for device categories and approximately $12.2 million for drugs and biologicals), which would represent only 0.18 percent of total projected OPPS payments for CY 2027 (approximately $111 billion). Therefore, we estimated that pass-through spending in CY 2027 would not exceed the 2.0 percent of total projected OPPS CY 2027 program spending limit provided for in section 1833(t)(6)(E) of the Act.

We estimate for this final rule with comment period that the amount of pass-through spending for the device categories and the drugs and biologicals that are continuing to receive pass-through payment in CY 2027 and the amount of pass-through spending for those device categories, drugs, and biologicals that first become eligible for pass-through payment during CY 2027 will be approximately $260.4 million (approximately $248.0 million for device categories and approximately $12.4 million for drugs and biologicals), which represents only 0.23 percent of total projected OPPS payments for CY 2027 (approximately $114 billion). Therefore, we estimate that pass-through spending in CY 2027 will not exceed the 2.0 percent of total projected OPPS CY 2027 program spending limit provided for in section 1833(t)(6)(E) of the Act.

VII. OPPS Payment for Hospital Outpatient Visits and Critical Care Services

For CY 2027, we proposed to continue our current clinic and emergency department (ED) hospital outpatient visit payment policies. For a description of these policies, we refer readers to the CY 2016 OPPS/ASC final rule with comment period (80 FR 70448 through 70449). We also proposed to continue our payment policy for critical care services for CY 2027 (91 FR 41899). For a description of this policy, we refer readers to the CY 2016 OPPS/ASC final rule with comment period (80 FR 70449 through 70453), and for the history of this payment policy, we refer readers to the CY 2014 OPPS/ASC final rule with comment period (78 FR 75043).

As we stated in the CY 2022 OPPS/ASC final rule with comment period (86 FR 63663), the volume control method for clinic visits furnished by excepted off-campus provider-based departments (PBDs) applies for CY 2022 and subsequent years. More specifically, we finalized a policy to continue to utilize a PFS-equivalent payment rate for the hospital outpatient clinic visit service described by HCPCS code G0463 when it is furnished by these departments for CY 2022 and subsequent years (86 FR 63664). As stated in the CY 2018 PFS final rule (82 FR 53020 through 53024), the PFS-equivalent rate for CY 2018 and subsequent years is 40 percent of the proposed OPPS payment. Under this policy, these departments will be paid 40 percent of the OPPS rate for the clinic visit service in CY 2027 (91 FR 41899).

In the CY 2023 OPPS/ASC final rule with comment period (87 FR 72047 through 72051), we finalized a policy for CY 2023 and subsequent years that excepted off-campus PBDs (departments that bill the modifier "PO" on claim lines) of rural Sole Community Hospitals (SCHs), as described under 42 CFR 412.92 and designated as rural for Medicare payment purposes, are exempt from the clinic visit payment policy that applies a PFS-equivalent payment rate for the clinic visit service, as described by HCPCS code G0463, when provided at an off-campus PBD excepted from section 1833(t)(21) of the Act. For the full discussion of this policy,

we refer readers to the CY 2023 OPPS/ASC final rule with comment period (87 FR 72047 through 72051).

We did not receive specific public comment on our existing clinic visit, critical care and ED hospital outpatient visits payment policies, except for comments submitted in the context of the proposed expansion of our volume control method to other services. Therefore, we are finalizing as proposed to continue these policies. For discussion of the existing clinic visit policy in the context of the proposed expansion of our volume control method to other services, see section X.A. of this final rule with comment period.

VIII. Payment for Partial Hospitalization and Intensive Outpatient Services

Since CY 2000, Medicare has paid for partial hospitalization program (PHP) services under the OPPS. Beginning in CY 2024, as authorized by section 4124 of the Consolidated Appropriations Act (CAA), 2023 (Pub. L. 117–328), Medicare began paying for intensive outpatient program (IOP) services furnished by hospital outpatient departments, community mental health centers (CMHCs), Federally qualified health centers, and rural health clinics, in addition to opioid treatment programs. Additional background on the partial hospitalization and intensive outpatient benefits is included in the following paragraphs.

We note that some commenters made comments on PHP and IOP topics that were not discussed in the CY 2027 OPPS/ASC proposed rule. These topics are out of scope for purposes of this notice and comment rulemaking, but we will consider these comments as we consider these issues for future rulemaking.

A. Background

1. Partial Hospitalization

A partial hospitalization program (PHP) is an intensive outpatient program of psychiatric services provided as an alternative to inpatient psychiatric care for individuals who have an acute mental illness, which includes, but is not limited to, conditions such as depression, schizophrenia, and substance use disorders (SUD). Section 1861(ff)(1) of the Act defines partial hospitalization services as the items and services described in paragraph (2) prescribed by a physician for an individual determined (not less frequently than monthly) by a physician to have a need for such services for a minimum of 20 hours per week and provided under a program described in paragraph (3) under the supervision of a physician pursuant to an individualized, written plan of treatment established and periodically reviewed by a physician (in consultation with appropriate staff participating in such program), which sets forth the physician's diagnosis, the type, amount, frequency, and duration of the items and services provided under the plan, and the goals for treatment under the plan.

Section 1861(ff)(2) of the Act describes the items and services included in partial hospitalization program services. Section 1861(ff)(3)(A) of the Act specifies that a PHP is a program furnished by a hospital to its outpatients or by a CMHC, as a distinct and organized intensive ambulatory treatment service, offering less than 24-hour-daily care, in a location other than an individual's home or inpatient or residential setting. Section 1861(ff)(3)(B) of the Act defines a CMHC for purposes of this benefit. We refer readers to sections 1833(t)(1)(B)(i), 1833(t)(2)(B), 1833(t)(2)(C), and 1833(t)(9)(A) of the Act and 42 CFR 419.21, for additional information regarding PHP.

PHP policies and payment have been addressed under OPPS since CY 2000. In CY 2008, we began efforts to strengthen the PHP benefit through extensive data analysis, along with policy and payment changes, by implementing two refinements to the methodology for computing the PHP median. For a detailed discussion on these policies, we refer readers to the CY 2008 OPPS/ASC final rule with comment period (72 FR 66670 through 66676). In CY 2009, we implemented several regulatory, policy, and payment changes. For a detailed discussion on these policies, we refer readers to the CY 2009 OPPS/ASC final rule with comment period (73 FR 68688 through 68697). In CY 2010, we retained the two-tier payment approach for partial hospitalization services and used only hospital-based PHP data in computing the PHP Ambulatory Payment Classification (APC) per diem costs, upon which PHP APC per diem payment rates are based (74 FR 60556 through 60559). In CY 2011 (75 FR 71994), we established four separate PHP APC per diem payment rates: two for CMHCs (APC 0172 and APC 0173) and two for hospital-based PHPs (APC 0175 and APC 0176). We also instituted a 2-year transition period for CMHCs to the CMHC APC per diem payment rates. For a detailed discussion, we refer readers to section X.B. of the CY 2011 OPPS/ASC final rule with comment period (75 FR 71991 through 71994). In CY 2012, we determined the relative payment weights for partial hospitalization services provided by CMHCs based on data derived solely from CMHCs and the relative payment weights for partial hospitalization services provided by

hospital-based PHPs based exclusively on hospital data (76 FR 74348 through 74352). In the CY 2013 OPPS/ASC final rule with comment period, we finalized our proposal to base the relative payment weights that underpin the OPPS APCs, including the four PHP APCs (APCs 0172, 0173, 0175, and 0176), on geometric mean costs rather than on the median costs. For a detailed discussion on this policy, we refer readers to the CY 2013 OPPS/ASC final rule with comment period (77 FR 68406 through 68412).

In the CY 2014 OPPS/ASC proposed rule (78 FR 43621 through 43622) and CY 2015 OPPS/ASC final rule with comment period (79 FR 66902 through 66908), we continued to apply our established policies to calculate the four PHP APC per diem payment rates based on geometric mean per diem costs using the most recent claims data for each provider type. For a detailed discussion on this policy, we refer readers to the CY 2014 OPPS/ASC final rule with comment period (78 FR 75047 through 75050). In the CY 2016 OPPS/ASC final rule with comment period (80 FR 70453 through 70467), we described our extensive analysis of the claims and cost data and ratesetting methodology, corrected a cost inversion that occurred in the final rule with comment period data with respect to hospital-based PHP providers, and renumbered the PHP APCs. In the CY 2017 OPPS/ASC final rule with comment period (81 FR 79687 through 79691), we continued to apply our established policies to calculate the PHP APC per diem payment rates based on geometric mean per diem costs and finalized a policy to combine the Level 1 and Level 2 PHP APCs for CMHCs and for hospital-based PHPs. We also implemented an 8-percent outlier cap for CMHCs to mitigate potential outlier billing vulnerabilities. For a comprehensive description of PHP payment policy, including a detailed methodology for determining PHP per diem amounts, we refer readers to the CY 2016 and CY 2017 OPPS/ASC final rules with comment period (80 FR 70453 through 70455 and 81 FR 79678 through 79680, respectively).

In the CYs 2018 and 2019 OPPS/ASC final rules with comment period (82 FR 59373 through 59381 and 83 FR 58983 through 58998, respectively), we continued to

apply our established policies to calculate the PHP APC per diem payment rates based on geometric mean per diem costs, designated a portion of the estimated 1.0 percent hospital outpatient outlier threshold specifically for CMHCs, and proposed updates to the PHP allowable HCPCS codes. We finalized these proposals in the CY 2020 OPPS/ASC final rule with comment period (84 FR 61352).

In the CY 2020 OPPS/ASC final rule with comment period (84 FR 61339 through 61350), we finalized a proposal to use the calculated CY 2020 CMHC geometric mean per diem cost and the calculated CY 2020 hospital-based PHP geometric mean per diem cost, but with a cost floor equal to the CY 2019 final geometric mean per diem costs as the basis for developing the CY 2020 PHP APC per diem rates. Also, we continued to designate a portion of the estimated 1.0 percent hospital outpatient outlier threshold specifically for CMHCs, consistent with the percentage of projected payments to CMHCs under the OPPS, excluding outlier payments.

In the April 30, 2020 interim final rule with comment (85 FR 27562 through 27566), effective as of March 1, 2020 and for the duration of the COVID–19 Public Health Emergency (PHE), hospital and CMHC staff were permitted to furnish certain outpatient therapy, counseling, and educational services (including certain PHP services), incident to a physician's services, to beneficiaries in temporary expansion locations, including the beneficiary's home, as long as the location met all conditions of participation to the extent not waived. A hospital or CMHC could furnish such services using telecommunications technology to a beneficiary in a temporary expansion location if that beneficiary was registered as an outpatient. In the CY 2023 OPPS/ASC final rule with comment period (87 FR 72247), we confirmed that these provisions applied only for the duration of the COVID–19 PHE. On May 11, 2023, the COVID–19 PHE ended, and accordingly, these flexibilities ended as well.

In the CY 2021 OPPS/ASC final rule with comment period (85 FR 86073 through 86080), we continued our current methodology to utilize cost floors, as needed. In the CY 2022

OPPS/ASC final rule with comment period (86 FR 63665 and 63666), as a result of the COVID–19 PHE, we finalized our proposal to calculate the PHP per diem costs using the year of claims consistent with the calculations that would be used for other OPPS services, by using the CY 2019 claims and the cost reports that were used for CY 2021 final rulemaking to calculate the CY 2022 PHP per diem costs. In addition, for CY 2022 and subsequent years, we finalized our proposal to use cost and charge data from the Hospital Cost Report Information System (HCRIS) as the source for the CMHC cost-to-charge ratios (CCRs), instead of using the Outpatient Provider Specific File (OPSF) (86 FR 63666).

In the CY 2023 OPPS/ASC final rule with comment period (87 FR 71995), we finalized our proposal to use the latest available CY 2021 claims but use the cost information from prior to the COVID–19 PHE for calculating the CY 2023 CMHC and hospital-based PHP APC per diem costs. The application of the OPPS standard methodology, including the effect of budget neutralizing all other OPPS policy changes unique to CY 2023, resulted in the final calculated CMHC PHP APC payment rate being unexpectedly lower than the CY 2022 final CMHC PHP APC rate. Therefore, we finalized utilizing the equitable adjustment authority of section 1833(t)(2)(E) of the Act to appropriately pay for CMHC PHP services at the same payment rate as for CY 2022, that is, $142.70. In addition, we clarified the payment under the OPPS for new HCPCS codes that designate non-PHP services provided for the purposes of diagnosis, evaluation, or treatment of a mental health disorder and are furnished to beneficiaries in their homes by clinical staff of the hospital that would not be recognized as PHP services; however, none of the PHP regulations would preclude a patient that is under a PHP plan of care from receiving other reasonable and medically necessary non-PHP services from a hospital (87 FR 72001 and 72002).

In the CY 2024 OPPS/ASC final rule with comment period (88 FR 81811), we revised the regulation at § 424.24(e)(1)(i) to require the physician certification for PHP services to include a certification that the patient requires such services for a minimum of 20 hours per

week, as required by section 1861(ff)(1) of the Act, as amended by section 4124(a) of Division FF of the CAA, 2023. In addition, we modified the regulations for PHP at § 410.43 to include references to SUD. In the same CY 2024 OPPS/ASC final rule with comment period, we also established separate payment rates for PHP days with 3 services and days with 4 or more services. Accordingly, we established four separate PHP APC per diem payment rates: one for CMHCs for 3-service days and another for CMHCs for 4-service days (APC 5853 and APC 5854, respectively), and one for hospital-based PHPs for 3-service days and another for hospital-based PHPs for 4-service days (APC 5863 and APC 5864, respectively). We also finalized a policy to utilize the separate CMHC rates for 3-service and 4-service PHP days as the Medicare Physician Fee Schedule (MPFS) rates, depending upon whether a nonexcepted off-campus hospital outpatient department furnishes three or four PHP services in a day. Lastly, we finalized several changes beginning in CY 2024 to align coding, billing, and payment between PHPs and intensive outpatient programs.

In the CY 2026 OPPS/ASC final rule with comment period (90 FR 53770 through 53780), we modified the payment rate methodology for calculation of CMHC costs for PHP. We applied the 40 percent MPFS Relativity Adjuster to the hospital-based PHP costs to determine the CMHC costs for PHP.

2. Intensive Outpatient Program Services

Section 4124(b) of the CAA, 2023, amended section 1861(ff) of the Act, establishing Medicare coverage for intensive outpatient services effective for items and services furnished on or after January 1, 2024. An intensive outpatient program (IOP) is a distinct and organized program of psychiatric services for individuals who have an acute mental illness, which includes, but is not limited to, conditions such as depression, schizophrenia, and SUD. Intensive outpatient services are not required to be provided in lieu of inpatient hospitalization. Section 1861(ff)(4) of the Act defines intensive outpatient services as the items and services described in section 1861(ff)(2) of the Act prescribed by a physician for an individual determined (not less

frequently than every other month) by a physician to have a need for such services for a minimum of 9 hours per week and provided under a program described in paragraph (3) under the supervision of a physician pursuant to an individualized, written plan of treatment established and periodically reviewed by a physician (in consultation with appropriate staff participating in such program), which plan sets forth the physician's diagnosis, the type, amount, frequency, and duration of the items and services provided under the plan, and the goals for treatment under the plan. Section 1861(ff)(2) of the Act describes the items and services included in intensive outpatient services. Section 1861(ff)(4)(C) of the Act specifies that an IOP is a program furnished by a hospital to its outpatients, by a CMHC, by a Federally qualified health center (FQHC), or by a rural health clinic (RHC) as distinct and organized intensive ambulatory treatment service, offering less than 24-hour-daily care, in a location other than an individual's home or inpatient or residential setting. Section 1861(ff)(3)(B) of the Act defines a CMHC for purposes of this benefit. We refer readers to sections 1833(t)(1)(B)(i), 1833(t)(2)(B), 1833(t)(2)(C), and 1833(t)(9)(A) of the Act and 42 CFR 419.21, for additional information regarding IOP.

In the CY 2024 OPPS/ASC final rule with comment period (88 FR 81812 through 81857), we established payment and program requirements for the IOP benefit furnished by a hospital to its outpatients, or by a CMHC, an FQHC, or an RHC. In addition, we established Medicare Part B coverage for IOP services provided by Opioid Treatment Programs (OTPs) for the treatment of opioid use disorder (OUD).

Consistent with the statutory definition of intensive outpatient services under section 1861(ff)(4) of the Act, we finalized regulations at 42 CFR 410.44 to set forth the conditions and exclusions applicable for intensive outpatient services, and at § 424.24 to set forth the content of the certification and plan of treatment requirements for intensive outpatient services. We also revised certain existing regulations at §§ 410.2, 410.3, 410.10, 410.27, 410.150, and 419.21 to add a regulatory definition of intensive outpatient services and to include intensive outpatient

services in the regulations for medical and other health services paid for under Medicare Part B, and in the case of § 419.21, under the OPPS. Additionally, we created regulations at § 410.111 to establish the requirements for coverage of IOP services furnished in CMHCs, and at § 410.173 to establish conditions of payment for IOP services furnished in CMHCs. Lastly, we revised § 410.155 to exclude IOP services from the outpatient mental health treatment limitation, consistent with the statutory requirement of section 1833(c)(2) of the Act, as amended by section 4124(b)(3) of the CAA, 2023.

In addition, as discussed in greater detail in the following sections, we established coding, billing, and payment policies for IOP that align with the policies established for PHP provided in the same settings. Specifically, we established four separate IOP APC per diem payment rates at the same rates we proposed for the PHP APCs: one for CMHCs for 3-service days and another for CMHCs for 4-service days (APC 5851 and APC 5852, respectively), and one for hospital-based IOPs for 3-service days and another for hospital-based IOPs for 4-service days (APC 5861 and APC 5862, respectively). Similar to the policy finalized for PHP, we finalized a policy to utilize the CMHC rates for 3-service and 4-service IOP days as the MPFS rates, depending upon whether a nonexcepted hospital outpatient department furnishes three or four IOP services in a day.

For IOP services provided by an RHC or FQHC, we established a three-service per day payment rate based on the same rate as APC 5861, which is the three-service hospital-based IOP rate (§ 405.2462(j)). In the CY 2025 PFS final rule, we established a four or more services per day payment rate for an IOP provided by an RHC or FQHC based on the same rate as APC 5862, which is the four or more services hospital-based IOP rate (89 FR 98017 and 98018). Information regarding payment policies for IOP services furnished by FQHCs and RHCs, including information regarding CY 2027 policies for those settings, can be found in the CY 2027 PFS final rule, which is published elsewhere in the **Federal Register**.

Furthermore, in the CY 2024 OPPS/ASC final rule with comment period, we established

a payment adjustment for IOPs provided by an OTP based on three times the payment rate for APC 5861 beginning in CY 2024 (§ 410.67(d)(4)(i)(F)). We finalized regulations at § 410.67(d)(4)(ii) to add that the payment amount for OTP intensive outpatient services will be geographically adjusted using the Geographic Adjustment Factor (GAF) described in § 414.26. Lastly, we amended § 410.67(d)(4)(iii) to add that payment for OTP intensive outpatient services is updated annually using the Medicare Economic Index described in § 405.504(d). Payment rates for IOP provided in the OTP setting are updated as part of the OTP fee schedule and are not addressed in this final rule with comment period.

In the CY 2026 OPPS/ASC final rule with comment period (90 FR 53770 through 53780), we modified the payment rate methodology for calculation of CMHC costs for IOP. We applied the 40 percent MPFS Relativity Adjuster to the hospital-based IOP costs to determine the CMHC costs for IOP.

B. Coding and Billing for PHP and IOP Services under the OPPS

In the CY 2024 OPPS/ASC final rule with comment period, we finalized a billing requirement that all providers use condition code 41 to indicate that a claim is for partial hospitalization services and use condition code 92 to identify intensive outpatient claims, effective January 1, 2024. Since the statutory definitions of both IOP and PHP generally include the same types of items and services covered, we stated in the CY 2024 OPPS/ASC final rule with comment period that we believe it is appropriate to align the programs using a consistent list of services, so that level of intensity would be the only differentiating factor between partial hospitalization services and intensive outpatient services. The use of condition codes 41 for PHP claims and 92 for IOP claims allows us to differentiate between these services for billing purposes.

We recognize that the level of intensity of mental health services that a patient requires may vary over time; therefore, we believe utilizing a consolidated list of HCPCS codes to identify services under both the IOP and PHP benefits supports a smooth transition for patients

when a change in the intensity of their services is necessary to best meet their needs. For example, a patient receiving IOP services may experience an acute mental health need that necessitates more intense services through a PHP. Alternatively, an IOP patient that no longer requires the level of intensity provided by the IOP can access less intense mental health services, such as individual mental health services. The full list of HCPCs codes recognized under the PHP and IOP benefits can be found in the Medicare Claims Processing Internet Only Manual, Chapter 4, sections 260.1 and 261.1, respectively, and their subsections, available at *https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c04.pdf*.

To qualify for payment for the IOP APC (5851, 5852, 5861, or 5862) or the PHP APC (5853, 5854, 5863, or 5864), one service provided that day must be from the Partial Hospitalization and Intensive Outpatient Primary list. We refer readers to the CY 2024 OPPS/ASC final rule with comment period for further discussion regarding our expectation that at least one of the services on the PHP and IOP Primary list will be indicated per day for patients who need the level of care offered by a PHP or IOP program. The PHP and IOP Primary List can be found in the CY 2024 OPPS/ASC final rule with comment period at 88 FR 81821.

Beginning in CY 2024, we recognized caregiver training services and Principal Illness Navigation (PIN) services as PHP and IOP services. We explained that the reported costs associated with providing such services are included when we calculate the PHP and IOP payment rates; however, these services do not count toward the determination of whether a PHP or IOP day is paid at the 3-service or 4-service rate. We refer readers to the CY 2024 OPPS/ASC final rule with comment period for a detailed discussion of this policy (88 FR 81823 through 81825).

As finalized in the CY 2024 OPPS/ASC final rule with comment period (88 FR 81821 and 81822), if new codes are established that represent the PHP and IOP services described under §§ 410.43(a)(4) and 410.44(a)(4), respectively, such codes are added to the list of codes recognized for payment for PHP or IOP through sub-regulatory guidance. We note that coding

updates frequently occur outside of the standard rulemaking timeline. We adopted this sub-regulatory process to pay expeditiously when new codes are created that describe any of the services enumerated at §§ 410.43(a)(4) and 410.44(a)(4), which PHPs and IOPs, respectively, would provide. We explained that this policy applies to new codes that are cross walked to a previously included code, or whose code descriptor is substantially similar to a descriptor for a code on the list or describes a service on the list. We stated that any additional services not described at § 410.43(a)(4) or § 410.44(a)(4) would be added to the lists in regulation through notice and comment rulemaking.

In the CY 2025 OPPS/ASC final rule with comment period (89 FR 94266 through 94268) and CY 2026 OPPS/ASC final rule with comment period (90 FR 53770 through 53780), we did not add any new services not described at § 410.43(a)(4) or § 410.44(a)(4) to the list of PHP and IOP services.

We did not propose to add any new services to the list of PHP and IOP services for CY 2027. The following is a summary of the comments we received regarding these policies and our responses.

Comment: A few commenters expressed support for the PHP and IOP list of services, the two-tiered structure based on the number of services per day, and the consolidated list of HCPCS codes for PHP and IOP services.

Response: We appreciate commenters' support.

Comment: A commenter expressed support for our coding policies for occupational therapy services furnished in PHPs and IOPs, noting that these policies reinforce the importance of occupational therapy services in PHPs and IOPs. This commenter stated that providers misinterpret program requirements regarding reporting, documentation, and integration of OT services in PHP and IOP and requested that CMS clarify billing compliance and reimbursement guidelines to improve beneficiary access to OT services. This commenter also advocated for including measures specific to occupational therapy in quality reporting programs. They further

stated that caregiver training and PIN services should count toward the determination of whether a PHP or IOP day is paid at the 3-service or 4-service rate.

Response: We thank the commenter for their support of our coding policies for occupational therapy services furnished in PHPs and IOPs. We will take the commenter's suggestions into consideration to potentially inform future rulemaking about quality measures. As explained in the CY 2024 OPPS/ASC final rule with comment period, we believe it is appropriate to exclude caregiver-focused services from the determination of the number of services provided per day, but we do include such services in the calculation of cost per day for determining the PHP and IOP payment rates (88 FR 81822).

Comment: A commenter encouraged CMS to ensure that future payment analyses and policy development recognize the resources required to provide comprehensive medication management as part of high-quality behavioral health care and that such services be reimbursed appropriately.

Response: We appreciate the comment regarding the importance of medication management. We agree that medication is an integral part of partial hospitalization and intensive outpatient programs and note that under §§ 410.43(a)(4) and 410.44(a)(4), partial hospitalization and intensive outpatient services include drugs and biologicals furnished for therapeutic purposes (other than drugs that can be self-administered); the services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients (including patients with substance use disorder); and patient training and education, to the extent the training and educational activities are closely and clearly related to the individual's care and treatment. Therefore, payment under the PHP or IOP benefit could include daily monitoring of medication compliance, side effects, and patient education. We further note that existing codes in the list of HCPCS applicable for PHP and IOP, such as CPT code 90792 (Psych diag eval w/ med srvcs), include medication management (88 FR 81827 through 81828). We will take the commenter's

recommendations into consideration as we consider potential future payment analyses and policy development.

Comment: A commenter stated that providers have communicated to them that the Medicare National Coverage Determination list of group 1 diagnosis codes for PHP or IOP approved for G0129 omits several commonly seen diagnoses including post-traumatic stress disorder (PTSD), complex or prolonged grief diagnoses, borderline personality disorder (BPD), and generalized anxiety disorders (GAD). They requested that CMS include these diagnoses in the list of group 1 diagnosis codes for PHP or IOP approved for G0129.

Response: We thank the commenter for raising the concerns of providers on this topic. There is no National Coverage Determination for G0129. We are aware that there are Partial Hospitalization and Intensive Outpatient Services related Local Coverage Determinations (LCDs) and LCD Reference Articles that are developed by our Medicare Administrative Contractors (MACs). More information on the LCD development process can be found at publication 100-08, Program Integrity Manual (PIM), Chapter 13 at *https://www.cms.gov/medicare/regulations-guidance/manuals/internet-only-manuals-ioms*. Should the commenter believe that a change to the LCD is needed, we encourage the commenter to work with their local MAC (found at *https://www.cms.gov/Medicare/Coverage/InfoExchange*) to request an informal meeting prior to requesting an LCD reconsideration. The LCD reconsideration process is also outlined in chapter 13 of the PIM.

Comment: A commenter requested that CMS identify administrative barriers to the use of telemedicine in PHP and IOP programs and work with Congress to remove them.

Response: As we have previously discussed in the CY 2023 OPPS/ASC final rule with comment period (87 FR 72000), section 1861(ff)(3)(A) of the Act, which defines partial hospitalization services, specifies that a PHP is a program furnished by a hospital to its outpatients or by a community mental health center (CMHC), as a distinct and organized

intensive ambulatory treatment service, offering less than 24- hour-daily care, in a location other than an individual's home or inpatient or residential setting. Section 1861(ff)(4) of the Act defines IOP by reference to section 1861(ff)(3) of the Act; that is, IOP services must be furnished in a location other than an individual's home or inpatient or residential setting. Accordingly, the limitation on furnishing PHP and IOP services in an individual's home is statutory. However, we will take this comment into consideration as we develop PHP and IOP policies for potential future rulemaking.

C. CY 2027 Payment Rates for PHP and IOP

For CY 2027, we proposed to maintain the current payment rate methodology that we use for calculating PHP and IOP payment rates for hospital-based providers. It has been our longstanding policy since CY 2011 to pay separate PHP APC per diem payment rates for CMHCs and hospital-based PHPs (75 FR 71992). As we explained in the CY 2026 OPPS/ASC final rule with comment period, beginning in CY 2024, we applied this payment structure to IOP because we expected (and subsequently have observed) differences in resource use between CMHCs and hospital OPDs for the provision of both PHP and IOP services (90 FR 53777).

Consistent with the payment methodology finalized in the CY 2026 OPPS/ASC final rule with comment period (90 FR 53775 through 53776), we explained in the CY 2027 OPPS/ASC proposed rule (91 FR 41901) that we would apply the 40 percent MPFS Relativity Adjuster to calculate PHP and IOP payment rates for CMHCs. Specifically, we would multiply the CY 2027 rates for the hospital-based PHP and IOP APCs by 0.4 to calculate the payment rates for the CMHC PHP and IOP APCs.

1. Background

Beginning in CY 2024, we established four separate PHP APC per diem payment rates: one for CMHCs for 3-service days and another for CMHCs for 4-service days (APC 5853 and APC 5854, respectively), and one for hospital-based PHPs for 3-service days and another for hospital-based PHPs for 4-service days (APC 5863 and APC 5864, respectively). In addition,

for hospital-based PHPs, we finalized a policy to calculate payment rates using the broader OPPS data set, instead of using hospital-based PHP data only. We explained that using the broader OPPS data set allows CMS to capture data from claims not identified as PHP, but that also include the service codes and intensity required for a PHP day. Because we established consistent coding and payment between the PHP and IOP benefits, we considered all OPPS data for PHP days and non-PHP days that include three or more of the same service codes. We established four separate IOP APC per diem payment rates at the same rates we proposed for the PHP APCs: one for CMHCs for 3-service days and another for CMHCs for 4-service days (APC 5851 and APC 5852, respectively), and one for hospital-based IOPs for 3-service days and another for hospital-based IOPs for 4-service days (APC 5861 and APC 5862, respectively).

In the CY 2024 OPPS/ASC final rule with comment period (88 FR 81829 and 81830), we noted that the standard PHP day is typically four services or more per day. We explained that we have historically provided payment for three services a day for extenuating circumstances when a beneficiary would be unable to complete a full day of PHP treatment. As we stated in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66672), it was never our intention that days with only three units of service should represent the number of services provided in a typical PHP day. Our intention was to cover days that consisted of three units of service only in certain limited circumstances. For example, as we noted in the CY 2009 OPPS/ASC proposed rule (73 FR 41513), we believe 3-service days may be appropriate when a patient is transitioning towards discharge (or days when a patient is at the beginning of his or her PHP stay). Another example of when it may be appropriate for a program to provide only three units of service in a day is when a patient is required to leave the PHP early for the day due to an unexpected medical appointment.

In the same CY 2024 OPPS/ASC final rule with comment period, we also explained that prior to CY 2024, we historically prepared the data by first applying PHP-specific trims and data exclusions and assessing CCRs. We direct the reader to the CY 2016 OPPS/ASC final rule with

comment period (80 FR 70463 through 70465) for a more complete discussion of these trims, data exclusions, and CCR adjustments. In prior rules, we typically included a discussion of PHP-specific data trims, exclusions, and CCR adjustments; we did not include that discussion in the CY 2024 OPPS/ASC proposed rule or final rule with comment period. We stated that these PHP-specific data trims and exclusions addressed limitations as well as anomalies in the PHP data. However, as noted earlier, we finalized a methodology for CY 2024 to calculate hospital-based PHP payment rates for three services per day and four services per day based on cost per day using the broader OPPS data set. Accordingly, we did not apply PHP-specific trims and data exclusions, but rather we applied the same trims and data exclusions consistent with the OPPS.

We stated in the CY 2024 OPPS/ASC final rule with comment period (88 FR 81830) that while no IOP benefit existed prior to the CAA, 2023, the types of items and services included in IOP had been, and were, paid for by Medicare either as part of the PHP benefit or under the OPPS more generally. Additionally, we stated that prior to the CAA, 2023, CMS had begun gathering information from interested parties on IOP under Medicare. In the CY 2023 OPPS/ASC proposed rule (87 FR 44679), we issued a comment solicitation on intensive outpatient mental health treatment, including SUD treatment furnished by IOPs, to collect information regarding whether there are any gaps in coding that may be limiting access to needed levels of care for treatment of mental health disorders or SUDs for Medicare beneficiaries, and specific information about IOP services, such as the settings of care in which these programs typically furnish services, the range of services typically offered, and the range of practitioner types that typically furnish these services.

In addition, in the same CY 2024 OPPS/ASC final rule with comment period, we explained that along with the requirements for IOP mandated by the CAA, 2023, we took into consideration the information we received from the comment solicitation to construct an appropriate data set to develop proposed rates for IOP. Since IOPs furnish the same types of services as PHP, just at a lower intensity, we stated that we believe it was appropriate to use the

same data and methodology for calculating payment rates for both PHP and IOP for CY 2024. We explained that although PHP claims can be specifically identified, there was no specific identifier or billing code to indicate IOP services that may have been provided before CY 2024. However, we noted that hospitals have been permitted to furnish and bill for many of these services as outpatient services under the OPPS. Thus, we analyzed a broader set of data that included both PHP and non-PHP days with three or more services in order to calculate proposed payment for PHP services. To establish consistent payment between PHP and IOP, we set IOP payment rates at the same rates as PHP. We stated that the primary goal in developing the payment rate methodology for IOP and PHP services was to pay providers an appropriate amount relative to the patients' needs, and to avoid cost inversion in future years. We stated that setting the IOP payment rates equal to the PHP payment rates was appropriate because IOP was a newly established benefit, and we did not have definitive data on utilization. However, we explained that both programs utilize the same services, but furnish them at different levels of intensity, with different numbers of services furnished per day and per week, depending on the program. Therefore, we stated that we expect it would be appropriate to pay the same per diem rates for IOP and PHP services unless future data analysis supports calculating rates independently.

In the CY 2024 OPPS/ASC final rule with comment period (88 FR 81833), we established a policy of applying the 4-service day payment rate (that is, payment for PHP APCs 5854 for CMHCs and 5864 for hospitals, and IOP APCs 5852 for CMHCs and 5862 for hospitals) for days with four or more services. For days with three or fewer services, we apply the 3-service day payment rate (that is, payment for PHP APCs 5853 for CMHCs and 5863 for hospitals, and IOP APCs 5851 for CMHCs and 5861 for hospitals). As we noted in the CY 2024 OPPS/ASC final rule with comment period, we expect days with fewer than three services would be very infrequent, and we intend to monitor the provision of these days among providers and individual patients.

In the CY 2025 OPPS/ASC final rule with comment period (89 FR 94269), for beneficiaries in a PHP or IOP, we maintained the payment rate methodology finalized in the CY 2024 OPPS/ASC final rule with comment period.

In the CY 2026 OPPS/ASC final rule with comment period (90 FR 53774 through 53775), we explained that the calculated CY 2026 geometric mean per diem cost for CMHC PHP and IOP providers would result in an inversion (that is, the CMHC three-service geometric mean per diem costs were greater than the CMHC four-service geometric mean per diem costs). We stated that we believed the inverted geometric mean per diem costs were influenced by the small number of CMHCs that bill Medicare for PHP and IOP services, as well as CMHCs with low costs that first began billing Medicare for services in CY 2024. We remedied this cost inversion and preserved our longstanding payment policy of appropriately reflecting the observed cost differences between the CMHC and hospital settings by applying the 40 percent MPFS Relativity Adjuster to the hospital-based PHP and IOP costs to calculate the PHP and IOP payment rates for CMHCs.

2. CY 2027 Payment Rate Methodology for PHP and IOP

For CY 2027, we proposed to maintain our current methodology of calculating separate rates for hospitals and CMHCs. For the four hospital-based PHP and IOP APCs (that is, APCs 5861, 5862, 5863, and 5864), we proposed to use the latest available cost information, from cost reports beginning three fiscal years prior to the year that is the subject of the rulemaking, and CY 2025 OPPS claims to update the payment rates. We explained that this proposal was consistent with the overall proposed use of cost data for the OPPS, which is discussed in section II.A.1.a. of the CY 2027 OPPS/ASC proposed rule (91 FR 41740).

In accordance with the methodology finalized in the CY 2024 OPPS/ASC final rule with comment period, we proposed to base the payment rate for each hospital-based PHP APC on the geometric mean per diem cost for days with three services and four or more services. We proposed to use the broader set of OPPS data to calculate the geometric mean costs for hospital

outpatient departments, and we proposed to apply the same trims and exclusions consistent with the OPPS. We also proposed to set the payment rates for the hospital-based IOP APCs based on the geometric mean per diem cost for PHP days with three services and four or more services.

For the four CMHC PHP and IOP APCs (that is, APCs 5851, 5852, 5853, and 5854), we proposed to calculate the CY 2027 geometric mean per diem costs based on 40 percent of the corresponding hospital-based PHP and IOP APCs (APCs 5861, 5862, 5863, and 5864, respectively), in keeping with the methodology established in the CY 2026 OPPS/ASC final rule with comment period (90 FR 53775 and 53776). We implemented this change in methodology for calculating the four CMHC PHP and IOP APCs to avoid possible future cost inversions (that is, the cost for 3-service days being greater than the cost for 4-service days). We explained in the CY 2026 OPPS/ASC final rule with comment period that we believe this methodology would continue to be generally appropriate for estimating CMHC costs and aligns with the methodology that is used for other nonexcepted OPPS services furnished by a nonexcepted off-campus hospital outpatient department (90 FR 53775 through 53776). For additional information on our analyses of the data used for setting the PHP and IOP payment rates for CY 2026 and application of the 40 percent MPFS Relativity Adjuster, we refer readers to sections VIII.C.2. and VIII.C.3. of the CY 2026 OPPS/ASC final rule with comment period (90 FR 53774 through 53779).

Lastly, we proposed that if more recent hospital cost data subsequently became available after the publication of the CY 2027 OPPS/ASC proposed rule (91 FR 41904), we would consider using such updated data as appropriate to determine the CY 2027 payment rates for the four hospital-based PHP and IOP APCs.

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comments: Several commenters supported our proposal to maintain the current methodology of calculating hospital-based and CMHC- based PHP and IOP payment rates for 3

services per day and 4 services per day.

Response: We thank commenters for their support.

Comment: A commenter expressed concern that CY 2027 PHP and IOP rates were set based on cost data that was several years old and no longer representative of the cost of furnishing hospital-based PHP and IOP services.

Response: We refer readers to the discussion of the use of cost data for the OPPS in section II.A.1.a. of this CY 2027 OPPS/ASC final rule with comment period. We note that our proposal for CY 2027 was to use the most recent available cost and claims data to set PHP and IOP payment rates and that the OPPS payment rates are adjusted annually for inflation.

Comment: A commenter stated that CMS proposed no increase in current payment rates for PHP and IOP services.

Response: The proposed and final CY 2027 geometric mean costs for hospital and CMHC-based PHP and IOP services for 4 or more services per day represent an increase over CY 2026. We refer readers to Table 118 in the CY 2026 OPPS/ASC final rule with comment period (90 FR 53779) and Table 78 in this final rule with comment period. We remind readers that due to the OPPS budget neutrality adjustments and the application of the final market basket update for CY 2027, the final APC payment rates may be higher or lower than their estimated APC geometric mean costs.

Comment: Multiple commenters stated that CMHC cost estimates do not reflect the actual costs of providing PHP and IOP and that the resources involved are comparable to those required for hospital-based programs. Commenters stated that CMS' policy of paying separate rates for hospitals and CMHCs creates arbitrary incentives for PHP and IOP services in settings other than CMHCs.

Response: We disagree with the commenters who believe CMS policy creates an incentive for PHP and IOP services in settings other than CMHCs. As discussed earlier in this section and in the CY 2027 OPPS/ASC proposed rule (91 FR 41902), our longstanding payment

policies reflect the cost differences between the CMHC and hospital settings, based on our observation of CMHCs incurring significantly different costs than hospitals in the provision of PHP services. As we explained in the CY 2026 OPPS/ASC final rule, we observed that on average, the CY 2024 and CY 2025 geometric mean costs for the CMHC PHP and IOP APCs were 40 percent of the CY 2024 and CY 2025 geometric mean costs for the hospital-based PHP and IOP APCs (90 FR 53778). We believe that the stark difference between hospital and CMHC costs for PHP and IOP services that we continue to observe in the data reflects the actual cost structure differences between facility types.

Furthermore, we have observed sustained increases in the number of Medicare PHP and IOP days billed by CMHCs. In CY 2024, CMHCs billed for approximately 92,000 PHP days and approximately 9,000 IOP days, making up around 38.2 percent of total PHP and IOP days billed under the OPPS in that year. By contrast, in CY 2025, CMHCs billed for approximately 145,000 PHP days and approximately 41,000 IOP days, growing to around 42.4 percent of total PHP and IOP days billed under the OPPS. We believe this trend indicates that the level of payment appropriately supports access to these services at CMHCs. We will continue to monitor changes in the provision of PHP and IOP and will take these comments into consideration to potentially inform future policy.

Comment: Multiple commenters urged CMS to implement a site-neutral payment for CMHCs and hospital-based providers for PHP and IOP services. Some commenters stated that CMHCs are entitled under sections 1832(a)(2)(J) and 1833(a)(2)(B)(iii) of the Act to receive payment for PHP/IOP under the same methodology as hospital outpatient departments. A few commenters cited 1833(t)(2)(B) of the Act and stated that CMS has the discretion to create APC groups for different classes of services, but not to create distinct APC groups based on where a service is provided. Some commenters supported site neutrality more generally across Medicare payment systems.

Response: It has been our longstanding policy since CY 2011 to pay separate PHP APC

per diem payment rates for CMHCs and hospital- based PHPs. In the CY 2011 OPPS/ASC final rule with comment period (75 FR 71992), we stated that section 1833(t)(9)(A) of the Act requires the Secretary to "review not less often than annually and revise the groups, the relative payment weights, and the wage and other adjustments described in paragraph (2) to take into account changes in medical practice, changes in technology, the addition of new services, new cost data, and other relevant information and factors." We stated that we believe we have authority to revise the groups and relative payment weights and to make other adjustments to the payment rates for PHP services, including basing rates on hospital-based PHP data only, combined hospital-based PHP and CMHC data, or CMHC data only, to take into account relevant information and factors that would allow us to more appropriately pay providers for the resource costs associated with providing PHP services. Accordingly, we finalized separate PHP APC per diem payment rates for hospital OPDs and CMHCs, and we have maintained that structure for payment since CY 2011. Beginning in CY 2024, we applied this payment structure to IOP because we expected (and subsequently have observed) differences in resource use between CMHCs and hospital OPDs for the provision of both PHP and IOP services.

In response to the commenters who cited to section 1833(t)(2)(B) of the Act, we believe we have authority to create APC groups as shown by our longstanding methodology for PHP and IOP. CMS data shows that PHP and IOP services furnished at hospital OPDs differ with respect to the use of resources from PHP and IOP services furnished at CMHCs; therefore, payment rates that recognize these resource differences are consistent with the statutory requirements under section 1833(t) of the Act.

We also disagree that paying CMHCs at the same higher rate as hospitals for these services would have a negligible impact on the Medicare program. Despite the small number of CMHCs billing Medicare, the volume of PHP and IOP services that they provide is significant. Our data from CY 2025 OPPS claims shows that CMHCs furnished approximately 42 percent of all PHP and IOP days that were paid under the OPPS. If we were to increase payment for these

PHP and IOP days by 150 percent (from 40 percent of the hospital-based payment rate to 100 percent of the hospital-based payment rate), as commenters have suggested, it would cause a significant increase in the total amount of PHP and IOP payments, both from the Medicare program and from Medicare beneficiaries in the form of coinsurance payments.

Comment: Some commenters stated that, given inflation and increased labor costs, the proposed rate is too low for CMHCs to effectively and appropriately staff and deliver PHPs and IOPs. The commenters stated that applying the 40 percent relativity adjuster could reduce CMHC payment rates compared to the hospital-based PHP and IOP payment rates.

Response: We appreciate the commenters' concerns; however, we disagree that the proposed rates are inadequate. We note that the OPPS payment rates are adjusted annually for inflation and that CMHC payment rates reflect those annual updates. We refer readers to the CY 2026 OPPS/ASC final rule with comment period for more extensive analysis of how CMHC costs align with the application of the 40 percent MPFS Relativity Adjuster to the hospital-based PHP and IOP costs (90 FR 53777 through 53778).

Comment: Some commenters stated that 40-percent methodology for determining CMHC rates is arbitrary and capricious under the Administrative Procedure Act because the data is inadequate to support the rate. Some of these commenters additionally stated that two of CMS's rationales were contradictory: the 40-percent adjuster had become necessary due to unstable CMHC cost data that resulted in a cost inversion, yet that same unstable data was used to support the 40-percent adjuster as we explained that CMHC geometric mean costs were on average 40 percent of hospital-based PHP and IOP geometric mean costs.

Response: Application of the 40 percent MPFS Relativity Adjuster allows CMS to set CMHC payment rates based on the best available data, consistent with section 1833(t)(9)(A) of the Act. The fact that CMHC cost data is less stable than desired for ratesetting does not mean, however, that it gives us no range indicating where CMHC costs fall in relation to hospital costs. When we tested the 40 percent adjuster against several years of CMHC and hospital cost data,

effectively increasing the CMHC dataset by adding years of cost reports, examining the ratio of CMHC costs to hospital costs per year, and taking an average to smooth out anomalies, we found that the 40 percent MPFS Relativity Adjuster provides stability and accuracy for CMHC PHP and IOP rates, both important elements in our payment methodologies. Our analysis indicates that the appropriateness of the CMHC payment methodology relative to patients' needs is fully supported by cost data and the rulemaking record. We refer readers to the extensive analysis and discussion in the CY 2026 OPPS/ASC final rule with comment period (90 FR 53774 through 53778).

Final Decision: After consideration of the public comments, we are finalizing the CY 2027 PHP and IOP payment rate methodology for hospitals and CMHCs as proposed. Table 78 shows the final calculated geometric mean per diem costs for hospital-based PHP and IOP APCs, and the final geometric mean per diem costs for CMHC PHP and IOP APCs based on the application of the 40 percent MPFS Relativity Adjuster for this CY 2027 OPPS/ASC final rule with comment period. Additional information about the data trims, data exclusions, and CCR adjustments applicable to the data used for the CY 2027 OPPS/ASC proposed rule can be found online at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html*.[2]

TABLE 78: FINAL CY 2027 PHP AND IOP APC GEOMETRIC MEAN PER DIEM COSTS

CY 2027 APC	Group Title	Final PHP and IOP APC Geometric Mean Per Diem Costs
5851	Intensive Outpatient (3 services per day) for CMHCs	$123.94
5852	Intensive Outpatient (4 or more services per day) for CMHCs	$202.96
5853	Partial Hospitalization (3 services per day) for CMHCs	$123.94
5854	Partial Hospitalization (4 or more services per day) for CMHCs	$202.96
5861	Intensive Outpatient (3 services per day) for hospital-based IOPs	$309.85
5862	Intensive Outpatient (4 or more services per day) for hospital-based IOPs	$507.39
5863	Partial Hospitalization (3 services per day) for hospital-based PHPs	$309.85
5864	Partial Hospitalization (4 or more services per day) for hospital-based PHPs	$507.39

D. Outlier Policy for CMHCs

For CY 2027, we proposed to maintain the calculations of the CMHC outlier percentage, cutoff point and percentage payment amount, outlier reconciliation, outlier payment cap, and fixed dollar threshold according to previously established policies to include PHP and IOP services (91 FR 41904). We refer readers to the CY 2024 OPPS/ASC final rule with comment period (88 FR 81834 through 81836) for more details on CMHC outlier policies, and to section II.G. of this final rule with comment period for our general policies for hospital outpatient outlier payments.

1. Background

As discussed in the CY 2004 OPPS/ASC final rule with comment period (68 FR 63469 and 63470), we created a separate outlier policy specific to the estimated costs and OPPS payments provided to CMHCs. We designated a portion of the estimated OPPS outlier threshold specifically for CMHCs, consistent with the percentage of projected payments to CMHCs under the OPPS each year, excluding outlier payments, and established a separate outlier threshold for CMHCs.

2. CMHC Outlier Percentage

In the CY 2018 OPPS/ASC final rule with comment period (82 FR 59267 and 59268), we described the current outlier policy for hospital outpatient payments and CMHCs. We note that we also discussed our outlier policy for CMHCs in more detail in section VIII.C. of that same final rule with comment period (82 FR 59381). We set our projected target for all OPPS aggregate outlier payments at 1.0 percent of the estimated aggregate total payments under the OPPS (82 FR 59267). This same policy was also reiterated in the CY 2019 OPPS/ASC final rule with comment period (83 FR 58996), the CY 2020 OPPS/ASC final rule with comment period (84 FR 61350), and the CY 2021 OPPS/ASC final rule with comment period (85 FR 86082). We did not propose any changes to the CMHC outlier percentage policy for CY 2027.

3. Cutoff Point and Percentage Payment Amount

Also described in the CY 2018 OPPS/ASC final rule with comment period (82 FR 59381), our policy has been to pay CMHCs for outliers if the estimated cost of the day exceeds a cutoff point. In CY 2006, we set the cutoff point for outlier payments at 3.4 times the highest CMHC PHP APC payment rate implemented for that calendar year (70 FR 68551). For CY 2018, the highest CMHC PHP APC payment rate was the payment rate for CMHC PHP APC 5853. In addition, in CY 2002, the final OPPS outlier payment percentage for costs above the multiplier threshold was set at 50 percent (66 FR 59889). In CY 2018, we continued to apply the same 50 percent outlier payment percentage that applies to hospitals to CMHCs and continued to use the existing cutoff point (82 FR 59381). Therefore, for CY 2018, we continued to pay for partial hospitalization services that exceeded 3.4 times the CMHC PHP APC payment rate at 50 percent of the amount of CMHC PHP APC geometric mean per diem costs over the cutoff point. This same policy was also reiterated in the CY 2019 OPPS/ASC final rule with comment period (83 FR 58996 and 58997), the CY 2020 OPPS/ASC final rule with comment period (84 FR 61351), the CY 2021 OPPS/ASC final rule with comment period (85 FR 86082 and 86083), the CY 2022 OPPS/ASC final rule with comment period (86 FR 63670), the CY 2023 OPPS/ASC final rule with comment period (87 FR 72004), and the CY 2024 OPPS/ASC final rule with comment period (88 FR 81835). In the CY 2024 OPPS/ASC final rule with comment period, we extended this policy to intensive outpatient services. We did not propose any changes to the cutoff point and payment amount policy for CY 2027.

4. Outlier Reconciliation

In the CY 2009 OPPS/ASC final rule with comment period (73 FR 68594 through 68599), we established an outlier reconciliation policy to address charging aberrations related to OPPS outlier payments. We addressed vulnerabilities in the OPPS outlier payment system that led to differences between billed charges and charges included in the overall CCR, which are used to estimate cost and apply to all hospitals and CMHCs paid under the OPPS. We initiated

steps to ensure that outlier payments appropriately account for the financial risk when providing an extraordinarily costly and complex service but are only being made for services that legitimately qualify for the additional payment.

For a comprehensive description of outlier reconciliation, we refer readers to the CY 2023 OPPS/ASC and CY 2019 OPPS/ASC final rules with comment period (83 FR 58874 and 58875 and 81 FR 79678 through 79680, respectively). We did not propose any changes to the outlier reconciliation policy for CY 2027.

5. Outlier Payment Cap

In the CY 2017 OPPS/ASC final rule with comment period, we implemented a CMHC outlier payment cap to be applied at the provider level, such that in any given year, an individual CMHC will receive no more than a set percentage of its CMHC total per diem payments in outlier payments (81 FR 79692 through 79695). Our analysis of CY 2014 claims data found that CMHC outlier payments began to increase similarly to the way they had prior to CY 2004. This was due to inflated costs from three CMHCs that accounted for 98 percent of all CMHC outlier payments that year and received outlier payments that ranged from 104 percent to 713 percent of their total per diem payments. To balance our concern about disadvantaging CMHCs with our interest in protecting the benefit from excessive outlier payments and to mitigate potential inappropriate outlier billing vulnerabilities, we finalized the CMHC outlier payment cap at 8 percent of the CMHC's total per diem payments (81 FR 79694 and 79695) to limit the impact of inflated CMHC charges on outlier payments. This cap was established after detailed analysis of claims data, which showed that a cap set at 8 percent would effectively address excessive outlier payments while minimally impacting CMHCs with legitimate high-cost cases. The cap applies to each CMHC's total per diem payments, which include both the Medicare payment portion and the beneficiary cost-sharing amount. The 8 percent cap continues to be calculated and applied on a calendar year basis, with outlier payments monitored throughout the year to ensure compliance with the cap.

This outlier payment cap only affects CMHCs; it does not affect other provider types (that is, hospital-based PHPs) and is in addition to and separate from the current outlier policy and reconciliation policy in effect. We did not propose any changes to the outlier payment cap for CY 2027.

Comment: A commenter indicated general support for the CMHC outlier cap while requesting that CMS evaluate whether requiring documentation that PHP and IOP services furnished followed a published behavioral health clinical pathway would better protect program integrity than a fixed outlier cap.

Response: We appreciate the commenter's perspective and will take it into consideration to potentially inform future program monitoring and research efforts.

6. Fixed-Dollar Threshold

In the CY 2018 OPPS/ASC final rule with comment period (82 FR 59267 and 59268), for the hospital outpatient outlier payment policy, we set a fixed-dollar threshold in addition to an APC multiplier threshold. Fixed-dollar thresholds are typically used to drive outlier payments for very costly items or services, such as cardiac pacemaker insertions. Currently, for CY 2026, CMHC PHP APCs (5853 or 5854) and IOP APCs (5851 or 5852) are the only APCs for which CMHCs may receive payment under the OPPS, and these APCs are for providing a defined set of services that are relatively low cost when compared to other OPPS services. Because of the relatively low cost of CMHC services that are used to comprise the structure of CMHC PHP APCs (5853 or 5854) and IOP APCs (5851 or 5852), it is not necessary to also impose a fixed-dollar threshold on CMHCs. Therefore, in the CY 2018 OPPS/ASC final rule with comment period, we did not set a fixed-dollar threshold for CMHC outlier payments (82 FR 59381). This same policy was also reiterated in the CY 2020 OPPS/ASC final rule with comment period (84 FR 61351), the CY 2021 OPPS/ASC final rule with comment period (85 FR 86083), the CY 2022 OPPS/ASC final rule with comment period (86 FR 63508), the CY 2023 OPPS/ASC final rule with comment period (87 FR 72004), the CY 2024 OPPS/ASC final rule

with comment period (88 FR 81836), the CY 2025 OPPS/ASC final rule with comment period (89 FR 94271), and the CY 2026 OPPS/ASC final rule with comment period (90 FR 53780). We did not propose any changes to the fixed-dollar threshold policy for CY 2027 and did not receive any public comments on this provision.

IX. Services That Will Be Paid Only as Inpatient Services

A. Background

The Inpatient Only (IPO) list was established in rulemaking as part of the initial implementation of the Outpatient Prospective Payment System (OPPS) in 2000, pursuant to the Secretary's authority under section 1833(t)(1)(B)(i) of the Act (65 FR 18455) to determine the services covered and paid for under the OPPS. The IPO list was created to identify services excluded from payment under the OPPS by designating certain procedures as "inpatient only" and therefore payable only when furnished in the inpatient hospital setting under Medicare Part A (65 FR 18442). Services included on the IPO list were those determined to require inpatient care because of the invasive nature of the procedures, the underlying physical condition of the Medicare patient, or the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged (70 FR 68695). The creation of the IPO list was based on the premise (rooted in the practice of medicine at that time) that Medicare should not pay for procedures furnished as outpatient services when those procedures were being performed on an inpatient basis virtually all of the time for the Medicare population because performing these procedures on an outpatient basis was not safe or appropriate, and therefore not reasonable and necessary under Medicare rules (86 FR 63671; 63 FR 47571). Designation of a service as inpatient only does not preclude the service from being furnished in a hospital outpatient setting but means that Medicare will not make payment for the service if it is furnished to a Medicare beneficiary in the hospital outpatient setting (65 FR 18443). Conversely, the absence of a procedure from the list should not be interpreted as identifying that procedure as appropriately performed only in the hospital outpatient setting (70 FR 68696). Rather, from the beginning, we have emphasized our expectation that, in every case, the physician or surgeon and hospital will exercise their professional judgment and assess the risk of the procedure or service to the individual patient, taking into account the site of service and act in that patient's best interest (65 FR 18456). We have also previously stated that for procedures that are not included on the

inpatient list, we rely on the practitioner's judgment to determine on a patient-by-patient basis whether or not a particular procedure would be most appropriately performed in the inpatient setting (70 FR 68698).

In the CY 2021 OPPS/ASC final rule with comment period (85 FR 86084 through 86088), we finalized a policy to eliminate the IPO list over the course of 3 years (85 FR 86093). We revised our regulation at 42 CFR 419.22(n) to state that, effective January 1, 2021, the Secretary shall eliminate the list of services and procedures designated as requiring inpatient care through a 3-year transition. As part of the first phase of this elimination of the IPO list, we removed 298 codes, including 266 musculoskeletal-related services, from the list beginning in CY 2021.

In the CY 2022 OPPS/ASC final rule with comment period, we halted the elimination of the IPO list and, after clinical review of the services removed from the IPO list in CY 2021 as part of the first phase of eliminating the IPO list, we returned most services removed from the IPO list in 2021 back to the IPO list beginning in CY 2022 (86 FR 63671 through 63736). We amended the regulation at § 419.22(n) to remove the reference to the elimination of the list of services and procedures designated as requiring inpatient care through a 3-year transition (86 FR 63676). We also finalized our proposal to codify the following five longstanding criteria for determining whether a service or procedure should be removed from the IPO list in the regulation at § 419.23 (86 FR 63672):

- Most outpatient departments are equipped to provide the service or procedure to the Medicare population.
- The simplest service or procedure described by the code may be performed in most outpatient departments.
- The service or procedure is related to codes that CMS has already removed from the Inpatient Only list.

- CMS determines that the service or procedure is being performed in numerous hospitals on an outpatient basis.

- CMS determines that the service or procedure can be appropriately and safely performed in an ambulatory surgical center, and is specified as a covered ambulatory surgical procedure, or CMS has proposed to specify it as a covered ambulatory surgical procedure.

For CY 2023 through CY 2025, we maintained the IPO list and continued to evaluate services brought forth by interested parties for removal using the five longstanding criteria (87 FR 72004 through 72012; 88 FR 81858 through 81863; and 89 FR 94271 through 94275).

In the CY 2026 OPPS/ASC final rule with comment period, we again finalized a policy to eliminate the IPO list over the course of three years, beginning by removing 285 mostly musculoskeletal procedures for CY 2026 (90 FR 53780 through 53802). As we stated in that rule, since the creation of the IPO list, there have been many new technologies and advances in surgical techniques and surgical care protocols, including the use of minimally invasive surgical procedures such as laparoscopy, improved perioperative anesthesia, expedited rehabilitation protocols, as well as significant enhancements to postoperative processes such as improvements in pain management, that have reduced the inpatient length of stay and the need for postoperative care following a surgical service. We also recognize that since we previously considered elimination of the IPO list in the CY 2021 OPPS/ASC final rule with comment period, there have also been other innovations in the practice of medicine; for example, innovations in infection control spurred by the COVID-19 PHE. Additionally, we believe that there are a number of safety mechanisms that will continue to ensure the safety of our beneficiaries and the quality of care, including physician judgment, State and local regulations, accreditation requirements, medical malpractice laws, hospital conditions of participation, and other CMS initiatives (90 FR 53857). Given the significant number of services on the list and that we would establish new reimbursement rates for those services under the OPPS, we recognized that interested parties may need time to adjust to the removal of procedures from the list. Providers

may need time to prepare to furnish newly removed procedures on an outpatient basis, update their billing systems, and gain experience with newly removed procedures eligible to be paid under either the IPPS or OPPS. Therefore, we finalized our proposal to transition services off the IPO list over a 3-year period (90 FR 53783). We also refer readers to the CY 2026 OPPS/ASC final rule with comment period for further discussion on operational and beneficiary considerations, including the continuation of 2-midnight exemptions for services removed from the IPO list, effects on beneficiary cost-sharing, and implications on the 3-day stay requirement for skilled nursing facilities (90 FR 53786 through 53788). After consideration of the comments received and the issues discussed, in the CY 2026 OPPS/ASC final rule with comment period, we finalized our proposal eliminating the criteria for removing procedures from the IPO list as it was then codified at § 419.23 and amended § 419.22(n) to state that, effective on January 1, 2026, the Secretary shall eliminate the list of services and procedures designated as requiring inpatient care through a 3-year transition period, with the list eliminated in its entirety by January 1, 2029 (90 FR 53788 to 53789 and 54086; 91 FR 8384). For further discussion on the elimination of the IPO list, please refer to section IX. of the CY 2026 OPPS/ASC final rule with comment period (90 FR 53780 through 53802).

B. Final CY 2027 Changes to IPO List

Currently, there are 1,438 services remaining on the IPO list. For CY 2027, we proposed to remove approximately half of the remaining IPO services as the second phase of the elimination of the IPO list. Therefore, we proposed to remove 637 services from the following clinical families: auditory, digestive, endocrine, female genital, hemic and lymphatic systems, integumentary, male genital, maternity care and delivery, mediastinum and diaphragm, respiratory, and urinary. As stated in the proposed rule, if we finalize our proposal to remove these services for CY 2027, the majority of remaining services are more complicated in nature, and we believe the services in these clinical families may require a lengthier review process and potential changes to our current APCs in order to determine an appropriate APC assignment. For

example, some of the remaining procedures for removal in CY 2028 would be from the neurological family, cardiovascular family, solid organ, intestinal, and islet cell transplants and related services. We believe these services require additional considerations due to their complex clinical nature and resources required. We expect that these remaining clinical families and services would be removed from the IPO list for CY 2028, during the third and final phase of the elimination.

The clinical families proposed for the second phase of the elimination of the IPO list were selected based on interested parties feedback and concerns regarding proper APC placement. In the CY 2026 OPPS/ASC proposed rule, we solicited comment on the order of removal of additional clinical families of services, and/or specific services, for each of the CY 2027 and CY 2028 rulemaking cycles (90 FR 33669). We received comments requesting that we wait to remove certain invasive procedures involving craniectomy, craniotomy, and/or burr holes and cardiovascular procedures until the last phase, and we stated we would take the suggestions into consideration in future rulemaking (90 FR 53788). After further consideration, we agreed with the commenters that we should wait to remove these more clinically complex and unique procedures, including the neurological and cardiovascular procedures, until the final phase. We believe that the complicated nature of the services in these clinical families may require a lengthier review process and potential changes to our current APCs to determine an appropriate APC assignment. Additionally, the clinical families listed above and proposed for removal in CY 2027 include multiple procedures that have been previously recommended by interested parties for removal from the IPO list. Based on our review, we also believe that the procedures in these clinical families require less adjustment to existing APCs compared to those clinical families we proposed to remove in CY 2028, including the neurological and cardiovascular clinical families, meaning, they have clinical similarities and resource needs similar to that of existing procedures payable under the OPPS. As these groups of services are the next most clinically similar families, they are the natural next step in the phase out of the IPO. Therefore,

we proposed to remove selected less-complex services in the auditory, digestive, endocrine, female genital, hemic and lymphatic systems, integumentary, male genital, maternity care and delivery, mediastinum and diaphragm, respiratory, and urinary clinical families from the IPO list for CY 2027 and proposed to maintain the remaining clinical families for CY 2027. If we finalize our policy as proposed, we expect to address all of the remaining clinical families and their removal during CY 2028 rulemaking.

As we have previously stated, when removing a service from the IPO list, we assign the service to an APC and include it as a payable procedure under the OPPS (67 FR 66740). As stated in previous rulemaking, services that are no longer included on the IPO list are payable in either the inpatient or hospital outpatient setting subject to the general coverage rules requiring that any procedure be reasonable and necessary, and payment should be made pursuant to the otherwise applicable payment policies (86 FR 63675). We determined the APC assignment for services removed from the IPO list by evaluating the clinical similarity and resource costs of the service compared to other services paid under the OPPS and reviewing the Medicare Severity Diagnosis Related Groups (MS–DRG) rate for the service under the IPPS. It should be noted, however, that we would generally expect the cost to provide a service in the outpatient setting to be less than the cost to provide the service in the inpatient setting (67 FR 66740). Additionally, sought comment and continue to seek comments on whether we should restructure or create any new APCs or C-APCs to allow for efficient OPPS payment for services that are removed from the IPO list to account for this significant increase in services that will now be eligible for OPPS payment.

In summary, we proposed to remove 637 services from the IPO list for CY 2027 as the second phase of the elimination of the IPO list (91 FR 41907). These services and their proposed status indicators and APC assignments (if applicable) are listed in the public use file titled "Proposed Procedures for Removal from the IPO List for CY 2027", which is available on the CMS website. The services proposed for removal from the IPO list for CY 2027 and their

proposed status indicators and APC assignments (if applicable) were also included in Addendum B of the CY 2027 OPPS/ASC proposed rule. The complete list of codes that describe services that are proposed to be paid by Medicare in CY 2027 as Inpatient Only services was included as Addendum E to the CY 2027 OPPS/ASC proposed rule.

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: Several commenters expressed support for our proposal to continue the elimination of the IPO list and remove 637 services for CY 2027. Commenters supported increasing flexibility for site-of-service determinations and increasing access and physician autonomy. Commenters stated that site-of-service determinations are best informed by the patient's physicians.

Commenters also expressed support for the removal of certain procedures from the IPO list. Several commenters supporting the removal of bariatric and metabolic services described by CPT codes 43644, 43645, 43775, 43843, 43845, 43847, 43848, and 43860. A commenter supported removing integumentary procedures, stating that continuing to provide these services primarily in the inpatient setting would increase the cost without a corresponding clinical benefit.

Response: We thank the commenters for their support.

Comment: Many commenters opposed our proposal to continue the elimination of the IPO list with the removal of 637 procedures, with patient safety continuing to be a main concern. Some commenters requested that CMS reverse its decision to eliminate the IPO list and reinstate the prior five criteria. Others suggested alternatives to removing all of the procedures from the IPO list, including individually reviewing each procedure for appropriateness in the outpatient setting or creating criteria based on factors such as average length of stay, peer-reviewed literature, patient comorbidities, clinical complexity, and infrastructure needed to safely furnish the procedure in the outpatient setting. Commenters also suggested creating criteria that would allow physicians to override an IPO designation and still receive payment for furnishing the

procedure in the outpatient setting when appropriate to allow physicians more flexibility while still maintaining the IPO list. Some commenters stated they understood CMS's goal to increase site-of-service flexibility but were concerned at the pace of which procedures were being removed from the IPO list. Commenters recommended that CMS wait to remove additional, more complex procedures until the effects of the CY 2026 removals are assessed. Commenters also asserted that the large number of codes coming off the IPO list over the 3-year elimination period could expose hospitals to increased audits and claims denials and not provide enough time for hospitals and physicians to establish clinical pathways and protocols.

Response: We thank the commenters for their input. As we previously stated in the CY 2021 OPPS/ASC final rule with comment period (85 FR 86087), we continue to believe that physicians can and should use their clinical knowledge and judgment to appropriately determine whether a procedure can be performed in a hospital outpatient setting or whether inpatient care is required for the beneficiary based on the beneficiary's specific needs and preferences, subject to the general coverage rules requiring that any procedure be reasonable and necessary, and that payment should be made pursuant to the otherwise applicable payment policies. We believe that patient safety and quality of care will be safeguarded by the physician's assessment of the risk of a procedure or service to the individual beneficiary and their selection of the most appropriate setting of care based on this risk, as well as State and local licensure requirements, accreditation requirements, hospital conditions of participation (CoPs), medical malpractice laws, and our quality and monitoring initiatives and programs. We also continue to believe that there have been significant developments in the practice of medicine that have allowed numerous services that were previously provided on an inpatient basis to now be provided safely and effectively in the outpatient setting. Therefore, we continue to believe it is not necessary for us to maintain an IPO list, nor do we currently believe that it is necessary to require specific HCPCS codes to remain payable only when furnished in the inpatient setting. Additionally, for these same reasons, we believe it is not necessary to adopt another method of revising the IPO list, such as

reviewing individual procedures against a new set of criteria.

Regarding the length of the phase-out period, as we stated in the CY 2026 OPPS/ASC final rule with comment period, we believe that gradually removing services from the IPO list over the 3-year phase-out period will allow for adequate time for providers to prepare to furnish newly removed procedures on an outpatient basis, update their billing systems, and gain experience with newly removed procedures eligible to be paid under either the IPPS or OPPS (90 FR 53788). Additionally, we believe that our policy to exempt procedures that have been removed from the IPO list from certain medical review activities to assess compliance with the 2-midnight rule until the Secretary determines that the service or procedure is more commonly performed in the Medicare population in the outpatient setting will prevent hospitals from the burden of audits and denials due to furnishing former IPO procedures in the inpatient setting.

Comment: Many commenters requested that CMS emphasize that the removal of codes from the IPO list does not imply that the hospital outpatient setting is automatically the most appropriate site-of-service for these procedures.

Response: As we have stated in previous rulemaking (82 FR 59384; 84 FR 61354; 90 FR 53784), the removal of a service from the IPO list does not require the service to be performed only on an outpatient basis. Rather, it allows for payment under the OPPS when the service is performed in an outpatient setting. Services that are removed from the IPO list can be and are performed on individuals who are admitted as inpatients (as well as individuals who are registered hospital outpatients), based on the physician's clinical knowledge and judgment.

Comment: Several commenters expressed concern that the removal of the proposed services and elimination of the IPO list could cause shifts in the site-of-care availability and cost impacts. One commenter was concerned that these changes may lead to increased reliance on Medicare Part B services and reduced access to Medicare Part A post-acute care benefits, such as SNF care. Commenters were also concerned that the continued elimination of the IPO list could lead to increased pressure on physicians to furnish former IPO list services in the lowest cost

setting, even if not clinically appropriate for that patient.

Many commenters expressed concern that Medicare Advantage (MA) plans and commercial payors may not follow CMS's lead that the absence of a procedure from the IPO list does not mean it is always appropriately performed in the outpatient setting, leading to denials for inpatient care or pressure for hospitals to provide these procedures in lower cost settings. Commenters requested that CMS continue to emphasize that MA plans must comply with general coverage and benefit conditions included in Traditional Medicare laws, including coverage criteria that governs inpatient admissions. Commenters also requested that CMS issue guidance to MA plans to ensure that they do not create internal policies that inpatient admissions are no longer appropriate for procedures coming off the IPO list or override a physician's determination that inpatient care is needed, apply prior authorizations in a limited manner, and appropriately follow CMS's 2-midnight rule.

Response: As many of the procedures coming off the IPO list are complex procedures that are not currently regularly performed in the hospital outpatient setting, we do not anticipate to see large shifts in site-of-care due to the elimination of the IPO list, nor do we anticipate that this will cause cost effects that would limit access to Medicare Part A services. We anticipate that procedures that do see significant increases in being performed in the outpatient setting will likely be procedures that are less complex and are already being performed regularly in the outpatient setting in the general population.

We consider discussions regarding MA plans to be out of scope of this OPPS/ASC rule, however, as we have previously stated, MA plans are required to comply with the 2-midnight benchmark. This is stated in the April 12, 2023 rule titled "Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly." In this rule, we codified that MA plans must comply with "General coverage and benefit conditions included in Traditional Medicare laws, unless superseded by laws applicable

to MA plans. This includes criteria for determining whether an item or service is a benefit available under Traditional Medicare." These criteria include "payment criteria for inpatient admissions at 42 CFR 412.3" and "services and procedures that the Secretary designates as requiring inpatient care under 42 CFR 419.22(n)." (88 FR 22328). These requirements mean that MA plans must comply with the 2-midnight rule and may not treat removal from the IPO list as requiring those procedures to be performed in the outpatient setting. We will take the commenters' request for additional guidance into consideration for future rulemaking.

Regarding changes made by commercial insurance providers and site selection for outpatient services as a result of us eliminating the IPO list, while we believe that these comments are outside the scope of the OPPS/ASC proposed rule, we note that commercial providers establish their own rules regarding payment for services. We also refer readers to our discussion below regarding CMS's limitations on interfering with the practice of medicine and our belief that the specific decision about the most appropriate care setting for a given surgical procedure is a complex medical judgment made by the physician based on the beneficiary's individual clinical needs.

Comment: Several commenters made requests regarding data monitoring and additional guidance. Commenters recommended that CMS monitor the effects of removing procedures from the IPO list, including factors such as hospital length of stay, readmissions, patient outcomes, and emergency department visits. Commenters requested that CMS provide guidance on patient selection criteria for performing these procedures in the hospital outpatient setting. Commenters also requested additional education from CMS regarding the exemptions from 2-midnights claims review for procedures removed from the IPO list, including identifying which procedures are exempt, citing that some hospitals were unaware of these exemptions. Additionally, commenters requested that CMS educate beneficiaries on potential higher cost-sharing for procedures performed in the outpatient setting, which some commenters expressed as a factor for opposing our proposal.

Response: We thank the commenters for their feedback. Annually, through rulemaking, we assess, monitor, and reevaluate hospital claims data, the clinical environment, and our overall payment policies to inform our proposals and final policies. We would welcome and use any data, analyses, or recommendations that interested parties would like to share with us to help inform IPO decision-making going forward. We will take these recommendations into consideration for future rulemaking and are open to receiving any relevant data in the interim.

Regarding providing additional guidance on patient selection criteria and site-of-service determinations, as we have previously stated (86 FR 63675), we note the balance between several factors on this important issue, namely, the prohibition on us interfering with the practice of medicine in section 1801 of the Act, the need to provide clear information about our billing and payment rules that ensure hospitals, physicians, and other interested parties can understand and operate within them, and our belief that the specific decision about the most appropriate care setting for a given surgical procedure is a complex medical judgment made by the physician based on the beneficiary's individual clinical needs and preferences and on the general coverage rules requiring that any procedure be reasonable and necessary.

Regarding requests for additional education on the exemptions from 2-midnights claims review for procedures removed from the IPO list, we remind commenters that procedures removed from the IPO list on or after January 1, 2021, are indefinitely exempted from site-of-service claim denials, initial medical review contractor referrals to RACs, and RAC reviews for ''patient status'' (that is, site-of-service) until the Secretary determines that the service or procedure is more commonly performed in the outpatient setting than the inpatient setting. For the exemption to end for a specific procedure, in a single calendar year we would need to have Medicare claims data indicating that the procedure was performed more than 50 percent of the time in the outpatient setting. We noted that the end of the exemption period for each procedure removed from the IPO list on or after January 1, 2021 would be announced via rulemaking. During the exemption period, Medicare review contractors have the opportunity to review such

claims in order to provide education for practitioners and providers regarding compliance with the 2-midnight rule, but claims identified as noncompliant are not denied with respect to the site-of-service under Medicare Part A. Information gathered by the Medicare review contractor when reviewing procedures as they are newly removed from the IPO list can be used for educational purposes but will not result in a claim denial during the exemption period.

We also refer commenters to the full discussion on these exemptions in section X.D. of the CY 2026 OPPS/ASC final rule with comment period (90 FR 53827 through 53832). We will take the request for further education into consideration for future implementation. As stated previously, services included on the IPO list tend to be surgical procedures that, if performed on an outpatient basis, would typically be the focus of the hospital outpatient stay and would likely be assigned to a comprehensive APC (C–APC) when they are removed from the IPO list. As such, these services would likely be considered a single episode of care with one payment rate and one copayment amount. In most instances, we expect that beneficiaries will not be responsible for multiple copayments for individual ancillary services associated with services removed from the IPO list, because the primary service will generally be assigned to a C–APC and the inpatient deductible cap will apply to the entire hospital claim, which is paid as a comprehensive service. Also, as stated previously, in the event there are separately payable OPPS services included on a claim with a service assigned to a C–APC, OPPS cost- sharing for an individual service is capped at the applicable Part A hospital inpatient deductible amount for that year for each service.

Comment: Many commenters provided recommendations on the methodology for assigning procedures coming off the IPO list to APCs. Commenters provided various methodologies, including crosswalking the CPT codes to ICD-10 PCS codes and establishing payment rates from corresponding IPPS short-stay claims, applying our universal low-volume policy to procedures coming off the IPO list, allowing MACs to use contractor pricing to determine the payment rate, and placing the procedures in New Technology APCs. A few

commenters also recommended that CMS wait to assign the remaining IPO procedures to APCs until the final year of the phase-out period or to extend the phase-out period to ensure that CMS does not assign procedures to inappropriate APCs just to meet the timeline. One commenter recommended that former IPO list procedures are included in the annual assessment of the two-times rule, regardless of claims volume for the first four years following removal from the IPO list, stating this would give CMS a structured and data-driven mechanism to assess, monitor, and manage the significant migration of complex procedures into the outpatient setting.

Some commenters recommended that CMS create new APCs and C-APCs to accommodate the services coming off the IPO list, including establishing additional levels in the Abdominal/Peritoneal/Biliary and Related Procedures, Laparoscopy and Related Procedures, and Gynecologic Procedures families and creating thoracic procedures APCs. A commenter also recommended that CMS establish a policy for code combinations that qualify for complexity adjustment but have no higher level in its APC family.

Response: We thank the commenters for their recommendations. Further discussion on how we assign former IPO procedures to APCs is included in our response to commenters' APC reassignment requests later in this section. We will take commenters' recommendations regarding APC assignment methodology and complexity adjustments into consideration for future rulemaking. At this time, we are not finalizing any additional APC levels for CY 2027 as a result of these comments. However, we will take the commenters' recommendations into consideration and continue to monitor claims data to identify any potential need to create new APCs.

Comment: Some commenters shared recommendations regarding the procedures and clinical families that were proposed to remain on the IPO list for CY 2027, with commenters encouraging CMS to propose new and higher APC levels for CY 2028 where appropriate. A commenter requested that for CY 2028, we assign the mechanical thrombectomy code described by CPT code 61645 to an APC based on its clinical and resource characteristics instead of an

existing endovascular APC that may not be homogeneous to its resource use. Ae commenter also recommended creating additional Endovascular Procedures APCs to accommodate the procedures that will come off the IPO list. A commenter supported keeping cardiovascular codes on the IPO list for CY 2027 and recommend that CMS issue proposed APC assignments for these procedures and amendments to the APCs and C-APCs to accommodate the removal of cardiovascular procedures as an RFI in the CY 2028 OPPS/ASC proposed rule to inform final proposals in the CY 2029 OPPS/ASC proposed rule. Another commenter recommended that we create a Level 6 Neurostimulator and Related Procedures APC to accommodate the neurostimulation procedures that will eventually be removed from the IPO list and require APC assignments.

A commenter requested that CMS also remove CPT codes 0235T (Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; visceral artery (except renal), each vessel), 0345T (Transcatheter mitral valve repair percutaneous approach via the coronary sinus), 0483T (Transcatheter mitral valve implantation/replacement (tmvi) with prosthetic valve; percutaneous approach, including transseptal puncture, when performed), 0484T (Transcatheter mitral valve implantation/replacement (tmvi) with prosthetic valve; transthoracic exposure (eg, thoracotomy, transapical)), and 33440 (Replacement, aortic valve; by translocation of autologous pulmonary valve and transventricular aortic annulus enlargement of the left ventricular outflow tract with valved conduit replacement of pulmonary valve (ross-konno procedure)). The commenter stated that these procedures are recognized nationally for being safely performed on the same day and would be appropriate to furnish in the outpatient setting.

Response: We thank the commenters for their recommendations and will take them into consideration for future rulemaking. Regarding the recommendation to remove CPT codes 0235T, 0345T, 0483T, 0484T, and 33440 from then IPO list for CY 2027, we are not accepting this recommendation. We plan to remove these procedures in future rulemaking with procedures

in their clinical families, which will allow us to review and make adjustments to the related APCs as necessary.

Comment: A commenter requested clarification on if CPT codes 0569T, 0570T, 0646T, 33710, 59514, 59525, and 59620 will be removed from the IPO list for CY 2027, as they were not listed as being proposed for removal or in Addendum E.

Response: CPT codes 0569T, 0570T, 0646T, 33710, 59514, 59525, and 59620 were not proposed for removal as these codes are being deleted by the AMA. They will no longer be effective starting in CY 2027.

Comment: Several commenters disagreed with certain proposed APC assignments for procedures proposed to be removed from the IPO list, requesting that these procedures be placed in higher APC levels or different APC families to better reflect the resource costs and clinical complexity of these procedures. Commenters also requested greater transparency regarding how CMS assigned these procedures to APCs. The services for which we received APC reassignment requests are listed in Table 79.

Response: We thank the commenters for their input. As we have previously stated, we determine the APC assignment for services removed from the IPO list by evaluating the clinical similarity and resource costs of the service compared to other services paid under the OPPS and by reviewing the MS–DRG rate for the service under the IPPS, though we note we would generally expect the cost to provide a service in the outpatient setting to be less than the cost to provide the service in the inpatient setting. After further clinical review and review of the limited available claims data for these procedures, we have reassigned some of the procedures recommended by commenters. The proposed and final APC and status indicator assignments for procedures for which commenters requested APC reassignments are listed in Table 79 below.

After consideration of public comments received, we are finalizing our proposal to remove 637 services from the IPO list for CY 2027 as the second phase of the elimination of the IPO list. We continue to believe that there are a number of safety mechanisms that will continue

to ensure the safety of our beneficiaries and the quality of care, including physician judgment, State and local regulations, accreditation requirements, medical malpractice laws, hospital conditions of participation, and other CMS initiatives. These services and their final status indicators and APC assignments (if applicable) are listed in the public use file titled "Final Procedures Removed from the IPO List for CY 2027", which is available on the CMS website. The complete list of codes that describe services that are finalized to be paid by Medicare in CY 2027 as inpatient only services is included as Addendum E to this CY 2027 OPPS/ ASC final rule with comment period, which is available on the CMS website.

TABLE 79: CY 2027 PROPOSAL AND FINAL APC ASSIGNMENTS FOR PROCEDURES RECOMMENDED FOR APC REASSIGNMENT BY COMMENTERS

CPT Code	Long Descriptor	CY 2027 Proposed SI	CY 2027 Proposed APC	CY 2027 Final SI	CY 2027 Final APC
11004	Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia and perineum	T	5053	T	5054
11005	Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; abdominal wall, with or without fascial closure	T	5053	T	5054
11006	Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia, perineum and abdominal wall, with or without fascial closure	T	5053	T	5054
19364	Breast reconstruction; with free flap (eg, ftram, diep, siea, gap flap)	J1	5092	J1	5092
19367	Breast reconstruction; with single-pedicled transverse rectus abdominis myocutaneous (tram) flap	J1	5092	J1	5092
32440	Removal of lung, pneumonectomy	J1	5182	J1	5184
32480	Removal of lung, other than pneumonectomy; single lobe (lobectomy)	J1	5182	J1	5183
32482	Removal of lung, other than pneumonectomy; 2 lobes (bilobectomy)	J1	5182	J1	5183
32484	Removal of lung, other than pneumonectomy; single segment (segmentectomy)	J1	5182	J1	5183
32486	Removal of lung, other than pneumonectomy; with circumferential resection of segment of bronchus followed by broncho-bronchial anastomosis (sleeve lobectomy)	J1	5182	J1	5184
32663	Thoracoscopy, surgical; with lobectomy (single lobe)	J1	5362	J1	5362
32666	Thoracoscopy, surgical; with therapeutic wedge resection (eg, mass, nodule), initial unilateral	J1	5362	J1	5362
32669	Thoracoscopy, surgical; with removal of a single lung segment (segmentectomy)	J1	5362	J1	5362
39503	Repair, neonatal diaphragmatic hernia, with or without chest tube insertion and with or without creation of ventral hernia	J1	5342	J1	5342

CPT Code	Long Descriptor	CY 2027 Proposed SI	CY 2027 Proposed APC	CY 2027 Final SI	CY 2027 Final APC
39540	Repair, diaphragmatic hernia (other than neonatal), traumatic; acute	J1	5342	J1	5342
39541	Repair, diaphragmatic hernia (other than neonatal), traumatic; chronic	J1	5342	J1	5342
43107	Total or near total esophagectomy, without thoracotomy; with pharyngogastrostomy or cervical esophagogastrostomy, with or without pyloroplasty (transhiatal)	J1	5163	J1	5165
43332	Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; without implantation of mesh or other prosthesis	J1	5163	J1	5342
43333	Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; with implantation of mesh or other prosthesis	J1	5163	J1	5342
43334	Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; without implantation of mesh or other prosthesis	J1	5163	J1	5342
43335	Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; with implantation of mesh or other prosthesis	J1	5163	J1	5342
43336	Repair, paraesophageal hiatal hernia, (including fundoplication), via thoracoabdominal incision, except neonatal; without implantation of mesh or other prosthesis	J1	5163	J1	5342
43337	Repair, paraesophageal hiatal hernia, (including fundoplication), via thoracoabdominal incision, except neonatal; with implantation of mesh or other prosthesis	J1	5163	J1	5342
43500	Gastrotomy; with exploration or foreign body removal	T	5301	T	5301
43501	Gastrotomy; with suture repair of bleeding ulcer	T	5301	J1	5302
43502	Gastrotomy; with suture repair of pre-existing esophagogastric laceration (eg, mallory-weiss)	T	5301	J1	5302
43520	Pyloromyotomy, cutting of pyloric muscle (fredet-ramstedt type operation)	T	5301	T	5301
43605	Biopsy of stomach, by laparotomy	T	5301	T	5301
43610	Excision, local; ulcer or benign tumor of stomach	T	5301	J1	5302
43611	Excision, local; malignant tumor of stomach	T	5301	J1	5302
43620	Gastrectomy, total; with esophagoenterostomy	T	5301	J1	5342
43621	Gastrectomy, total; with roux-en-y reconstruction	T	5301	J1	5342
43622	Gastrectomy, total; with formation of intestinal pouch, any type	T	5301	J1	5342
43631	Gastrectomy, partial, distal; with gastroduodenostomy	T	5301	J1	5342
43632	Gastrectomy, partial, distal; with gastrojejunostomy	T	5301	J1	5342
43633	Gastrectomy, partial, distal; with roux-en-y reconstruction	T	5301	J1	5342
43634	Gastrectomy, partial, distal; with formation of intestinal pouch	T	5301	J1	5342
43640	Vagotomy including pyloroplasty, with or without gastrostomy; truncal or selective	T	5301	T	5301
43641	Vagotomy including pyloroplasty, with or without gastrostomy; parietal cell (highly selective)	T	5301	T	5301

CPT Code	Long Descriptor	CY 2027 Proposed SI	CY 2027 Proposed APC	CY 2027 Final SI	CY 2027 Final APC
43800	Pyloroplasty	T	5301	T	5301
43810	Gastroduodenostomy	T	5301	J1	5303
43820	Gastrojejunostomy; without vagotomy	T	5301	J1	5303
43843	Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty	J1	5303	J1	5303
43845	Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch)	J1	5303	J1	5303
43847	Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption	J1	5303	J1	5303
43848	Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device (separate procedure)	J1	5303	J1	5303
43860	Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine resection; without vagotomy	J1	5303	J1	5303
44120	Enterectomy, resection of small intestine; single resection and anastomosis	J1	5303	J1	5303
44125	Enterectomy, resection of small intestine; with enterostomy	J1	5303	J1	5303
44130	Enteroenterostomy, anastomosis of intestine, with or without cutaneous enterostomy (separate procedure)	J1	5303	J1	5303
44140	Colectomy, partial; with anastomosis	J1	5341	J1	5341
44141	Colectomy, partial; with skin level cecostomy or colostomy	J1	5341	J1	5341
44143	Colectomy, partial; with end colostomy and closure of distal segment (hartmann type procedure)	J1	5341	J1	5341
44144	Colectomy, partial; with resection, with colostomy or ileostomy and creation of mucofistula	J1	5341	J1	5341
44145	Colectomy, partial; with coloproctostomy (low pelvic anastomosis)	J1	5341	J1	5341
44146	Colectomy, partial; with coloproctostomy (low pelvic anastomosis), with colostomy	J1	5341	J1	5341
44147	Colectomy, partial; abdominal and transanal approach	J1	5341	J1	5342
44150	Colectomy, total, abdominal, without proctectomy; with ileostomy or ileoproctostomy	J1	5341	J1	5342
44151	Colectomy, total, abdominal, without proctectomy; with continent ileostomy	J1	5341	J1	5342
44155	Colectomy, total, abdominal, with proctectomy; with ileostomy	J1	5341	J1	5342
44156	Colectomy, total, abdominal, with proctectomy; with continent ileostomy	J1	5341	J1	5342
44157	Colectomy, total, abdominal, with proctectomy; with ileoanal anastomosis, includes loop ileostomy, and rectal mucosectomy, when performed	J1	5341	J1	5342
44158	Colectomy, total, abdominal, with proctectomy; with ileoanal anastomosis, creation of ileal	J1	5341	J1	5342

CPT Code	Long Descriptor	CY 2027 Proposed SI	CY 2027 Proposed APC	CY 2027 Final SI	CY 2027 Final APC
	reservoir (s or j), includes loop ileostomy, and rectal mucosectomy, when performed				
44160	Colectomy, partial, with removal of terminal ileum with ileocolostomy	J1	5341	J1	5341
44204	Laparoscopy, surgical; colectomy, partial, with anastomosis	J1	5361	J1	5361
44205	Laparoscopy, surgical; colectomy, partial, with removal of terminal ileum with ileocolostomy	J1	5361	J1	5361
44206	Laparoscopy, surgical; colectomy, partial, with end colostomy and closure of distal segment (hartmann type procedure)	J1	5361	J1	5361
44207	Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis)	J1	5361	J1	5361
44210	Laparoscopy, surgical; colectomy, total, abdominal, without proctectomy, with ileostomy or ileoproctostomy	J1	5361	J1	5362
44211	Laparoscopy, surgical; colectomy, total, abdominal, with proctectomy, with ileoanal anastomosis, creation of ileal reservoir (s or j), with loop ileostomy, includes rectal mucosectomy, when performed	J1	5361	J1	5362
44212	Laparoscopy, surgical; colectomy, total, abdominal, with proctectomy, with ileostomy	J1	5361	J1	5362
44316	Continent ileostomy (kock procedure) (separate procedure)	J1	5341	J1	5341
44625	Closure of enterostomy, large or small intestine; with resection and anastomosis other than colorectal	J1	5341	J1	5341
44626	Closure of enterostomy, large or small intestine; with resection and colorectal anastomosis (eg, closure of hartmann type procedure)	J1	5341	J1	5341
44640	Closure of intestinal cutaneous fistula	J1	5341	J1	5341
44650	Closure of enteroenteric or enterocolic fistula	J1	5341	J1	5341
44660	Closure of enterovesical fistula; without intestinal or bladder resection	J1	5341	J1	5341
44661	Closure of enterovesical fistula; with intestine and/or bladder resection	J1	5341	J1	5342
44800	Excision of meckel's diverticulum (diverticulectomy) or omphalomesenteric duct	J1	5341	J1	5341
45119	Proctectomy, combined abdominoperineal pull-through procedure (eg, colo-anal anastomosis), with creation of colonic reservoir (eg, j-pouch), with diverting enterostomy when performed	J1	5342	J1	5342
45126	Pelvic exenteration for colorectal malignancy, with proctectomy (with or without colostomy), with removal of bladder and ureteral transplantations, and/or hysterectomy, or cervicectomy, with or without removal of tube(s), with or without removal of ovary(s), or any combination thereof	J1	5342	J1	5342
45136	Excision of ileoanal reservoir with ileostomy	J1	5342	J1	5342
45397	Laparoscopy, surgical; proctectomy, combined abdominoperineal pull-through procedure (eg, colo-anal anastomosis), with creation of colonic reservoir (eg, j-pouch), with diverting enterostomy, when performed	J1	5342	J1	5362

CPT Code	Long Descriptor	CY 2027 Proposed SI	CY 2027 Proposed APC	CY 2027 Final SI	CY 2027 Final APC
45400	Laparoscopy, surgical; proctopexy (for prolapse)	J1	5341	J1	5361
45402	Laparoscopy, surgical; proctopexy (for prolapse), with sigmoid resection	J1	5341	J1	5362
47120	Hepatectomy, resection of liver; partial lobectomy	J1	5341	J1	5341
47122	Hepatectomy, resection of liver; trisegmentectomy	J1	5341	J1	5341
47125	Hepatectomy, resection of liver; total left lobectomy	J1	5341	J1	5341
47130	Hepatectomy, resection of liver; total right lobectomy	J1	5341	J1	5341
47380	Ablation, open, of 1 or more liver tumor(s); radiofrequency	J1	5341	J1	5342
48140	Pancreatectomy, distal subtotal, with or without splenectomy; without pancreaticojejunostomy	J1	5341	J1	5342
48145	Pancreatectomy, distal subtotal, with or without splenectomy; with pancreaticojejunostomy	J1	5341	J1	5342
48146	Pancreatectomy, distal, near-total with preservation of duodenum (child-type procedure)	J1	5341	J1	5342
48150	Pancreatectomy, proximal subtotal with total duodenectomy, partial gastrectomy, choledochoenterostomy and gastrojejunostomy (whipple-type procedure); with pancreatojejunostomy	J1	5341	J1	5342
48152	Pancreatectomy, proximal subtotal with total duodenectomy, partial gastrectomy, choledochoenterostomy and gastrojejunostomy (whipple-type procedure); without pancreatojejunostomy	J1	5341	J1	5342
48153	Pancreatectomy, proximal subtotal with near-total duodenectomy, choledochoenterostomy and duodenojejunostomy (pylorus-sparing, whipple-type procedure); with pancreatojejunostomy	J1	5341	J1	5342
48154	Pancreatectomy, proximal subtotal with near-total duodenectomy, choledochoenterostomy and duodenojejunostomy (pylorus-sparing, whipple-type procedure); without pancreatojejunostomy	J1	5341	J1	5342
48155	Pancreatectomy, total	J1	5341	J1	5342
49215	Excision of presacral or sacrococcygeal tumor	J1	5073	J1	5073
49596	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); greater than 10 cm, incarcerated or strangulated	J1	5342	J1	5342
49616	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); 3 cm to 10 cm, incarcerated or strangulated	J1	5342	J1	5342
49617	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of	J1	5342	J1	5342

CPT Code	Long Descriptor	CY 2027 Proposed SI	CY 2027 Proposed APC	CY 2027 Final SI	CY 2027 Final APC
	mesh or other prosthesis when performed, total length of defect(s); greater than 10 cm, reducible				
49618	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); greater than 10 cm, incarcerated or strangulated	J1	5342	J1	5342
49621	Repair of parastomal hernia, any approach (ie, open, laparoscopic, robotic), initial or recurrent, including implantation of mesh or other prosthesis, when performed; reducible	J1	5342	J1	5342
49622	Repair of parastomal hernia, any approach (ie, open, laparoscopic, robotic), initial or recurrent, including implantation of mesh or other prosthesis, when performed; incarcerated or strangulated	J1	5342	J1	5342
57305	Closure of rectovaginal fistula; abdominal approach	J1	5414	J1	5414
57308	Closure of rectovaginal fistula; transperineal approach, with perineal body reconstruction, with or without levator plication	J1	5414	J1	5415
58943	Oophorectomy, partial or total, unilateral or bilateral; for ovarian, tubal or primary peritoneal malignancy, with para-aortic and pelvic lymph node biopsies, peritoneal washings, peritoneal biopsies, diaphragmatic assessments, with or without salpingectomy(s), with or without omentectomy	J1	5415	J1	5416
58950	Resection (initial) of ovarian, tubal or primary peritoneal malignancy with bilateral salpingo-oophorectomy and omentectomy;	J1	5415	J1	5416
58951	Resection (initial) of ovarian, tubal or primary peritoneal malignancy with bilateral salpingo-oophorectomy and omentectomy; with total abdominal hysterectomy, pelvic and limited para-aortic lymphadenectomy	J1	5415	J1	5416
58952	Resection (initial) of ovarian, tubal or primary peritoneal malignancy with bilateral salpingo-oophorectomy and omentectomy; with radical dissection for debulking (ie, radical excision or destruction, intra-abdominal or retroperitoneal tumors)	J1	5415	J1	5416
58953	Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking;	J1	5415	J1	5416
58954	Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking; with pelvic lymphadenectomy and limited para-aortic lymphadenectomy	J1	5415	J1	5416
58956	Bilateral salpingo-oophorectomy with total omentectomy, total abdominal hysterectomy for malignancy	J1	5415	J1	5416
58958	Resection (tumor debulking) of recurrent ovarian, tubal, primary peritoneal, uterine malignancy (intra-abdominal, retroperitoneal tumors), with	J1	5415	J1	5416

CPT Code	Long Descriptor	CY 2027 Proposed SI	CY 2027 Proposed APC	CY 2027 Final SI	CY 2027 Final APC
	omentectomy, if performed, with pelvic lymphadenectomy and limited para-aortic lymphadenectomy				

X. Nonrecurring Policy Changes

A. Method to Control Unnecessary Increases in the Volume of Outpatient Services Furnished in Excepted Off-Campus Provider-Based Departments (PBDs)

1. Background

In the CY 2019 OPPS/ASC final rule with comment period (83 FR 59004 through 59015), we adopted a method to control unnecessary increases in the volume of clinic visit services furnished in excepted off-campus provider-based departments (PBDs). We refer readers to the CY 2019 OPPS/ASC final rule with comment period for a detailed discussion of the background, legislative provisions, and payment policies we developed to address unnecessary increases in the volume of covered outpatient department (OPD) services. Later in this section of the preamble we discuss the policy we finalized in the CY 2019 OPPS/ASC final rule with comment period and its expanded application under the OPPS in subsequent years.

In the CY 2019 OPPS/ASC final rule with comment period, we finalized a policy to use our authority under section 1833(t)(2)(F) of the Act to adopt a method to control unnecessary increases in the volume of covered OPD services. We applied an amount equal to the site-specific Medicare Physician Fee Schedule (PFS) payment rate for non-excepted items and services furnished by a non-excepted off-campus PBD (the PFS payment rate) for the clinic visit service, as described by HCPCS code G0463, when provided at an off-campus PBD excepted from section 1833(t)(21) of the Act (departments that bill the modifier "PO" on claim lines). However, we phased in the application of the reduction in payment for the clinic visit service described by HCPCS code G0463 in the excepted provider-based department setting over 2 years. For CY 2019, the payment reduction was phased-in by applying 50 percent of the total reduction in payment that would have applied if these departments were paid the site-specific PFS rate for the clinic visit service. The PFS-equivalent rate was 40 percent of the OPPS payment for CY 2019 (that is, 60 percent less than the OPPS rate). We provided for a 2-year phase-in of this policy under which one-half of the total 60 percent payment reduction (a 30

percent reduction) was applied in CY 2019. These departments were paid approximately 70 percent of the OPPS rate (100 percent of the OPPS rate minus the 30 percent payment reduction that was applied in CY 2019) for the clinic visit service in CY 2019.

For CY 2020, the second year of the 2-year phase-in, we stated that we would apply the total reduction in payment that is applied if these departments (departments that bill the modifier "PO" on claim lines) are paid the site-specific PFS rate for the clinic visit service described by HCPCS code G0463. For CY 2020 and subsequent years, the PFS-equivalent rate was 40 percent of the proposed OPPS payment (that is, 60 percent less than the OPPS rate).

In addition, as we stated in the CY 2019 OPPS/ASC final rule with comment period (83 FR 59013), we implemented this policy in a non-budget neutral manner. We did so to ensure that our method for controlling the unnecessary growth in the volume of clinic visits furnished by excepted off-campus PBDs did not simply increase other unnecessary expenditures within the OPPS, thus driving different utilization-distorting decisions.

In the CY 2023 OPPS/ASC final rule with comment period (87 FR 71748), we finalized a policy which provided that off-campus PBDs (departments that bill the modifier "PO" on claim lines) of rural Sole Community Hospitals (SCHs), as described under 42 CFR 412.92 and designated as rural for Medicare payment purposes, are exempt from the clinic visit payment policy that applies a PFS-equivalent payment rate for the clinic visit service, as described by HCPCS code G0463, when provided at an off-campus PBD excepted from section 1833(t)(21) of the Act. For the full discussion of this policy, we refer readers to the CY 2023 OPPS/ASC final rule with comment period (87 FR 72047 through 72051). For CY 2024 and subsequent years, we continued to exempt excepted off-campus PBDs of rural SCHs from the clinic visit payment policy.

In the CY 2026 OPPS/ASC final rule with comment period (90 FR 53448), we finalized a policy to use our authority under section 1833(t)(2)(F) of the Act to adopt a method to control unnecessary increases in the volume of covered OPD services for additional services. We

finalized a policy for CY 2026 and subsequent years to apply an amount equal to the site-specific PFS payment rate for non-excepted items and services furnished by a non-excepted off-campus PBD (the PFS-equivalent payment rate) for any HCPCS codes assigned to the drug administration services APCs, when provided at an off-campus PBD excepted from section 1833(t)(21) of the Act (departments that bill the modifier "PO" on claim lines) (90 FR 53821). In the CY 2026 OPPS/ASC final rule with comment period (90 FR 53824), we also finalized a policy which provided that off-campus PBDs (departments that bill the modifier "PO" on claim lines) of rural SCHs, as described under 42 CFR 412.92 and designated as rural for Medicare payment purposes, are exempt from the volume control method policy for drug administration services that applies a PFS-equivalent payment rate for the drug administration services APCs (5691-5694), when provided at an off-campus PBD excepted from section 1833(t)(21) of the Act. For the full discussion of both policies, we refer readers to the CY 2026 OPPS/ASC final rule with comment period (90 FR 53802 through 53824).

We noted in the CY 2026 OPPS/ASC final rule with comment period (90 FR 53810 through 53812) that section 1833(t)(2)(F) of the Act provides authority to implement this policy. The U.S. Court of Appeals for the District of Columbia Circuit held in *American Hospital Ass'n v. Azar* (*AHA v. Azar*) that a service-specific, non-budget-neutral reduction of the reimbursement rate for OPD services "qualifies as a 'method for controlling unnecessary increases in the volume of covered [outpatient] services" under that provision. 964 F.3d 1230, 1245 (D.C. Cir. 2020) (quoting section 1833(t)(2)(F) of the Act, 42 U.S.C. 1395l(t)(2)(F)) (brackets in original), *cert. denied sub nom. Am. Hosp. Ass'n v. Becerra*, 141 S. Ct. 2853 (2021) (No. 20-1113). The D.C. Circuit reasoned in part that "[t]he lower the reimbursement rate for a service, the less the incentive to provide it, all else being equal[,]" and "[r]educing the reimbursement rate . . . is naturally suited to addressing unnecessary increases in the overall volume of a service provided by hospitals." *Id.* at 1241. It ultimately concluded that the policy "falls comfortably within the plain text" of section 1833(t)(2)(F) of the Act, *id.* at 1241, "and 'fits the design of the statute as a

whole . . . and its object and policy," *id.* at 1245 (quoting *Good Samaritan Hosp. v. Shalala*, 508 U.S. 402, 418 (1993)). We noted in the CY 2026 OPPS/ASC final rule with comment period (90 FR 53810) that we continue to believe that our interpretation of the Act is the best one, and that this policy falls well within the Act's delegation to the Secretary to "develop a method for controlling unnecessary increases in the volume of covered OPD services."

2. Expanding the Method to Control Unnecessary Increases in the Volume of Outpatient Services Furnished in Excepted Off-Campus Provider-Based Departments

As described in the CY 2019 OPPS/ASC final rule with comment period, we found that earlier rulemaking efforts were insufficient to control the unnecessary growth of certain covered OPD services and as a result we implemented a method to control for unnecessary growth in covered OPD services by adjusting the payment rate for clinic visits in excepted off-campus PBDs to the PFS-equivalent rate rather than the higher OPPS rate. While this regulatory change has had a positive impact, we noted in the CY 2026 OPPS/ASC proposed rule that there is evidence of continued unnecessary growth in the volume of OPD services driven by site-of-service payment differentials rather than clinical need for other service families.

We continue to be concerned that beneficiaries are being driven into higher-cost settings of care because of financial incentives when they could safely receive care in a lower-cost setting. This creates greater financial burden both for Medicare and for beneficiaries in the form of increased coinsurance. Volume increases that seek to take advantage of financial incentives created by payment policy rather than clinical need are unnecessary and therefore warrant policy changes to address these increases. As the D.C. Circuit explained, "[i]t is reasonable to think that Congress . . . would have wanted the agency to avoid causing unnecessary volume growth with its own reimbursement practices." *AHA v. Azar*, 964 F.3d at 1245. Accordingly, for CY 2026, we finalized a policy to remove this differential for drug administration services delivered in excepted PBDs. We are continuing to study and identify services that we believe have

experienced unnecessary growth in volume driven by site-of-service payment differentials rather than clinical need.

In the CY 2026 OPPS/ASC proposed and final rules, we indicated we are particularly concerned about the services within the imaging without contrast APCs (APCs 5521-5524). Imaging without contrast services are often high-volume, low-intensity services that can be provided in OPDs or freestanding offices. In the CY 2026 OPPS/ASC proposed rule, we stated that we are concerned that these services have experienced unnecessary growth and that a volume control method may be appropriate to apply in the future (90 FR 33690). Additionally, we solicited comments on whether it might be appropriate to apply a volume control method to the imaging without contrast APCs in the future.

Many healthcare services can be performed in multiple settings. Even when there is little variation in the service provided across settings, the Federal Supplementary Medical Insurance Trust Fund and Medicare beneficiaries typically pay more when that service is performed in an OPD than when the same service is performed in a freestanding physician office. That payment differential creates an incentive for providers to shift the care of beneficiaries to an OPD rather than a freestanding physician office or ASC, even if the services can be safely performed in the freestanding physician office or an ASC. Generally, 20 percent of any increased payment is the responsibility of the beneficiary in the form of coinsurance. Taking into account that any payment differential occurs across millions of claims for a variety of services each year, this threatens to create a significant source of unnecessary spending both by Medicare beneficiaries in the form of unnecessarily high copayments and by Medicare in the form of unnecessarily high Medicare payments for services that are being performed in an OPD because of the site-of-care payment difference.

In the CY 2019 OPPS/ASC final rule with comment period, we discussed vertical consolidation and the practice of hospitals purchasing freestanding physician practices and converting the billing from the PFS to higher paying OPD visits. These conversions shift market

share from freestanding physician offices to OPDs. We stated that we believed there was a correlation among the increasing volume of OPD clinic visits, vertical integration, and the higher OPPS payment rates for clinic visits. More favorable reimbursement for hospital-owned sites compared to physician-owned sites has been shown to encourage hospitals' acquisition of physician practices.[145] [146] Once a practice is acquired and designated as an OPD, physician services can be billed at higher hospital-based rates. This type of consolidation has been associated with higher Medicare spending and more intense treatment patterns.[147] [148] [149]

The impact of vertical integration and the increases in volume of outpatient services extends to multiple clinic families. Studies have shown that, after vertical integration, the number of imaging tests performed in hospital sites of care increased while the number of procedures performed in nonhospital sites of care decreased.[150]

Our policy in the CY 2019 OPPS/ASC final rule with comment period to pay for clinic visits in excepted off-campus PBDs at the PFS-equivalent rate addressed the financial incentive for only one type of service in one outpatient setting. However, the share of other ambulatory services billed under the OPPS has continued to increase. We built upon this policy in the CY 2026 OPPS/ASC proposed rule to address the unnecessary growth in drug administration services. Like with clinic visit and drug administration services, we believe the difference in payment between OPDs and freestanding offices creates a strong incentive for providers to shift imaging without contrast services to the higher-cost setting.

For the CY 2027 proposed rule, we examined the growth in imaging without contrast services provided in excepted PBDs. Imaging without contrast services are diagnostic imaging procedures that do not require the administration of contrast agents and instead rely on standard imaging modalities such as X-ray, ultrasound, computed tomography (CT), magnetic resonance

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[145] *https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0830.*
[146] *https://onlinelibrary.wiley.com/doi/10.1111/1475-6773.13613.*
[147] *https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2463591.*
[148] *https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.01183.*
[149] *https://onlinelibrary.wiley.com/doi/10.1111/1475-6773.14172.*
[150] *https://pmc.ncbi.nlm.nih.gov/articles/PMC9924392/.*

imaging (MRI), and dual-energy X-ray absorptiometry scans (DXA) to produce clinically meaningful images. These services are generally low- to moderate-complexity and are routinely used to evaluate a wide range of conditions, including musculoskeletal injuries, organ structure, and disease screening. Imaging without contrast services can be safely and effectively furnished in multiple settings, including freestanding physician offices and hospital OPDs, without compromising diagnostic quality or patient safety.

For example, in 2023, for transthoracic echocardiograms (HCPCS 93306), a high-volume imaging without contrast service frequently provided in both OPDs and freestanding physician offices, Medicare paid 294 percent more for services in an OPD than in a freestanding office.[151] HCPCS code 77080, which describes a DXA scan measuring bone density at the axial skeleton (hips, pelvis, spine), is the most frequently billed imaging without contrast code in excepted PBDs. In 2025, this service had a freestanding physician office payment rate of around $30 and an OPPS payment rate of approximately $106, making the same scan more than three times as expensive in the OPD than in the freestanding physician office. Based on our claims data analysis, the volume of this service has grown by over 55 percent in excepted PBDs between 2016 and 2025. Conversely, from 2016 through 2024, the volume of HCPCS code 77080 has only grown by 2 percent in the freestanding physician office setting. This service can be and routinely is safely performed in either setting, but there is a clear financial incentive to perform this service in excepted PBDs due to substantially higher payment in the outpatient setting compared to the freestanding physician office setting.

For the CY 2027 OPPS/ASC proposed rule, we estimated that 70 HCPCS codes account for over 95 percent of the volume of imaging without contrast services provided in excepted PBDs (91 FR 41909). These codes comprise the overwhelming majority of imaging without contrast services provided in excepted PBDs. From 2016 to 2025, the provision of these services grew over 38 percent. From 2016 to 2025, these increases in volume have resulted in a 33

[151] *https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch8_MedPAC_Report_To_Congress_SEC.pdf.*

percent increase in spending, corresponding to approximately $126 million in additional spending in CY 2025. We believe this growth in the volume of imaging without contrast services in excepted PBDs can largely be attributed to the financial incentive to furnish low-complexity imaging services in OPDs rather than freestanding physician offices.

We considered whether other factors, such as coding changes, updates to clinical practice guidelines, or shifts in beneficiary case mix, might explain this growth. However, we believe these alternative explanations are unlikely to account for the observed patterns. Our analysis focuses on a stable set of high-volume HCPCS codes that consistently represent the vast majority of imaging without contrast services over time, limiting the likelihood that coding changes are driving the increase. In addition, we are not aware of any broad changes in clinical guidelines during this period that would warrant substantial increases in the use of routine, low- to moderate-complexity imaging services across these modalities. Finally, although there may be some variation in beneficiary characteristics over time, the magnitude of the growth in utilization, particularly when considered alongside declining fee-for-service enrollment and relatively stable or modest volume growth in freestanding physician offices, suggests that changes in case mix are not the primary driver of growth in excepted PBDs. Taken together, these considerations support the conclusion that site-of-service payment differentials, rather than clinical or coding factors, are a principal contributor to the observed increases in volume.

We stated in the CY 2026 OPPS/ASC proposed rule that we believe that financial incentives have driven volume from the freestanding office setting to the higher paying OPD setting, creating unnecessary increases in the volume of OPD services. We also stated that we believe that this problem is pervasive and exists across a number of service families. Section 1833(t)(2)(F) of the Act directs the Secretary to "develop a method for controlling unnecessary increases in the volume of covered OPD services," and CMS has previously interpreted this provision to permit payment adjustments that address financial incentives contributing to such increases. Consistent with this authority, CMS may implement a volume control method for

imaging without contrast services furnished in excepted off-campus PBDs, where evidence demonstrates increases in utilization and that increase is disproportionately concentrated in higher-paid hospital outpatient settings. Because these services are commonly furnished in physician offices and do not generally require hospital-level resources, higher OPPS payment rates may incentivize shifts in site of care and increased utilization that are not clinically driven. As CMS established in the CY 2019 OPPS/ASC final rule with comment period and reaffirmed in subsequent rulemaking, including the CY 2026 OPPS/ASC final rule with comment period, and as the D.C. Circuit held in *AHA v. Azar*, 964 F.3d 1230 (D.C. Cir. 2020), aligning payment rates across settings for clinically comparable services is an appropriate "method" to mitigate these incentives. Accordingly, applying a PFS-equivalent payment rate to imaging without contrast services in excepted PBDs represents a reasonable approach to controlling unnecessary increases in OPD service volume.

Any time a service is provided in the higher cost OPD when it could be provided safely in the freestanding physician office but is not because of financial incentives, it potentially represents unnecessary utilization of the OPD setting. In CY 2019, we started by addressing a pervasive problem with the clinic visit provided in excepted PBDs. In that case, it was practical to address only a single code, G0463, the clinic visit. For CY 2026, we finalized a policy to address drug administration services provided at excepted PBDs. We chose to address payment for these services across the APC family, meaning all codes assigned to these APCs, as we believe this volume control method should apply to all drug administration services at excepted PBDs. For CY 2027, we again proposed addressing services across an APC family.

Our authority under section 1833(t)(2)(F) of the Act to adopt a method to control unnecessary increases in the volume of covered OPD services authorizes us to address real-world effects of these payment inequalities. Given these continued disparities, we stated we believed it was necessary to further examine and refine our volume control method by identifying additional covered OPD services that we believe are being shifted to the hospital setting based on financial

incentives rather than medical necessity. We conducted an analysis of imaging without contrast services paid under the OPPS and present our findings from the CY 2027 OPPS/ASC proposed rule on the utilization and payment of these services in the sections discussed later in this section of the preamble.

3. Utilization of Imaging Without Contrast Services

The high volume of imaging without contrast services and the magnitude of rate differences between the freestanding physician office and OPD settings make it a family of services likely to migrate to a higher paying setting of care. Imaging without contrast services can be performed in either freestanding physician offices or OPDs. In the OPPS, imaging without contrast services are categorized into four levels of complexity. Payments are set at a category level, called an Ambulatory Payment Classification (APC). The APCs for imaging without contrast service are 5521 (Level 1 Imaging Without Contrast), 5522 (Level 2 Imaging Without Contrast), 5523 (Level 3 Imaging Without Contrast), and 5524 (Level 4 Imaging Without Contrast). For 2026, 337 Healthcare Common Procedure Coding System (HCPCS) codes make up the four levels of the imaging without contrast APCs. Although there are 337 HCPCS codes in the four imaging without contrast APCs, we estimated that 70 HCPCS codes account for over 95 percent of the volume of imaging without contrast services provided in excepted PBDs. This trend extends to non-excepted PBDs, where 70 HCPCS codes also make up over 95 percent of claims volume. There is an approximate 90 percent overlap of the top 70 most frequently billed imaging without contrast codes in excepted and non-excepted PBDs. HCPCS codes that are similar in terms of cost and clinical attributes are placed in the same APC. All HCPCS codes in the same APC have the same OPPS payment rate. The individual HCPCS and APC assignments are available in Addendum B to this final rule with comment period.

We evaluated the growth in volume and spending for multiple families of APCs in OPDs across multiple years of claims data. If commenters wished to replicate any of our analyses, the CMS website included information about obtaining the ‘‘Limited Data Set,’’

https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/limited-data-set-lds through which OPPS claims data are available for purchase. Additionally, we made publicly available a file containing the 70 HCPCS codes that we estimated account for more than 95 percent of the volume of imaging without contrast services provided in excepted PBDs.

The PO modifier was established to identify services furnished in off-campus PBDs and became mandatory following implementation of section 603 of the Bipartisan Budget Act of 2015 (Pub. L. 114-74). CMS finalized this requirement in the CY 2016 OPPS/ASC final rule with comment period, requiring hospitals to report the PO modifier for services provided in excepted off-campus PBDs beginning January 1, 2016. We subsequently established the PN modifier to identify services furnished in non-excepted off-campus PBDs, which are paid under the PFS-equivalent rate rather than the full OPPS rate. Hospitals were required to begin reporting the PN modifier starting January 1, 2017. The mandatory use of the PO and PN modifiers has enabled CMS, MedPAC, and the hospital industry to track utilization patterns.

We found that there has been an increase in the volume of services paid through the imaging without contrast APCs (5521-5524) over time, which indicates that there has been migration of these services to the OPD setting. From 2016 to 2025, the volume of the 70 HCPCS codes which account for over 95 percent of imaging without contrast services provided in excepted PBDs grew over 38 percent. From 2016 to 2025, these increases in volume have resulted in a 33 percent increase in spending, corresponding to approximately $126 million in additional spending in CY 2025. This growth persisted even with the introduction of the PFS-equivalent rate for PBDs subject to section 603 of the Bipartisan Budget Act of 2015 starting in 2017. The COVID-19 Public Health Emergency (PHE) did impact utilization across the OPPS, but we have seen the volume of imaging without contrast services rebound and return to this pattern of unnecessary volume growth. Between 2016 and 2025, we have seen increases in the

volume of imaging without contrast services provided in OPDs utilized per beneficiary.[152] Between 2016 and 2025, for the top 70 most frequently billed imaging without contrast HCPCS codes provided in excepted PBDs, there has been an over 67 percent increase in utilization per beneficiary. This upward trend persists despite a declining Part B FFS population. During this same time, for example, FFS enrollment decreased by approximately 17 percent, indicating that imaging services are being used more frequently on a per-beneficiary basis rather than growth being driven by enrollment.

In addition to looking at the growth in volume and spending at the APC level for imaging without contrast services provided at excepted PBDs, we also examined the growth in volume at the HCPCS code level. Analysis of HCPCS-level utilization trends from 2016 through 2025 indicates that several imaging without contrast services experienced particularly pronounced growth in volume, with increases far exceeding overall Medicare enrollment growth. Several codes experienced growth in the excepted PBDs that outpaced growth in the freestanding physician office setting.

HCPCS code 77080, which describes a DXA scan measuring bone density at the axial skeleton (hips, pelvis, spine), is the most frequently billed imaging without contrast code in excepted PBDs. In 2025, this service had a freestanding physician office payment rate of around $30 and an OPPS payment rate of approximately $106, making the same scan more than three times as expensive in the OPD compared to the freestanding physician office. Based on our claims data analysis, the volume of this service has grown by over 55 percent in excepted PBDs between 2016 and 2025. In contrast, from 2016 to 2025, utilization of this code in the freestanding physician office setting declined modestly, by less than half a percent. HCPCS code 71045, which describes a simple chest x-ray, was created in 2018 as part of the 2018 CPT/HCPCS code restructuring for chest radiography. In 2025, this service had a physician office payment rate of around $17 and an OPPS payment rate of approximately $88, making the

[152] Based on our analysis of claims data and Medicare FFS enrollment.

same scan 417 percent more expensive in the OPD than in the freestanding physician office. Based on our claims data analysis, the volume of this service has grown by over 92 percent in excepted PBDs between 2018 and 2025. From 2018 to 2025, this code decreased in volume by 33 percent in the freestanding physician office setting.

The volume for HCPCS 71250, which describes a CT scan of the chest performed without contrast dye, increased roughly 72 percent in the excepted PBD setting between 2016 and 2025. In contrast, the freestanding physician office setting experienced a comparatively modest increase of 33 percent over the same time period. In 2025, this service has a freestanding physician office payment rate of around $83 and an OPPS payment rate of approximately $106, making the same CT scan 27 percent more expensive in the OPD than in the freestanding physician office.

Similarly, HCPCS 70551, which describes an MRI scan of the brain, including the brainstem, performed without contrast material grew by 41 percent between 2016 and 2025 at excepted PBDs. From 2016 to 2025, this code only grew by 14 percent in the freestanding physician office setting. In 2025, this service had a freestanding physician office payment rate of around $127 and an OPPS payment rate of approximately $243, making the same scan 91 percent more expensive in the OPD than in the freestanding physician office.

HCPCS 76536, which describes an ultrasound of the head and neck, had excepted PBD volume increase 48 percent from 2016 to 2025. The same code only experienced a 4 percent increase in volume in the freestanding physician office setting during the same time period. In 2025, this service had a physician office payment rate of around $82 and an OPPS payment rate of approximately $106, making the same scan 29 percent more expensive in the OPD than in the freestanding physician office.

Breast imaging services also demonstrated substantial increases, with the volume of ultrasound breast complete (HCPCS 76641) increasing 52 percent in the excepted PBD setting from 2016 to 2025. From 2016 to 2025, this code decreased in volume by 25 percent in the

freestanding physician office setting. In 2025, this service had a freestanding physician office payment rate of around $66 and an OPPS payment rate of approximately $106, making the same scan 60 percent more expensive in the OPD than in the freestanding physician office.

These services are generally low- to moderate-complexity imaging procedures that can be safely performed in multiple settings, and their growth in volume in excepted PBDs suggests increased utilization intensity beyond what would be expected based solely on growth in the Medicare population. We stated in the proposed rule that we believed that the financial incentives created by payment policy rather than clinical need are a significant factor in shifting these services to OPDs. If there was not a material difference in payment rates, we stated we believed fewer of these services would have shifted to OPDs and the corresponding increase in Medicare payments and beneficiary cost-sharing would not have occurred (91 FR 41911).

We also examined trends across excepted and non-excepted PBDs, alongside the freestanding physician office setting. There are approximately four times as many providers billing with the PN modifier (non-excepted PBDs) as compared to the PO modifier (excepted PBDs) (91 FR 41911). This substantial difference suggests that non-excepted PBD services are distributed across a much broader provider base, while volume in excepted PBDs remains concentrated among a smaller group of providers.

Excepted PBDs continue to account for the overwhelming share of imaging without contrast volume, even as non-excepted PBDs have grown steadily in recent years. Across the highest-volume services, the gap remains substantial: in 2025, excepted PBDs furnished roughly 4 to 5 times the volume of non-excepted PBDs for key services, accounting for about 75–82 percent of total combined PBD volume. For example, excepted PBDs represent approximately 81 percent of volume for HCPCS 77080 (DXA bone density scan), 79 percent for HCPCS 71046 (chest x-ray, 2 views), 79 percent for HCPCS 93306 (complete transthoracic echocardiography), and 83 percent for HCPCS 71250 (CT thorax without contrast). In the freestanding physician office setting, in comparison, these same services show relatively stable or modest growth over

time rather than rapid expansion. Importantly, these are routine imaging services that rely on widely available equipment and standardized protocols and they are clinically comparable regardless of setting, meaning they can be safely and effectively performed in freestanding physician offices, non-excepted PBDs, or excepted PBDs without meaningful differences in patient acuity or quality.

For example, in its 2023 report, MedPAC examined APCs where such potentially unnecessary payment differentials exist.[153] To identify appropriate APCs, MedPAC compared the volume of services in each APC that was provided in OPDs, ASCs, and freestanding offices over the period of 2016 through 2021, but omitted 2020 because the COVID-19 PHE affected the volume of care in ambulatory settings. If freestanding offices had the highest volume for an APC, MedPAC concluded that the services in that APC could be provided safely in freestanding offices for most beneficiaries and that beneficiaries would be able to access the services in that APC. Therefore, for those services, it would be reasonable to align the OPPS payment rates with the PFS payment rates. MedPAC found that all four of the imaging without contrast APCs had higher volume in freestanding facilities than in OPDs, indicating that these services can be safely provided to beneficiaries in a lower cost setting of care.

We stated we believed MedPAC's analysis aligns well with the rationale CMS adopted in the CY 2019 OPPS/ASC final rule with comment period: we consider OPPS utilization potentially unnecessary if the beneficiary can safely receive the same services in a lower-cost setting but instead receives care in the hospital outpatient setting because of site-of-service payment differentials.

In our review of the utilization of imaging without contrast services in excepted PBDs, we found increases in the volume of services over time, increases in the volume of services provided per beneficiary, and significant volume growth for some individual HCPCS codes within the imaging without contrast APC family. We believed that these changes represent

[153] *www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch8_MedPAC_Report_To_Congress_SEC.pdf.*

unnecessary increases in the volume of covered OPD imaging without contrast services and, therefore, we proposed to apply our volume control method to these services under section 1833(t)(2)(F) of the Act.

4. Payment for Imaging Without Contrast Services at PBDs

As discussed in the CY 2017 OPPS/ASC interim final rule with comment period (81 FR 79726), we established a Medicare PFS relativity adjuster that is applied to the OPPS rate for the billed non-excepted items and services furnished in a non-excepted off-campus PBD to calculate payment rates under the PFS. The PFS relativity adjuster reflects the estimated overall difference between the payment that would otherwise be made to a hospital under the OPPS for the non-excepted items and services furnished in non-excepted off-campus PBDs and the resource-based payment under the PFS for the technical aspect of those services with reference to the difference between the facility and nonfacility (office) rates and policies under the PFS. The PFS relativity adjuster, as discussed in the CY 2018 PFS final rule, is set at 40 percent of the amount that would have been paid under the OPPS (82 FR 53028). Non-excepted PBDs are required to use the modifier "PN" so that the PFS relativity adjuster is applied to the payment of their claim. Excepted PBDs use the modifier "PO" on their claims to indicate that the service was provided at an excepted off-campus PBD and that payment should generally be made at the OPPS rate.

In the CY 2019 OPPS/ASC final rule with comment period, we stated that we consider the shift of services from the freestanding physician office to the hospital OPD unnecessary if the beneficiary can safely receive the same services in a lower-cost setting but is instead receiving services in the higher paid setting (83 FR 59006). To better understand the migration of services to off-campus OPDs, we analyzed claims data for imaging without contrast services to assess whether increases in volume and spending could be driven by payment incentives. We examined the top 70 most frequently billed HCPCS codes in the imaging without contrast APC family at both excepted and non-excepted off-campus PBDs. These 70 HCPCS codes account for over 95

percent of the volume of imaging without contrast services in off-campus PBDs. We found that over 90 percent of these codes in the imaging without contrast APCs were in the top 70 most frequently billed codes at both excepted and non-excepted off-campus PBDs with slight variations in the order based on volume. We therefore concluded that the majority of HCPCS codes in the imaging without contrast APCs were being billed with both the "PO" and "PN" modifiers, indicating that these imaging without contrast services were safely being provided in both excepted and non-excepted PBDs.

We also compared OPPS and PFS payment rates by using PFS payment rates for the most frequently billed imaging without contrast HCPCS codes by excepted PBDs (departments that bill the modifier "PO" on claim lines) and volume-weighing them to create a PFS proxy average APC payment rate for all imaging without contrast services. Using this approach, we found that, on average, OPPS payment rates for excepted off-campus PBDs are approximately 2.5 times higher than PFS rates, while non-excepted PBD rates are closely aligned with the PFS. At the APC level, PFS payments range from about 31 percent to 54 percent of OPPS payments, confirming a substantial and consistent payment differential. A similar pattern is observed for beneficiary cost-sharing, where average cost-sharing in excepted PBDs is more than double that in freestanding physician offices, while cost-sharing for services provided in non-excepted PBDs is closely aligned with cost-sharing in freestanding physician offices.

We stated that we believed that the differential in our payment rates created a payment incentive that led to unnecessary growth for the services in the imaging without contrast APCs. We consider the shift of services from the physician office to the hospital OPD unnecessary if the beneficiary can safely receive the same services in a lower-cost setting but is instead receiving services in the higher paid setting due to payment incentives. We believed the OPPS payment rate for the imaging without contrast APCs being several times greater than the PFS rate created such a payment incentive and that the growth in imaging without contrast services at excepted PBDs was therefore unnecessary.

We did not believe that the imaging payment limitation established under section 5102 of the Deficit Reduction Act (DRA) of 2005 (Pub. L. 109-171), codified at section 1848 of the Act, constrained our ability to implement a volume control method for imaging without contrast services furnished in excepted off-campus PBDs. The DRA provision applies specifically to services paid under the PFS and limits payment to the lesser of the PFS or OPPS amount, but it does not directly affect payment for services furnished in PBDs. The DRA functions as a ceiling on PFS payments, ensuring they do not exceed OPPS rates, while the PFS relativity adjuster is used to scale payments appropriately when applied in the PBD setting. As a result, using PFS-equivalent rates for imaging without contrast services in excepted PBDs aligns excepted PBD payment rates under the OPPS with payment rates for these services under the PFS and therefore would not conflict with the DRA.

5. Patient Severity and Cost of Care

In comments to the CY 2019 OPPS/ASC proposed rule and subsequent rulemaking, we heard from commenters that the higher payments for services in hospital outpatient settings are justified by the level of care patients need, the higher costs of providing care in hospitals, and the costs of maintaining emergency care and standby capacity. We recognize that OPDs serve unique patient populations and provide services to medically complex beneficiaries; however, we believed that there was no evidence to demonstrate the need for higher payment for services provided in OPDs that could also be provided in lower-cost settings. This was particularly relevant for imaging without contrast services, which are generally low- to moderate-complexity diagnostic procedures, such as standard CT, MRI, ultrasound, radiography, and bone density testing, that do not require the administration of contrast agents or the associated monitoring and infrastructure. These services can be safely and effectively furnished in multiple settings, including freestanding physician offices, without compromising quality or patient safety.

In general, despite marked differences in payment rates for a range of services, identical services are being delivered to very similar patients across physicians' offices, hospital OPDs,

and ASCs.[154] [155] Moreover, a 2023 literature review found no peer-reviewed evidence that shows differences in the quality of services delivered across hospital OPDs and freestanding physicians' offices.[156] In their 2023 report, MedPAC evaluated risk scores from the CMS hierarchical condition category (CMS–HCC) risk-adjustment model to compare the medical complexity of OPD patients with patients in freestanding offices. They found that, on average, OPD patients have higher risk scores, which suggests that OPD patients are potentially more medically complex than those in physician offices. However, they also found substantial overlap in the CMS–HCC risk scores of patients in these two settings, which suggests that the difference in patient severity between settings is small. Their analysis showed that the effects of patient severity on cost of care for the aligned services is not statistically significant as the services, like imaging without contrast services, are generally of low complexity. In addition, if there is a need to bill for more complex cases, under the OPPS, providers can often bill separately for additional services that a patient might need such as prolonged observation, emergency medications, or additional diagnostic testing furnished in response to a complication or change in the patient's condition during the outpatient encounter. Accordingly, we continued to believe that higher OPPS payment rates for imaging without contrast services were not justified by differences in patient complexity or resource needs and may instead contribute to unnecessary increases in utilization in higher-cost settings.

6. Impact of Unnecessary Increases in Volume on the OPPS

Our concern with unnecessary increases in the volume of imaging without contrast services was tied to the health and sustainability of the OPPS. As described in Table 80 in the CY 2019 OPPS/ASC final rule with comment period, we found that the mean and median annual increases in the volume and intensity of hospital outpatient services were about 5.5 percent and

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[154] *https://tobin.yale.edu/sites/default/files/2023-10/Site-Neutral%20Payment%20Literature%20Review%2010302023.pdf.*
[155] *https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch8_MedPAC_Report_To_Congress_SEC.pdf.*
[156] *https://tobin.yale.edu/sites/default/files/2023-10/Site-Neutral%20Payment%20Literature%20Review%2010302023.pdf.*

5.4 percent, respectively, from 2011 to 2019. Over that period, the estimated increase in aggregate annual hospital incurred payments through Medicare FFS Part B was $28.2 billion.[157]

More recent data indicated that this trend has persisted and accelerated. As shown in Table 80, from 2019 through 2027, hospital outpatient costs per FFS enrollee are projected to grow at a mean annual rate of approximately 7.7 percent and a median annual rate of 9.2 percent.[158] After a temporary decline in 2020, annual growth rebounded sharply to 19.7 percent in 2021. From 2022 through 2027, the projected year-over-year annual growth rates are expected to range from 4.7 percent to 9.5 percent annually. As seen in Table 81, over this period outpatient hospital spending per FFS enrollee is projected to increase from $1,738 in 2019 to $3,238 in 2027, an increase of about 86 percent.[159] This translates to an increase of approximately $35 billion in aggregate annual incurred reimbursements for hospital outpatient services between 2019 and 2027. This level of growth exceeds that observed in other categories of Part B services in dollar terms and occurs despite relatively stable or declining FFS enrollment over much of the period.

When looking at this time period it is important to note that PHE likely contributed significantly to the increase in claims volume in 2021. During the acute phase of the pandemic in 2020, many outpatient services were delayed or deferred as beneficiaries postponed routine care and providers limited non-urgent services. As these restrictions eased in 2021, utilization rebounded sharply as providers worked through substantial backlogs of postponed services and beneficiaries returned for deferred evaluations and treatment. This pent-up demand for outpatient care likely contributed to the pronounced increase in year-over-year outpatient hospital cost growth observed in 2021.

TABLE 80: GROWTH IN HOSPITAL OUTPATIENT COSTS PER FEE-FOR-SERVICE ENROLLEE[160]

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[157] Available in Table IV.B6. at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2019.pdf*.
[158] *https://www.cms.gov/oact/tr/2025*.
[159] *https://www.cms.gov/oact/tr/2025*.
[160] Available in Table IV. B3. at *https://www.cms.gov/oact/tr/2025*.

Calendar Year	Percent Increase
2019	5.2
2020	-5.8
2021	19.7
2022	4.7
2023	8.4
2024	9.4
2025	9.4
2026 (Estimated)	9.2
2027 (Estimated)	9.5

TABLE 81: OUTPATIENT HOSPITAL SPENDING PER FEE-FOR-SERVICE ENROLLEE[161]

Calendar Year	Outpatient Hospital Spending Per Fee-For-Service Enrollee
2019	$1,738.46
2020	$1,663.57
2021	$2,021.31
2022	$2,072.33
2023	$2,230.61
2024	$2,450.22
2025	$2,700.77
2026 (Estimated)	$2,952.52
2027 (Estimated)	$3,237.60

Taken together, the sustained acceleration in per-enrollee spending and aggregate expenditures suggests that factors beyond underlying beneficiary need, such as increases in service volume and intensity, are contributing to spending growth in the hospital outpatient setting. Continued increases in the volume of imaging without contrast services raise concerns about potentially unnecessary utilization. Such trends have implications for Medicare program expenditures and beneficiary cost-sharing, as well as for the financial sustainability of the OPPS.

As we stated in the CY 2019 OPPS/ASC final rule with comment period (83 FR 59018), there is evidence that increased volume and intensity of certain covered OPD services is likely driven by financial incentives to furnish services in hospitals in order to receive higher reimbursement, rather than making site-of-service decisions based on medical necessity. We continue to be concerned with the rate of increase in program expenditures under the OPPS for several reasons. The OPPS was originally designed to manage Medicare spending growth by

[161] Available in Table IV.B4. at *https://www.cms.gov/oact/tr/2025.*

replacing a cost-based system with a prospective payment system. Contrary to this Congressional purpose, the OPPS has continued to be one of the fastest growing sectors of Medicare payments out of all payment systems under Medicare Parts A and B.[162] Furthermore, we are concerned that the persisting rate of growth relative to other payment systems suggests that payment incentives, rather than patient acuity or medical necessity, continue to affect site-of-service decision-making. This site-of-service selection has an impact on not only the Medicare program, but also on Medicare beneficiary out-of-pocket spending. Our authority to implement volume control methods is an important tool in combating unnecessary OPPS utilization. We have seen success in stemming unnecessary growth in the volume of clinic visits at excepted PBDs. Since 2019, when we began phasing in our volume control method, there has been a 25 percent decrease in the volume of clinic visit services performed in excepted PBDs. Since 2023, the volume of clinic visit services at excepted PBDs has stayed relatively steady. We believed that imaging without contrast services provided at excepted PBDs were in need of similar treatment.

7. Multiple Procedure Discounts

In the CY 2009 OPPS/ASC final rule with comment period (73 FR 68559 through 86569), we finalized a policy that, effective January 1, 2009, we make a single payment each time a hospital submits a claim for more than one imaging procedure within an imaging family on the same date of service, to reflect and promote the efficiencies hospitals can achieve when performing multiple imaging procedures during a single session. We utilize three imaging families based on imaging modality for purposes of this methodology: (1) ultrasound; (2) computed tomography (CT) and computed tomographic angiography (CTA); and (3) magnetic resonance imaging (MRI) and magnetic resonance angiography (MRA). The HCPCS codes subject to the multiple imaging composite policy and their respective families are listed in Table 82 of this final rule with comment period.

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[162] *https://www.gpo.gov/fdsys/pkg/FR-2018-11-21/pdf/2018-24243.pdf.*

While there are three imaging families, there are five multiple imaging composite APCs due to the statutory requirement under section 1833(t)(2)(G) of the Act that we differentiate payment for OPPS imaging services provided with and without contrast. While the ultrasound procedures included under the policy do not involve contrast, both CT/CTA and MRI/MRA scans can be provided either with or without contrast. The five multiple imaging composite APCs established in CY 2009 are:

- APC 8004 (Ultrasound Composite);
- APC 8005 (CT and CTA without Contrast Composite);
- APC 8006 (CT and CTA with Contrast Composite);
- APC 8007 (MRI and MRA without Contrast Composite); and
- APC 8008 (MRI and MRA with Contrast Composite).

We make a single payment for those imaging procedures that qualify for payment based on the composite APC payment rate, which includes any packaged services furnished on the same date of service. The standard (non-composite) APC assignments continue to apply for single imaging procedures and multiple imaging procedures performed across families. As discussed in section XA. of this final rule with comment period, for CY 2027 we proposed to continue to pay for all multiple imaging procedures within an imaging family performed on the same date of service using the multiple imaging composite APC payment methodology.

The multiple imaging composite APC policy reflects the efficiencies that hospitals can achieve when furnishing multiple imaging procedures within the same imaging family during a single session. A similar principle underlies the multiple procedure payment reduction (MPPR) policy for diagnostic imaging services under the PFS. Under the MPPR policy, when multiple diagnostic imaging procedures are furnished to the same patient in the same session, payment for the technical component of the subsequent procedures is reduced to reflect efficiencies associated with the preparation of the patient, positioning, and other clinical and administrative activities that do not need to be repeated for each additional imaging procedure. Both the OPPS

multiple imaging composite APC policy and the PFS MPPR policy recognize that furnishing multiple imaging services during the same encounter generally requires fewer resources than furnishing those services separately. Consistent with other services furnished in non-excepted PBDs, when multiple imaging procedures are performed at a non-excepted PBD and paid through one of the multiple imaging composite APCs, providers are required to report modifier "PN," and the PFS relativity adjuster is applied to the composite APC payment.

As discussed later in this section, we proposed to apply our volume control methodology to the imaging without contrast APCs (5521-5524). We believed it was also appropriate to apply the volume control methodology to APCs 8004 (Ultrasound Composite), 8005 (CT and CTA without Contrast Composite), and 8007 (MRI and MRA without Contrast Composite). APCs 8004, 8005, and 8007 are comprised of HCPCS codes assigned to the imaging without contrast APCs that would be subject to the volume control methodology when paid separately. In other words, the underlying imaging without contrast services that qualify a claim for payment under APCs 8004, 8005, and 8007 are the same imaging procedures for which we proposed to apply the volume control methodology under the standard APC payment structure.

Accordingly, excluding APCs 8004, 8005, and 8007 from the volume control methodology would result in different payment treatment for the same underlying imaging procedures based solely on whether those procedures were paid separately or through a multiple imaging composite APC. We do not believe such differential treatment would be appropriate. Moreover, because APCs 8004, 8005, and 8007 are comprised of HCPCS codes assigned to the imaging without contrast APCs that would be subject to the volume control methodology when paid separately, excluding these composite APCs would allow a portion of the same imaging services that contribute to the volume concerns identified previously to be paid outside the volume control methodology when furnished in excepted PBDs. Further, because these composite APCs are already subject to the PFS relativity adjuster when furnished at non-excepted PBDs, excluding them from the volume control methodology in excepted PBDs could

create inconsistent payment incentives across settings and undermine the effectiveness of the volume control methodology. Therefore, we proposed to apply the volume control methodology to APCs 8004, 8005, and 8007.

8. Payment for Imaging without Contrast Services for CY 2027 and Subsequent Years

As we stated in the CY 2019 OPPS/ASC final rule with comment period, we consider the shift of services from the freestanding physician office to the hospital OPD unnecessary if the beneficiary can safely receive the same services in a lower-cost setting but is instead receiving services in the higher paid setting due to payment incentives (83 FR 59006). We believe the increase in the volume of imaging without contrast services is due to the payment incentive that exists to provide this service in the higher-cost setting. Because these services could generally be safely provided in a lower-cost setting, we believe that the growth in imaging without contrast services paid under the OPPS is unnecessary. Further, we believe that paying for imaging without contrast services provided at excepted off-campus PBDs at the PFS-equivalent rate could be an effective method to control the unnecessary increase in the volume of these services because the payment differential that is driving the site-of-service decision will be removed. We believe this method will control unnecessary volume increases both in terms of the number of covered OPD services furnished and costs associated with those services.

Therefore, given the unnecessary increases in the volume of imaging without contrast services in hospital OPDs, we proposed to apply the PFS-equivalent payment rate to HCPCS codes assigned to the imaging without contrast APCs and to services paid through APCs 8004 (Ultrasound Composite), 8005 (CT and CTA without Contrast Composite), and 8007 (MRI and MRA without Contrast Composite) when furnished at an off-campus PBD excepted from section 1833(t)(21) of the Act (departments that bill modifier "PO" on claim lines). Under our authority in section 1833(t)(2)(F) of the Act, we would implement this proposal by applying an amount equal to the site-specific PFS payment rate for non-excepted items and services furnished by a non-excepted off-campus PBD (the PFS-equivalent payment rate). Table 82 shows the specific

APCs that we would identify for this proposal, which are APCs 5521 through 5524, 8004, 8005, and 8007. Off-campus PBDs that are not excepted from section 603 (departments that bill the modifier "PN") already receive a PFS-equivalent payment rate for any HCPCS codes assigned to the imaging without contrast APCs.

TABLE 82: PROPOSED APCS NEWLY PAID THE PFS-EQUIVALENT RATE FOR SERVICES PROVIDED AT EXCEPTED OFF-CAMPUS PBDS FOR CY 2027

APC	APC Description
5521	Level 1 Imaging without Contrast
5522	Level 2 Imaging without Contrast
5523	Level 3 Imaging without Contrast
5524	Level 4 Imaging without Contrast
8004	Ultrasound Composite
8005	CT and CTA without Contrast Composite
8007	MRI and MRA without Contrast Composite

In the CY 2019 OPPS/ASC final rule with comment period (83 FR 59013), we finalized our method to address the unnecessary increases in utilization of clinic visits in the OPD setting in a non-budget neutral manner. In the CY 2026 OPPS/ASC final rule with comment period (90 FR 53448), we likewise finalized an expansion of our method to address the unnecessary increases in utilization of drug administration services in the OPD setting in a non-budget neutral manner. For CY 2027, we proposed to implement this proposed method to address the unnecessary increases in utilization of imaging without contrast services in the OPD setting in a non-budget neutral manner. We continued to believe that, while section 1833(t)(9)(B) of the Act requires that certain changes made under the OPPS be made in a budget neutral manner, this section does not apply to the volume control method under section 1833(t)(2)(F) of the Act. In particular, section 1833(t)(9)(A) of the Act, titled "Periodic review," provides, in part, that the Secretary must annually review and revise the groups, "the relative payment weights, and *the wage and other adjustments* described in paragraph (2) to take into account changes in medical practice, changes in technology, the addition of new services, new cost data, and other relevant information and factors" (emphasis added). Section 1833(t)(9)(B) of the Act, titled "Budget neutrality adjustment" provides that if "the Secretary makes *adjustments* under subparagraph

(A), then the *adjustments* for a year may not cause the estimated amount of expenditures under this part for the year to increase or decrease from the estimated amount of expenditures under this part that would have been made if the adjustments had not been made" (emphasis added). However, a volume-control method under section 1833(t)(2)(F) of the Act is not an "adjustment" under paragraph (2). Unlike the wage adjustment under section 1833(t)(2)(D) of the Act and the outlier, transitional pass-through, and equitable adjustments under section 1833(t)(2)(E) of the Act, section 1833(t)(2)(F) of the Act refers to a "method" for controlling unnecessary increases in the volume of covered OPD services, not an "adjustment." Likewise, sections 1833(t)(2)(D) and (E) of the Act also explicitly require the adjustments authorized by those subparagraphs to be budget neutral, while the volume control method authority at section 1833(t)(2)(F) of the Act does not. Therefore, the volume control method proposed under section 1833(t)(2)(F) of the Act is not one of the adjustments under section 1833(t)(2) of the Act that is referenced under section 1833(t)(9)(A) of the Act that must be included in the budget neutrality adjustment under section 1833(t)(9)(B) of the Act. Moreover, section 1833(t)(9)(C) of the Act specifies that if the Secretary determines under methodologies described in subparagraph (2)(F) that the volume of services paid for under this subsection increased *beyond* amounts established through those methodologies, the Secretary *may* appropriately adjust the update to the conversion factor otherwise applicable in a *subsequent* year. We therefore continue to interpret this provision to mean that the Secretary can implement a volume control method under section 1833(t)(2)(F) of the Act in a non-budget neutral manner in the year in which the method is implemented, and that the Secretary may then make further adjustments to the conversion factor in a subsequent year to account for volume increases that are *beyond* the amounts estimated by the Secretary under the volume control method (see 83 FR 59009).

We stated in the CY 2019 OPPS/ASC final rule with comment period (83 FR 59010) that we believe implementing a volume control method in a budget neutral manner would not appropriately reduce the overall unnecessary volume of covered OPD services, and instead

would simply shift the movement of the volume within the OPPS system in the aggregate, a concern similar to the one we discussed in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66613). We believe that concern applies to imaging without contrast services just the same. The estimated payment impact for various provider classifications is displayed in Table 112: CY 2027 Changes for Services Provided in the Hospital Outpatient Prospective Payment System of this final rule with comment period. For CY 2027, the estimated savings were $260 million, with $190 million of the savings accruing to Medicare, and $70 million saved by Medicare beneficiaries in the form of reduced beneficiary coinsurance. And beginning in 2028, the savings from the proposed policy would begin to flow into the baseline for Medicare Advantage rates, thus resulting in a significant increase in savings in subsequent years. For 2027, the Medicare Advantage rates had already been calculated at the time of this final rule with comment period and thus the 2027 Medicare Advantage rates are not impacted by the proposed policy. From 2027-2036 we estimated that this policy would lower net Part B spending by $7.2 billion. The 10-year estimated payment impact is displayed in Table 111: Estimated Effect of Changes to Imaging without Contrast Services when Furnished at Excepted Off-Campus Providers. To effectively establish a method for controlling the unnecessary growth in the volume of imaging without contrast services furnished by excepted off-campus PBDs that did not simply reallocate expenditures that are unnecessary within the OPPS, we believed that this method must be adopted in a non-budget neutral manner. The impact associated with this proposal is further described in section XXVII. of this final rule with comment period.

While we are refining our method to control for unnecessary increases in the volume of hospital OPD services, we continue to recognize the importance of not impeding development or beneficiary access to new innovations. We solicited public comments on other ways or other services for which we should exercise the Secretary's statutory authority under section 1833(t)(2)(F) of the Act.

We received public comments on these proposals. The following is a summary of the

comments we received and our responses.

Comment: Numerous commenters, including organizations representing private health insurance plans, physicians and independent physician practices, outpatient imaging providers, consumer organizations, and individual Medicare beneficiaries, supported the proposal to apply our volume control method to imaging without contrast services furnished in excepted off-campus PBDs. Commenters agreed that this method would help control unnecessary increases in the volume of imaging services furnished in excepted off-campus PBDs when beneficiaries can generally safely receive the same services in a lower-cost setting but instead receive care in a higher-cost setting due to payment incentives. Commenters stated that higher payments to OPDs for imaging services that can be safely furnished in lower-cost settings increase costs for Medicare beneficiaries and taxpayers and may encourage care to shift toward higher-paid OPDs.

Several commenters highlighted the substantial differences in Medicare payment for imaging services furnished in hospital outpatient departments compared to freestanding physician offices and other freestanding settings. Commenters provided examples of imaging services for which Medicare payment in the hospital outpatient setting is substantially higher than payment for the same service in a freestanding physician office. For example, commenters noted that a bone density scan may be paid at nearly three times the freestanding physician office rate when furnished in a hospital outpatient department and cited substantial payment differences for ultrasound, x-ray, CT, and other diagnostic imaging services. Commenters stated that these payment differences increase both Medicare program expenditures and beneficiary cost sharing without corresponding differences in the imaging service furnished or the quality of care provided. Several commenters emphasized that higher out-of-pocket costs can create a barrier to obtaining medically necessary diagnostic care, particularly for beneficiaries living on fixed incomes or those who require repeated imaging services. Commenters stated that beneficiaries may delay or forgo clinically appropriate imaging because of these costs, potentially delaying diagnosis and treatment. One physician commenter described patients who had delayed essential

imaging and follow-up care because of hospital-based charges and facility fees.

Commenters generally agreed that imaging without contrast services can be routinely and safely furnished in lower-cost ambulatory settings. Several commenters stated that routine imaging services furnished in hospital outpatient departments and freestanding settings use the same or similar equipment, standardized protocols, technologists, and interpreting physicians. Commenters stated that hospital ownership does not itself result in a clinically different service or higher quality of care and that payment for comparable services should reflect the resources required to furnish the service rather than the ownership or billing designation of the facility.

Several commenters also agreed with our concern that payment differentials between the OPPS and PFS contribute to hospital acquisition of physician practices and independent imaging facilities and the migration of imaging services to higher-cost hospital outpatient settings. Commenters stated that these payment differences may encourage consolidation, reduce competition from independent practices and imaging facilities, and increase costs for Medicare and its beneficiaries.

Commenters also highlighted the utilization trends presented in the proposed rule as support for the proposal, including the growth in the volume of imaging without contrast services furnished in excepted off-campus PBDs and growth in utilization per beneficiary. Some commenters also noted that non-excepted off-campus PBDs already receive PFS-equivalent payment for these services and have continued to furnish imaging services under that payment methodology.

Several commenters also supported implementing the proposed policy in a non-budget neutral manner. Commenters stated that doing so would allow Medicare and beneficiaries to realize savings from controlling unnecessary volume rather than redistributing those savings to other services paid under the OPPS.

Response: We appreciate the commenters' support. As discussed in the CY 2027 OPPS/ASC proposed rule (91 FR 41734), we share the commenters' concerns regarding the

effect of payment incentives on site of service decision-making and the downstream effects created by these payment disparities. As we noted in the CY 2019 OPPS/ASC proposed rule by quoting a MedPAC report (83 FR 37140), "[a] large source of growth in spending on services furnished in hospital outpatient departments (HOPDs) appears to be the result of the unnecessary shift of services from (lower cost) physician offices to (higher cost) HOPDs." We continue to believe that these shifts in site of service are unnecessary if the beneficiary can safely receive the same services in a lower-cost setting but instead receives care in a higher-cost setting due to payment incentives.

In addition to the concern that the difference in payment is leading to unnecessary increases in the volume of covered outpatient department services, we remain concerned that this shift in care setting increases beneficiary cost-sharing liability because Medicare payment rates for the same or similar services are generally higher in hospital outpatient departments than in freestanding physician offices. Higher beneficiary cost sharing is not only a financial concern. We are also concerned that higher out-of-pocket costs may discourage beneficiaries from obtaining clinically appropriate services or cause them to delay necessary diagnostic care. This concern may be particularly significant for beneficiaries who require repeated imaging services and beneficiaries with limited financial resources. Reducing unnecessary differences in payment across settings therefore has the potential to both reduce beneficiary cost-sharing liability and reduce financial barriers to receiving needed care. For example, as discussed in the CY 2027 OPPS/ASC proposed rule (91 FR 41909), in 2025, the freestanding physician office payment rate for a DXA scan described by HCPCS code 77080 was approximately $30, compared to approximately $106 under the OPPS. Similarly, the freestanding physician office payment rate for a chest x-ray described by HCPCS code 71045 was approximately $17, compared to approximately $88 under the OPPS. Because beneficiaries are generally responsible for 20 percent of the Medicare payment amount through coinsurance, these payment differences can translate into meaningfully higher out-of-pocket costs for the same or similar service simply

because it is furnished in the higher-paid setting. For beneficiaries living on fixed incomes, particularly those who require repeated diagnostic imaging, these differences can accumulate and may create a financial barrier to obtaining timely care.

We also agree with commenters that the substantial differences in payment for imaging without contrast services across settings create a financial incentive to furnish these services in the higher-paid OPD setting. Imaging without contrast services are routinely furnished in freestanding physician offices and other lower-cost ambulatory settings. We continue to believe that to the extent similar services can be safely provided in more than one setting, it is not prudent for the Medicare program to pay more for these services in one setting than another solely because of the site in which the service is furnished.

As discussed in the CY 2027 OPPS/ASC proposed rule (91 FR 41910 through 41912), our review of imaging without contrast services found increases in the volume of these services over time and increases in the volume of services provided per beneficiary. We believe that these changes represent unnecessary increases in the volume of covered outpatient department imaging without contrast services and that it is appropriate to apply our volume control method to these services.

We further agree that our experience with non-excepted off-campus PBDs is relevant to our assessment of this policy. Imaging without contrast services are furnished in both excepted and non-excepted off-campus PBDs, even though non-excepted off-campus PBDs generally receive the PFS-equivalent payment rate. As discussed in the proposed rule, there are approximately four times as many providers billing the "PN" modifier as providers billing the "PO" modifier. The continued furnishing of these services in non-excepted off-campus PBDs supports our conclusion that imaging without contrast services can continue to be furnished in an off-campus hospital setting under the PFS-equivalent payment methodology.

We appreciate the comments supporting the implementation of this policy in a non-budget neutral manner. As we stated in the CY 2027 OPPS/ASC proposed rule and consistent

with our discussion in the CY 2019 and CY 2026 OPPS/ASC rulemakings, we believe implementing a volume control method in a budget neutral manner would not appropriately reduce the overall unnecessary volume of covered OPD services and instead would simply shift the volume of services within the OPPS system in the aggregate.

Comment: In its comment letter, the Medicare Payment Advisory Commission (MedPAC) supported expanding the PFS-equivalent payment rate to imaging without contrast services furnished in excepted off-campus PBDs. MedPAC highlighted its June 2023 Report to the Congress, in which it recommended more closely aligning payment rates across ambulatory settings for selected services that are safe and appropriate to provide in all ambulatory settings when doing so does not pose a risk to beneficiary access. MedPAC noted that its report included an illustrative framework that could be helpful in identifying services for which it might be safe and appropriate to align payment rates and encouraged CMS to consult with clinicians, industry, and other interested parties when determining which services to choose. MedPAC further noted that its June 2023 recommendation was not limited to off-campus PBDs and recommended applying site-neutral payment rates for selected services furnished in both off-campus and on-campus hospital outpatient departments

MedPAC stated that payment alignment between the OPPS and PFS should not adversely affect hospitals' ability to be available 24/7 for emergency care, with particular attention paid to safety-net and rural providers. Additionally, MedPAC recommended maintaining the packaging of ancillary items in the OPPS.

MedPAC reiterated a point from its June 2023 Report to the Congress in which it noted some benefits of making budget-neutral adjustments for some OPPS services in conjunction with site-neutral payments. For example, MedPAC stated that applying a budget-neutral payment adjustment with a site-neutral policy would increase OPPS payment rates for other services, including emergency department visits, which would support hospitals' emergency care and standby capacity.

Response: We thank MedPAC for its comment and support of this policy. We continue to find MedPAC's work valuable as we identify services that may have experienced unnecessary increases in volume in the OPPS. As discussed in the CY 2027 OPPS/ASC proposed rule (91 FR 41912), MedPAC's framework for identifying services that can safely and appropriately be furnished in lower-cost ambulatory settings informed our consideration of imaging without contrast services. We agree that beneficiary access and the ability to safely furnish a service in alternative settings are important considerations when determining whether application of our volume control method is appropriate.

We note that imaging without contrast services are routinely furnished in freestanding physician offices. As discussed in the CY 2027 OPPS/ASC proposed rule (91 FR41912), MedPAC found that all four imaging without contrast APCs had higher volume in freestanding facilities than in OPDs. We believe this supports our conclusion that these services can generally be safely furnished to beneficiaries in lower-cost settings of care and aligns well with the rationale CMS adopted in the CY 2019 OPPS/ASC final rule with comment period (83 FR 59004 through 59015): we consider OPPS utilization unnecessary if the beneficiary can safely receive the same services in a lower-cost setting but instead receives care in the hospital outpatient setting because of payment differentials that result in the unnecessary provision of OPD services.

We also acknowledge MedPAC's recommendation to align payment rates for selected services furnished in on-campus as well as off-campus OPDs. The policy finalized in this rule for CY 2027 and subsequent years is limited to imaging without contrast services furnished in excepted off-campus PBDs. We appreciate MedPAC's recommendation regarding on-campus OPDs and may take this recommendation into consideration in future rulemaking.

We also appreciate MedPAC's comments regarding rural providers and hospitals' emergency and standby capacity. As discussed later in this section, we are finalizing our proposal to exempt rural Sole Community Hospitals from the expanded volume control method.

We do not believe that our volume control method will adversely impact hospitals' ability to provide 24/7 emergency care. We are applying our volume control method to a limited set of services provided in a limited set of OPD departments and do not believe that the financial impact of this provision will significantly impact hospitals' ability to provide 24/7 emergency care. Our final policy will only impact imaging without contrast services furnished in excepted off-campus PBDs and billed with the "PO" modifier.

We understand that MedPAC's June 2023 recommendation proposed to make some site-neutral adjustments in a budget neutral manner. However, we are using our authority under section 1833(t)(2)(F) of the Act to implement a volume control method to control unnecessary increases in the volume of imaging without contrast services. Under sections 1833(t)(2)(F) and (9)(C) of the Act, we are not required to budget neutralize the volume control method here, and as we stated in the CY 2019 OPPS/ASC final rule with comment period (83 FR 59013), we believe implementing a volume control method in a budget neutral manner would not reduce the overall unnecessary volume of covered OPD services and instead would simply shift services within the OPPS system because of payment incentives rather than medical necessity.

Comment: Numerous commenters who supported our proposal also encouraged CMS to expand the volume control method to additional services that can safely and routinely be furnished in lower-cost settings. Commenters stated that the payment incentives that have contributed to unnecessary increases in the volume of clinic visits, drug administration services, and imaging without contrast services may exist for other covered OPD services and encouraged CMS to continue identifying services for which payment differentials may influence site-of-service decisions.

Several commenters recommended that CMS use MedPAC's work identifying services appropriate for payment alignment as a starting point for future policies. Commenters cited MedPAC's identification of 66 clinical services, including 57 APCs for which services are most commonly furnished in freestanding physician offices, and stated that these services may be

appropriate candidates for future application of the volume control method. Some commenters recommended that CMS develop a more systematic approach for identifying additional services, considering factors such as whether services can safely and routinely be furnished in lower-cost settings, the magnitude of payment differences across settings, trends in utilization and site of service, and evidence that payment differences may be contributing to shifts toward hospital outpatient departments.

Some commenters specifically recommended expanding the volume control method to additional imaging services, including imaging with contrast, nuclear medicine, cardiac perfusion imaging, and other ambulatory imaging services that commenters stated can safely be furnished in lower-cost settings. Other commenters encouraged CMS to continue evaluating oncology-related imaging and other outpatient services commonly furnished in freestanding physician practices. Commenters also identified a range of other services and procedures for potential future consideration, including certain skin procedures, urology services, nerve injections, diagnostic and minor procedures, cardiology services, gastroenterology procedures, ophthalmology procedures, orthopedic procedures, and otolaryngology services.

Several commenters also recommended that CMS expand the volume control method to services furnished in on-campus hospital outpatient departments, including clinic visits. Commenters stated that the rationale for addressing payment incentives that encourage shifts to higher-cost OPDs may also apply to services furnished in on-campus departments when those services can safely be furnished in freestanding physician offices or other lower-cost settings. Commenters stated that expanding the policy to on-campus departments could further reduce Medicare spending and beneficiary cost sharing and reduce incentives for provider consolidation.

Some commenters recommended that CMS proceed cautiously with any future expansion and consider beneficiary access, patient complexity, quality and safety, geographic availability of alternative sites of care, hospital infrastructure and emergency capabilities, and provider readiness. Commenters recommended that CMS use a data-driven approach and provide

opportunities for interested parties' input before applying the volume control method to additional services or settings.

Response: We thank commenters for their recommendations regarding additional services and settings that may be appropriate for application of our volume control method. As discussed in the CY 2027 OPPS/ASC proposed rule, we continue to believe that the financial incentives created by differences in payment across settings are not limited to the services currently subject to our volume control method. We continue to believe that shifts in site of service are unnecessary if the beneficiary can safely receive the same services in a lower-cost setting but instead receives care in a higher-cost setting due to payment incentives.

We appreciate commenters' specific recommendations regarding additional imaging services, clinic visits furnished in on-campus hospital outpatient departments, and other clinical service families. We appreciate the analyses and recommendations commenters provided regarding factors that could be considered when evaluating additional services and settings, as well as commenters' recommendations regarding beneficiary access, patient complexity, quality and safety, and the availability of alternative sites of care.

Given the wide array of information presented through this public comment process, we may take the technical recommendations and other detailed feedback provided regarding other services and settings into consideration in future notice-and-comment rulemaking.

We received several comments arguing that CMS lacks the statutory authority to reduce payments to excepted off-campus PBDs, particularly in a non-budget neutral manner. We discuss these comments below.

Comment: Commenters suggested that legal developments since the D.C. Circuit's decision in *AHA v. Azar*, 964 F.3d 1230 (D.C. Cir. 2020), which upheld the agency's invocation of its authority under section 1833(t)(2)(F) of the Act, undermine the agency's reliance on section 1833(t)(2)(F) of the Act for the proposed volume-control methodology. Commenters stated that the D.C. Circuit in *AHA v. Azar* reviewed HHS' interpretation under the two-step

framework of *Chevron U.S.A. Inc. v. Natural Resources Defense Council*, 467 U.S. 837 (1984), but *Chevron* has since been overruled by *Loper Bright Enterprises v. Raimondo*, 603 U.S. 369 (2024). Commenters noted that, following *Loper Bright*, courts may not defer to an agency statutory interpretation simply because a statute is ambiguous. Commenters therefore contended that the agency's reading of section 1833(t)(2)(F) of the Act is not the best interpretation of the law.

Commenters contended that section 1833(t)(2)(F) of the Act does not authorize HHS to lower payments only for certain services performed by certain providers, including those excepted under section 1833(t)(21) of the Act. Commenters stated that CMS' interpretation would allow the agency to supersede the payment system established by Congress and make non-budget-neutral reductions to particular services based on a general statutory direction to develop a method for controlling unnecessary increases in volume.

Some commenters also cited *Bridgeport Hospital v. Becerra*, 108 F.4th 882 (D.C. Cir. 2024), and stated that the decision further supports their view that CMS may not rely on general statutory authority to depart from a more specific, congressionally prescribed Medicare payment methodology.

Response: We continue to believe that section 1833(t)(2)(F) of the Act gives the Secretary authority to develop a method for controlling unnecessary increases in the volume of covered OPD services, including a method that controls unnecessary volume increases by removing a payment differential that is driving site-of-service decisions and, as a result, is unnecessarily increasing service volume.

As an initial matter, the Supreme Court in *Loper Bright* expressly disclaimed that its opinion should alter the holdings of past cases. "By [overruling *Chevron*]," the Supreme Court explained, "we do not call into question prior cases that relied on the *Chevron* framework. The holdings of those cases that specific agency actions are lawful . . . are still subject to statutory *stare decisis* despite our change in interpretive methodology." *Loper Bright*, 603 U.S. at 412.

Prior to *Loper Bright*, the D.C. Circuit upheld CMS's invocation of our authority under section 1833(t)(2)(F) of the Act whereby we adopted a method to control for unnecessary increases in the volume of the relevant service in a manner nearly identical to that at issue here. *See AHA v. Azar*, 964 F.3d at 1241–45. *Loper Bright* does not change that result. The D.C. Circuit's holding that our volume-control methodology complies with section 1833(t)(2)(F) of the Act therefore is still good law. *See also Agendia Inc. v. Kennedy*, No. 24-5180, 2025 WL 1467116, at *3 (D.C. Cir. May 22, 2025) ("The Supreme Court's intervening decision in *Loper Bright* . . . does not alter the consequences of claim preclusion.").

Moreover, the best reading of section 1833(t)(2)(F) of the Act, which states "the Secretary shall develop a method for controlling unnecessary increases in the volume of covered OPD services," is that it delegates significant discretionary authority to the Secretary. *See Loper Bright*, 603 U.S. at 395 (explaining that the "best reading of a statute [may be] that it delegates discretionary authority to an agency"). Because, as the D.C. Circuit explained, our policy "falls comfortably within the plain text of subparagraph (2)(F)" and is further supported by the broader statutory context, *AHA v. Azar*, 964 F.3d at 1241, our policy does not fall outside the "outer statutory bounds" of the delegation, as discussed in *Loper Bright*. This is especially true when one considers that section 1833(t)(2)(F) of the Act was enacted against the backdrop of the Secretary's longstanding rulemaking authority under sections 1102(a) and 1871(a) of the Act, *cf. Cboe Global Mkts., Inc. v. SEC*, 155 F.4th 704, 715 (D.C. Cir. 2025) (finding similar statutory rulemaking authority supported conclusion that Congress delegated significant discretion to agency), and in the context of a statute (section 1833(t) of the Act) that repeatedly delegates significant discretionary authority to the Secretary to design the manner in which OPPS payments will be calculated.

As we noted in the CY 2019 OPPS/ASC final rule with comment period (83 FR 58818) and in our decision to complete the two-year phase of this policy in the CY 2020 OPPS/ASC final rule with comment period (84 FR 61366), "[a] large source of growth in spending on

services furnished in hospital outpatient departments (HOPDs) appears to be the result of the shift of services from (lower cost) physician offices to (higher cost) HOPDs." We continue to believe that these shifts in the sites of service are unnecessary if the beneficiary can safely receive the same services in a lower-cost setting but instead receives care in a higher-cost setting due to payment incentives. We continue to believe that the difference in payment is leading to unnecessary increases in the volume of covered outpatient department services, and we remain concerned that this shift in care setting increases beneficiary cost-sharing liability because Medicare payment rates for the same or similar services are generally higher in hospital outpatient departments than in freestanding physician offices. We continue to believe that our method addresses the concerns described in the CY 2019 OPPS/ASC final rule with comment period (83 FR 59005).

As we stated in the CY 2019 OPPS/ASC final rule with comment period (83 FR 59013), we believe implementing a volume control method in a budget neutral manner would not appropriately reduce the overall unnecessary volume of covered OPD services and instead would simply shift services within the OPPS system because of payment rather than medical necessity. We also outlined in the CY 2019 OPPS/ASC final rule with comment period (83 FR 59013) that while section 1833(t)(9)(B) of the Act requires that certain changes made under the OPPS be made in a budget neutral manner, this section does not apply to the volume control method under section 1833(t)(2)(F) of the Act.

Here, as in *AHA v. Azar*, we have identified an unnecessary increase in volume in a set of OPPS payment codes based on payment differentials between the OPPS and the PFS. As in *AHA v. Azar*, CMS has tailored a methodology to eliminate that unnecessary volume increase by eliminating its cause. And as the D.C. Circuit already found in *AHA v. Azar*, that falls comfortably within the agency's delegated authority under section 1833(t)(2)(F) of the Act.

The D.C. Circuit's decision in *Bridgeport Hospital* does not undermine the precedential value of the D.C. Circuit's earlier decision in *AHA v. Azar*. *See LaShawn A. v. Barry*, 87 F.3d

1389, 1395 (D.C. Cir. 1996) (en banc) (explaining that when a prior panel in the same circuit has decided an issue, the law-of-the-circuit doctrine precludes reconsideration of that decision). Moreover, *Bridgeport Hospital* addressed a completely different payment policy promulgated under a completely different statute. The *Bridgeport* panel concluded that a particular wage-index policy applied under the Inpatient Prospective Payment System (IPPS) exceeded the Secretary's authority under sections 1886(d)(3)(E) and 1886(d)(5)(I)(i) of the Act. *See* 108 F.4th at 887–91. In doing so, the *Bridgeport* panel focused on the specificity and length of section 1886(d)'s wage-index provision and section 1886(d) as a whole, concluding that it did not give the Secretary discretion to change the wage-index values produced within the statutory formula. *See id.* at 889 n.3 (observing that the IPPS "section on inpatient reimbursement formulas" is "longer than many books").

Here, in contrast, section 1833(t)(2) of the Act (entitled "System requirements") expressly gives the Secretary significant discretion by instructing in subparagraph (F) that "the Secretary shall develop a method for controlling unnecessary increases in the volume of covered OPD services." The statute does this in the context of a statutory payment scheme (OPPS) where Congress has delegated to the Secretary significant discretion to design the particulars of that payment system. For example, in contrast to the IPPS statute's wage-index language in section 1886(d)(3)(E) of the Act, section 1833(t)(2)(D) of the Act delegates to the Secretary authority to "determine a wage adjustment factor [for OPPS] to adjust the portion of payment and coinsurance attributable to labor-related costs for relative differences in labor and labor-related costs across geographic regions in a budget neutral manner" in the context of a statute that expressly precludes judicial review of such determinations—and numerous others related to OPPS, including the Secretary's development of volume control methods under section 1833(t)(2)(F)—in section 1833(t)(12) of the Act.

Finally, as we stated in the FY 2026 IPPS/LTCH PPS final rule (90 FR36853), we respectfully disagree with the D.C. Circuit's decision in *Bridgeport*.

Comment: Commenters stated that the D.C. Circuit in *AHA v. Azar* failed to account for section 603 of the Bipartisan Budget Act of 2015 (BBA of 2015), which enacted section 1833(t)(21) of the Act. Commenters stated that the BBA of 2015 created two categories of provider-based departments (PBDs): (1) those established before November 2, 2015, and (2) those established after that date. For those PBDs in existence prior to November 2, 2015, commenters stated that the Congress required CMS to continue paying off-campus PBDs, referred to in the statute as excepted off-campus PBDs, under the OPPS; however, for post-November 2, 2015 PBDs, the Congress required CMS to pay PBDs under another applicable Part B payment system. Commenters believed that the Congress reinforced this policy choice by providing that certain "mid-build" PBDs should receive the same payment treatment as existing, pre-November 2, 2015 off-campus PBDs in section 1833(t)(21)(B)(v) of the Act.

Some commenters noted that section 603 of the BBA of 2015 represents Congress' thoughtful consideration of recommendations to eliminate differences in payment between hospital outpatient departments and freestanding physicians' offices in certain circumstances, and that CMS's proposal undermines the balance struck by Congress. Commenters stated that the agency cannot rely solely on *AHA v. Azar* and must instead address why the text and history of section 603 of the BBA of 2015 do not foreclose the agency's authority to apply the proposed volume control method to imaging without contrast services furnished in excepted off-campus PBDs.

Response: As we stated in the CY 2019 OPPS/ASC final rule with comment period (83 FR 59008), we continue to believe the changes required by section 603 of the BBA of 2015 made in section 1833(t) of the Act had the effect of addressing some of the concerns related to shifts in settings of care and overutilization of services in the hospital outpatient setting for new off-campus PBDs that began billing Medicare for OPPS services after November 1, 2015. In enacting section 603 of the BBA of 2015, Congress addressed the specific circumstances that lead to the proliferation of new off-campus provider-based departments. As we stated in the CY

2017 OPPS/ASC final rule with comment period (81 FR 79711), with section 603 of the BBA of 2015, we believe Congress may have been trying to address the incentive for hospitals to purchase physician's offices and convert them to OPDs without changing their location or patient population. In this final rule with comment period, we are addressing new and separate circumstances: the over utilization of imaging without contrast services in the OPPS.

We disagree with commenters that by enacting legislation that does not reference section 1833(t)(2)(F) of the Act, Congress meant to circumscribe our authority under that preexisting statutory provision. As the D.C. Circuit explained when rejecting the same claim in *AHA v. Azar*: "Nothing in the text of section 603 [of the BBA of 2015] indicates that preexisting off-campus PBDs are forever exempt from adjustments to their reimbursement. Rather, the text of the law exempts those providers from the change mandated by section 603 itself, leaving the exempted providers subject to all the provisions of the OPPS statute, including subparagraph (2)(F)." 964 F.3d at 1246.

Additionally, as the D.C. Circuit there explained, even assuming that section 603 of the BBA of 2015 could be read to judge increases in volume at preexisting off-campus PBDs are not "unnecessary" under section 1833(t)(2)(F) of the Act, that judgment would extend only to 2015 and "would not mean that Congress considered acceptable the continued volume increases later taking place" in other years. *Id.*

Finally, the commenters are also wrong that *Loper Bright* undermines the D.C. Circuit's analysis of section 603 of the BBA of 2015 in *AHA v. Azar*. Nothing in the appellate court's analysis of section 603 of the BBA of 2015 suggests that the court found the provision ambiguous or incorrectly deferred to the agency's interpretation of it. *See id.* And contrary to the commenters' suggestion, the court fully considered any impact of section 603 of the BBA of 2015 on the agency's authority under the OPPS statute, even if it characterized the section 603 argument as an "alternative" argument made by the plaintiffs in that case.

Comment: Commenters reiterated their objections from prior rulemaking that the

proposed payment reductions constitute "adjustments" that are subject to the budget neutrality requirements set forth in section 1833(t)(9)(B) of the Act and urged CMS to implement any volume control method in a budget neutral manner.

Commenters stated that section 1833(t)(9)(A) of the Act refers to the groups, relative payment weights, wage adjustments, and "other adjustments described in paragraph (2)," and therefore encompasses a payment reduction implemented under section 1833(t)(2)(F) of the Act. Commenters stated that characterizing the policy as a "method" rather than an "adjustment" does not change the fact that the policy reduces payment rates for particular OPD services.

Some commenters also disagreed with CMS's interpretation of section 1833(t)(9)(C) of the Act. Commenters stated that this provision provides a specific mechanism for responding to volume that exceeds amounts established through methodologies under section 1833(t)(2)(F) of the Act—an adjustment to the update to the conversion factor in a subsequent year—and does not authorize CMS to implement service-specific payment reductions in a non-budget neutral manner.

Response: As we stated in the CY 2019 OPPS/ASC final rule with comment period (83 FR 59009), we believe that while section 1833(t)(9)(B) of the Act does require that many changes made under the OPPS be made in a budget neutral manner, this provision does not apply to the volume control method under section 1833(t)(2)(F) of the Act as outlined through our proposals in CY 2019, CY 2026, and CY 2027 rulemakings. As we noted in the CY 2019 OPPS/ASC proposed rule (83 FR 37138 through 37143), unlike the wage adjustment under section 1833(t)(2)(D) of the Act and the outlier, transitional pass-through, and equitable adjustments under section 1833(t)(2)(E) of the Act, section 1833(t)(2)(F) of the Act refers to a "method" for controlling unnecessary increases in the volume of covered OPD services, not an adjustment. Likewise, sections 1833(t)(2)(D) and (E) of the Act also explicitly require the adjustments authorized by those paragraphs to be budget neutral, while the volume control method authority at section 1833(t)(2)(F) of the Act does not include such a requirement.

Therefore, we continue to believe that the volume control method proposed under section 1833(t)(2)(F) of the Act is not one of the adjustments under section 1833(t)(2) of the Act that is referenced under section 1833(t)(9)(A) of the Act that must be included in the budget neutrality adjustment under section 1833(t)(9)(B) of the Act.

Moreover, section 1833(t)(9)(C) of the Act specifies that if the Secretary determines under methodologies described in paragraph (2)(F) of section 1833(t) of the Act that the volume of services paid for under this subsection increased beyond amounts established through those methodologies, the Secretary may appropriately adjust the update to the conversion factor otherwise applicable in a subsequent year. We continue to interpret this provision to mean that the Secretary will have implemented a volume control method under section 1833(t)(2)(F) of the Act in a non-budget neutral manner in the year in which the method is implemented. Further, as we stated in the CY 2019 OPPS/ASC proposed rule (83 FR 37138 through 37143), we believe that implementing a volume control method in a budget neutral manner would not appropriately reduce the overall unnecessary volume of covered OPD services and instead would simply shift the volume within the OPPS system in the aggregate.

In addition, the D.C. Circuit in *AHA v. Azar* held not only that budget neutrality is not required under a volume control method, but that making that method budget neutral would be contrary to the purpose and intent of the Medicare statute. For example, the appellate court emphasized that subparagraph (2)(F) of the Act "says nothing about budget-neutrality," and specifically rejected the plaintiffs' claim that volume-control methods must be budget neutral. 964 F.3d at 1241. After all, it would be "anomalous" for the statute to require a rate cut made for purposes of volume control to be "implemented budget-neutrally" because, if we were required "to redistribute the costs traceable to the provision of unnecessary services throughout the OPPS," the result would be "no net savings to Medicare," "largely negating the point of reducing reimbursement in the first place." *Id.* at 1241–42. This common-sense interpretation is thus supported by the text and structure of the OPPS statute, as both we (see 83 FR 37142 through

37143) and the D.C. Circuit have explained.

Comment: Several commenters raised concerns regarding the timeframe and data CMS used to evaluate changes in the volume of imaging without contrast services furnished in excepted off-campus PBDs. Commenters questioned CMS's use of CY 2016 as a baseline, noting that 2016 was the first year hospitals were required to report the informational "PO" modifier for services furnished in excepted off-campus PBDs and stating that first-year reporting may have been incomplete or inconsistent. Commenters recommended that CMS test its findings using alternative baseline years, such as CY 2017 or CY 2018.

Some commenters also recommended that CMS place greater weight on more recent utilization trends. Commenters stated that the period analyzed by CMS spans implementation of section 603 of the BBA of 2015 and the mid-build exception and therefore captures growth associated with the acquisition, construction, and development of off-campus PBDs. Commenters stated that more recent data show relatively stable utilization in excepted off-campus PBDs and stated that CMS should focus on utilization following implementation of section 603 when determining whether there is currently an unnecessary increase in volume. Other commenters stated that CMS should consider a sufficiently long historical period because relying only on recent utilization could include prior shifts from freestanding physician offices to OPDs into the baseline and obscure the effects of consolidation and site-of-service payment differentials.

Several commenters also questioned CMS's use of the 70 HCPCS codes that accounted for more than 95 percent of imaging without contrast volume in excepted off-campus PBDs in CY 2025 to evaluate historical utilization. Commenters stated that these codes represented a smaller proportion of imaging without contrast volume in earlier years and that changes in HCPCS coding during the analysis period make comparisons using a fixed set of current codes potentially misleading. Commenters noted that analyses accounting for predecessor and successor codes and including the full set of imaging without contrast services produced

substantially less growth than CMS's analysis. Commenters also stated that a significant portion of the growth identified by CMS was attributable to codes that did not exist or had no reported volume in the baseline year and recommended that CMS account for coding changes when evaluating historical utilization.

Several commenters also requested that CMS make available additional information regarding the data and methodology used to conduct its utilization analysis. Commenters stated that providing the underlying claims analysis, including information regarding the HCPCS codes, claims fields, settings of care, and methodology used to calculate changes in utilization, would allow interested parties to reproduce CMS's analysis and more fully evaluate the basis for the proposed policy.

Response: We thank the commenters for their input. Based on these comments, we conducted additional analyses to determine whether using alternative baseline periods or the full set of imaging without contrast services would change our conclusion that these services have experienced unnecessary increases in volume.

We first considered commenters' concerns regarding the use of CY 2016 as the baseline year. Using CY 2017 as the baseline, total utilization increased by approximately 5 percent through CY 2025, while utilization per FFS beneficiary increased by approximately 26 percent. Similarly, using CY 2018 as the baseline, total utilization increased by approximately 6 percent through CY 2025, while utilization per FFS beneficiary increased by approximately 26 percent. Even when examining the more recent period from CY 2021 through CY 2025, total utilization increased by approximately 9 percent and utilization per FFS beneficiary increased by approximately 20 percent. We therefore do not believe that our conclusion depends on the selection of CY 2016 as the baseline year.

We also considered commenters' concerns regarding the 70 HCPCS codes examined in the proposed rule. We acknowledge that these codes represented a smaller proportion of imaging without contrast services in the earlier years of our analysis than in more recent years.

Specifically, these 70 HCPCS codes represented approximately 75 percent of imaging without contrast volume in excepted off-campus PBDs in CYs 2016 and 2017, compared with approximately 94 percent in CY 2018 and more than 95 percent in CY 2025. We therefore also examined historical utilization using the full set of HCPCS codes identified as imaging without contrast services based on CY 2025 claims data, rather than limiting our analysis to the 70 high-volume HCPCS codes discussed in the proposed rule.

Our analysis of historical utilization for this full set of imaging without contrast HCPCS codes continues to demonstrate growth in utilization in excepted off-campus PBDs. Total volume increased from approximately 2.79 million claims in CY 2016 to approximately 3.03 million claims in CY 2025, an increase of approximately 9 percent. Moreover, after accounting for changes in Medicare FFS enrollment, utilization per FFS beneficiary increased by approximately 31 percent over this period. We therefore do not believe that our conclusion depends on limiting our analysis to the 70 HCPCS codes discussed in the proposed rule.

We also do not believe that it would be appropriate to examine only data from more recent years. In our CY 2027 OPPS/ASC proposed rule analysis, we started our claims review in CY 2016 to examine what volume looked like during and following the period of consolidation and growth of excepted PBDs and in subsequent years. Rather than a reason to exclude these data, we believe fully understanding how the growth of excepted off-campus PBDs affected the volume of imaging without contrast services is important in examining unnecessary increases in the volume of outpatient services.

Looking only at data from more recent years removes the context for the changes that occurred in the OPPS over the longer historical period. Even if utilization for a particular service has leveled off in recent years, that does not mean that earlier unnecessary increases in volume are no longer reflected in current utilization. If utilization increased unnecessarily in earlier years and subsequently remained at that higher level, examining only the more recent period would include that earlier increase into the baseline and could obscure the extent of the historical

growth. Accordingly, we believe it is appropriate to consider utilization over a longer period when evaluating whether there have been unnecessary increases in the volume of covered OPD services.

We also acknowledge commenters' requests for additional information regarding the data and methodology underlying our analysis. In the CY 2027 OPPS/ASC proposed rule, we described the data, time period, settings of care, and HCPCS codes used in our analysis and presented the utilization trends on which our proposal was based. We believe the information provided in the proposed rule was sufficient to allow interested parties to obtain the raw data and conduct analyses intended to replicate or test our analysis. Several commenters submitted their own analyses of utilization trends using Medicare claims data and the parameters described in the proposed rule, including analyses using alternative sets of HCPCS codes, baseline years, and settings of care. These analyses allowed commenters to identify specific methodological concerns and alternative interpretations of the data, which we have considered and addressed in this final rule with comment period.

Based on our review of the proposed-rule data and these additional analyses, we continue to believe that imaging without contrast services have experienced unnecessary increases in the volume of covered OPD services and that it is appropriate to apply our volume control method to these services.

Comment: Several commenters stated that CMS's analysis does not support applying the volume control method to all HCPCS codes assigned to the four imaging without contrast APCs. Commenters noted that the proposed policy would apply to more than 300 HCPCS codes, while CMS's proposed rule utilization analysis focused on 70 high-volume codes. Commenters stated that the remaining codes encompass a broad range of imaging modalities and clinical circumstances and stated that CMS should identify unnecessary increases in volume at the individual HCPCS code level before applying the volume control method to a service.

Commenters further stated that some HCPCS codes subject to the proposed policy had

little or no utilization in excepted off-campus PBDs during the period examined by CMS. Commenters stated that CMS cannot control an unnecessary increase in volume for a service for which there has been no utilization or no demonstrated increase in utilization. Commenters similarly identified services with little or no utilization in freestanding physician offices and stated that these services do not support CMS's premise that the affected services are being shifted from freestanding physician offices to OPDs because of payment incentives. Commenters therefore recommended that CMS limit the policy to individual services for which the agency has demonstrated unnecessary increases in OPD volume and meaningful utilization in lower-cost settings.

Response: We thank the commenters for their input. We disagree that we must demonstrate an unnecessary increase in volume independently for every individual HCPCS code assigned to the imaging without contrast APCs before applying our volume control method at the APC level. As we explained in the CY 2026 OPPS/ASC final rule with comment period in response to similar comments regarding drug administration services (90 FR 53815), we have evaluated unnecessary utilization at the APC level and intentionally chosen to apply the volume control method at the APC level rather than at the individual service level.

We continue to believe this approach is consistent with the structure of the OPPS established under section 1833(t) of the Act. Section 1833(t)(2)(A) of the Act requires the Secretary to develop a classification system for covered OPD services, and section 1833(t)(2)(B) of the Act provides for the establishment of groups of covered OPD services within that classification system so that the services within each group are comparable clinically and with respect to the use of resources. Consistent with these provisions, we group services under the OPPS into APCs and generally establish payment at the APC level. We therefore believe it is appropriate to evaluate unnecessary increases in volume and apply our volume control method to groups of clinically and resource-similar services at the APC level rather than requiring each individual HCPCS code within an APC to independently demonstrate the same utilization

pattern.

In the CY 2027 OPPS/ASC proposed rule, we examined the 70 most frequently billed HCPCS codes for imaging without contrast services, which accounted for more than 95 percent of imaging without contrast volume furnished in excepted off-campus PBDs in CY 2025. As discussed previously, in response to comments regarding our use of these 70 HCPCS codes, we conducted an additional analysis of historical utilization using the full set of imaging without contrast HCPCS codes identified based on CY 2025 claims data. That additional analysis does not change our conclusion that imaging without contrast services have experienced unnecessary increases in volume.

We acknowledge that some individual HCPCS codes assigned to these APCs have little or no utilization in excepted off-campus PBDs or freestanding physician offices. However, as we explained in the CY 2026 OPPS/ASC final rule with comment period (90 FR 53815), the fact that some less frequently used codes within an APC are rarely utilized in either setting does not detract from the larger finding of unnecessary increases in volume for the services in the APCs as a whole. A code with no utilization in an excepted off-campus PBD also contributes no volume to the utilization trends on which our APC-level finding is based.

Consistent with our approach to the drug administration APC family, we believe applying the methodology to the imaging without contrast APCs is a practical and appropriate way to control unnecessary increases in the volume of this family of services. Accordingly, the fact that some less frequently used codes within these APCs are rarely utilized in either the OPD or freestanding physician office setting does not detract from our APC-level finding or our conclusion that application of the volume control method to the imaging without contrast APCs is appropriate.

Comment: Several commenters stated that the utilization trends for individual imaging without contrast services do not consistently support CMS's conclusion that payment differences are causing services to shift from physician offices to excepted off-campus PBDs. Commenters

identified services for which utilization increased in both settings, remained stable in physician offices, or increased more rapidly in freestanding physician offices than in excepted off-campus PBDs. Commenters stated that these varying trends undermine the conclusion that a common payment incentive is responsible for increased utilization across imaging without contrast services.

Commenters also stated that observed increases in excepted off-campus PBD utilization may reflect factors other than shifts from freestanding physician offices attributable to payment incentives. Commenters cited shifts from inpatient to outpatient care, changes in clinical practice and screening recommendations, advances in imaging technology, changes in disease prevalence and beneficiary demographics, physician referral patterns, hospital investments in imaging capacity, and closures or acquisitions of independent imaging facilities as potential explanations for changes in utilization.

Several commenters also questioned CMS's reliance on increases in utilization per Medicare FFS beneficiary. Commenters stated that increased enrollment in Medicare Advantage may have changed the composition of the remaining FFS population, potentially leaving a population that is older or more clinically complex and requires more imaging services. Commenters stated that accounting for changes in the composition of the FFS population would reduce the measured increase in per-beneficiary utilization and recommended that CMS account for beneficiary case mix when evaluating utilization trends. Commenters also requested that CMS disclose whether its per-beneficiary analysis adjusts for changes in the composition of the Medicare FFS population, including changes associated with increasing enrollment in Medicare Advantage.

Response: We thank the commenters for their input. We acknowledge that utilization patterns vary across individual imaging without contrast services and that not every service demonstrates the same pattern of utilization across settings. However, we do not believe that an increase in utilization in the freestanding physician office setting, including an increase that

occurs at the same time as growth in excepted off-campus PBDs, demonstrates that there is no unnecessary utilization in the excepted PBD setting. As we explained in the CY 2026 OPPS/ASC final rule with comment period (90 FR 53814), taking individual utilization trends out of their full historical context does not provide an accurate gauge of the actual growth of services in excepted PBDs.

We also reviewed the specific utilization trends identified by commenters. Our review continues to show substantial increases in the volume of several high-volume imaging without contrast services furnished in excepted off-campus PBDs. For example, between CY 2016 and CY 2025, utilization in excepted off-campus PBDs increased by approximately 72 percent for HCPCS code 71250, 56 percent for HCPCS code 77080, 52 percent for HCPCS code 76641, 48 percent for HCPCS code 76536, and 41 percent for HCPCS code 70551. These increases occurred notwithstanding differing utilization trends for these services in freestanding physician offices. We therefore do not believe that differing utilization patterns for individual services demonstrate that payment differences are not a substantial cause of unnecessary increases in volume across the imaging without contrast APCs.

We also do not believe that the existence of other factors that may contribute to increased utilization, such as changes in clinical practice, screening recommendations, technology, beneficiary characteristics, referral patterns, or the availability of imaging capacity, demonstrates that the payment differential between the OPPS and PFS does not constitute a substantial cause of unnecessary increases in OPD volume. Our determination does not depend on a finding that payment differences are the sole cause of increased utilization. Rather, as we have explained in prior rulemaking, we consider shifts in the site of service unnecessary if the beneficiary can safely receive the same service in a lower-cost setting but instead receives care in a higher-cost setting due to the payment incentives created by the difference in payment amounts.

We specifically considered commenters' assertion that increases in utilization in excepted off-campus PBDs may reflect shifts from the inpatient to outpatient setting. We agree that shifts

from inpatient to outpatient care may partially explain changes in utilization for particular services. However, this does not explain why services that can appropriately migrate from the inpatient setting are furnished in excepted off-campus PBDs rather than in freestanding physician offices or other lower-cost ambulatory settings. A decline in inpatient utilization accompanied by an increase in outpatient utilization demonstrates that the site of care has changed, but it does not establish what the distribution of that outpatient volume would have been absent the payment differential between the OPPS and PFS.

Once a service can safely be furnished outside of the inpatient setting, the payment differential between outpatient settings remains relevant. To the extent the same service can safely be furnished in a freestanding physician office or other lower-cost setting, the higher payment available in an excepted off-campus PBD creates a significant incentive for some portion of that volume to remain in or shift to the higher-paid OPD setting. Commenters did not demonstrate how much of the observed increase in excepted off-campus PBD utilization would have occurred absent that payment differential. Accordingly, evidence of an inpatient-to-outpatient shift does not demonstrate that the resulting increase in excepted off-campus PBD volume is necessary or that payment incentives do not contribute to the setting in which those services are ultimately furnished.

We also considered commenters' concerns regarding changes in the composition of the Medicare FFS population. We clarify that our per-beneficiary utilization analysis accounts for changes in the number of Medicare FFS beneficiaries by dividing utilization by Medicare Part B FFS enrollment for the applicable year. The analysis does not adjust for changes in the demographic characteristics, health status, or clinical risk of the FFS beneficiary population over time. We do not believe that such an adjustment is necessary or appropriate for purposes of this analysis. The purpose of examining utilization per FFS beneficiary is to determine whether changes in aggregate utilization can be explained by changes in the size of the FFS population, rather than to estimate the amount of imaging that would be clinically necessary for a particular

beneficiary population. Developing a case-mix adjustment for this purpose would require determining which beneficiary characteristics should be expected to affect utilization of the broad range of imaging services included in these APCs and the extent to which those characteristics should affect expected utilization. We do not believe commenters provided a sufficiently supported methodology for making such an adjustment. Moreover, even if such an adjustment could estimate the portion of increased imaging utilization attributable to changes in beneficiary characteristics, it would not establish the setting in which those medically necessary services needed to be furnished.

Moreover, even if changes in the composition of the FFS population explain some portion of the increase in imaging services per beneficiary, that would not demonstrate that the resulting increase in services furnished in excepted off-campus PBDs is necessary. Beneficiaries with greater clinical needs may appropriately require more imaging services, but that does not mean those services must be furnished in the higher-paid OPD setting. As discussed previously, our concern is not whether the underlying imaging service is medically necessary. Rather, we consider increases in covered OPD services unnecessary when a beneficiary can safely receive the same medically necessary service in a lower-cost setting but instead receives it in the higher-paid OPD setting due to payment incentives. Our policy does not prevent a physician from determining that an OPD is the appropriate setting for a particular beneficiary based on the beneficiary's clinical needs.

Based on our review of the proposed-rule data, our additional analyses, and the information provided by commenters, we continue to believe that the payment differential between the OPPS and PFS is a significant driver of unnecessary increases in the volume of imaging without contrast services furnished in excepted off-campus PBDs. The fact that individual services may exhibit different utilization patterns, or that factors other than payment may also affect utilization, does not change our conclusion.

Comment: Several commenters stated that utilization trends in non-excepted off-campus

PBDs undermine CMS's conclusion that the payment differential between the OPPS and PFS contributes to unnecessary increases in the volume of imaging without contrast services. Commenters noted that non-excepted off-campus PBDs already receive the PFS-equivalent payment rate and stated that utilization of imaging without contrast services in these departments has nevertheless increased substantially, in some cases more rapidly than in excepted off-campus PBDs. Commenters stated that this growth suggests that eliminating the payment differential may reduce Medicare expenditures without affecting where services are furnished.

Commenters also stated that CMS had not established an appropriate counterfactual for determining what utilization would have been in the absence of the OPPS payment differential. Commenters stated that growth in non-excepted off-campus PBD utilization may reflect factors such as growth in the number of these departments, hospital consolidation and referral patterns, beneficiary case mix, geography, and changes in the availability of independent imaging facilities.

Conversely, other commenters cited an analysis of Maryland, where hospitals operate under a global budget model, showing that the share of imaging without contrast services furnished in OPDs declined relative to the rest of the country. Commenters stated that this comparison provides evidence that payment incentives may influence the setting in which imaging services are furnished.

Response: We thank the commenters for their input. We disagree that growth in imaging without contrast services furnished in non-excepted off-campus PBDs demonstrates that the OPPS/PFS payment differential does not contribute to unnecessary increases in volume. Under section 603 of the BBA of 2015, new off-campus PBDs generally enter the Medicare program as non-excepted departments. Accordingly, growth in aggregate utilization in non-excepted off-campus PBDs reflects, at least in part, growth in the number of departments subject to that payment methodology and does not provide a direct comparison of how excepted and non-excepted PBDs respond to different payment rates.

We also cannot observe what utilization in non-excepted off-campus PBDs would have been had those departments instead received the higher OPPS payment. The fact that utilization increased under the PFS-equivalent payment methodology therefore does not establish that utilization would not have been greater in the absence of that methodology. More fundamentally, our concern is not that imaging utilization should never increase under PFS-equivalent payment. Rather, our concern is whether the higher payment available under the OPPS creates an additional incentive for services that can safely be furnished in a lower-cost setting to instead be furnished in the higher-paid OPD setting.

We also note that non-excepted off-campus PBDs continue to furnish substantial volumes of imaging without contrast services while receiving the PFS-equivalent payment rate. We believe the continued furnishing of these services at significant volume demonstrates that imaging without contrast services can be furnished in an off-campus hospital setting under the PFS-equivalent payment methodology.

We also considered the analysis submitted by commenters comparing utilization in Maryland, where hospitals operate under a global budget model, with the rest of the country. The analysis found that from CY 2017 through CY 2024, the regression-adjusted share of imaging without contrast services furnished in OPDs declined from approximately 32 percent to 24 percent in Maryland, while remaining approximately 50 percent outside Maryland.[163]

We recognize that Maryland's payment system differs from those applicable in other States and that this comparison does not establish what utilization in excepted off-campus PBDs would have been absent the OPPS/PFS payment differential. Nevertheless, because Maryland's global budget model creates different incentives regarding the volume of hospital outpatient services, we believe the differing utilization patterns provide additional evidence consistent with our conclusion that payment incentives can affect site of service.

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[163] *https://assets.arnoldventures.org/uploads/PDFs/Site-Neutrality-Impact-of-Payment-Differentials-and-Updated-Savings-Estimates.pdf.*

For these reasons, we continue to believe that growth in non-excepted off-campus PBD utilization does not undermine our conclusion that the OPPS/PFS payment differential is a substantial cause of unnecessary increases in the volume of imaging without contrast services furnished in excepted off-campus PBDs.

Comment: A few commenters stated that CMS cannot determine that there have been unnecessary increases in the volume of imaging without contrast services without first identifying a necessary level or rate of growth. Commenters stated that CMS has not established what level of utilization would be considered necessary and therefore has no basis for determining what portion of the observed growth is unnecessary. Some commenters recommended that CMS establish a benchmark for expected utilization and monitor volume against that benchmark before applying a payment reduction.

Some commenters also stated that CMS appears to conflate unnecessary increases in the volume of covered OPD services with medically unnecessary imaging. Commenters stated that the fact that an imaging service could potentially be furnished in a lower-cost setting does not establish that the underlying service was medically unnecessary or clinically inappropriate.

Commenters also recommended that CMS consider other methods for addressing unnecessary or inappropriate imaging utilization, including medical-necessity requirements, claims review, prior authorization or other utilization management policies, clinical practice guidelines, and appropriate use criteria. Some commenters specifically recommended that CMS reconsider or modernize the Medicare Appropriate Use Criteria program for advanced diagnostic imaging as an alternative to the proposed payment policy.

Response: We disagree that section 1833(t)(2)(F) of the Act requires us to establish a specific level or rate of necessary volume growth before determining that there have been unnecessary increases in the volume of covered OPD services. As we explained in the CY 2026 OPPS/ASC final rule with comment period (90 FR 53815), because site-of-service payment differentials affect utilization throughout the OPPS, it would be extremely difficult to determine,

at the HCPCS or APC level, the precise amount of volume that would have occurred absent that influence. We do not believe that establishing a retrospective benchmark would materially improve our ability to identify unnecessary increases in volume and, as discussed in prior rulemaking, such an approach could raise concerns similar to those associated with prior benchmark-based volume control methodologies.

We also clarify that our use of the term "unnecessary" does not mean that the underlying imaging service was medically unnecessary for the beneficiary. Our concern under section 1833(t)(2)(F) of the Act is with unnecessary increases in the volume of covered OPD services. As we have explained in prior rulemaking, we consider a shift in site of service unnecessary when a beneficiary can safely receive the same medically necessary service in a lower-cost setting but instead receives it in the higher-paid OPD setting because of the payment incentive created by the difference in payment amounts. Accordingly, determining whether an individual imaging service satisfies Medicare medical-necessity requirements would not resolve the site-of-service issue addressed by this policy.

We appreciate commenters' recommendations regarding other approaches to addressing unnecessary utilization, including medical-necessity review, prior authorization, utilization management, clinical practice guidelines, and appropriate use criteria. As discussed in the CY 2026 OPPS/ASC final rule with comment period (90 FR 53825), we previously solicited public comment on other methods that may be warranted to control unnecessary increases in the volume of outpatient services besides changes to payment rates, including prior authorization and other utilization management policies. We continue to appreciate interested parties' input regarding these alternative approaches and may consider these recommendations in future rulemaking.

For purposes of the policy finalized in this rule, however, we continue to believe that applying the PFS-equivalent payment rate to imaging without contrast services furnished in excepted off-campus PBDs is an appropriate method to address the site-of-service payment differential that is a substantial cause of unnecessary increases in the volume of covered OPD

services. We will continue to monitor the effects of this policy on utilization, as we have done for our clinic visit and drug administration volume control policies.

Comment: Commenters reiterated concerns raised in response to prior rulemaking that OPDs are more likely to serve Medicare patients who are sicker, more clinically complex, and more likely to be disabled or living in poorer, rural communities than patients treated in independent physician offices. In support of these concerns, commenters again cited studies prepared for the American Hospital Association that were also cited in comments on the CY 2026 OPPS/ASC proposed rule and discussed in the CY 2026 OPPS/ASC final rule with comment period (90 FR 53819 through 53820).

Commenters again cited a study finding that, compared to beneficiaries treated in independent physician offices, beneficiaries receiving care in OPDs were more likely to be:

- Under age 65 and disabled,
- Reside in a rural county,
- Be dually eligible for Medicare and Medicaid,
- Have serious chronic conditions, and
- Have recently used hospital care, including emergency department and inpatient hospital services.

Commenters also again cited a related study comparing beneficiaries with cancer treated in OPDs to beneficiaries with cancer treated in freestanding physician offices, which similarly found that beneficiaries receiving cancer care in OPDs were more likely to be disabled, reside in rural areas, be dually eligible, have multiple serious chronic conditions, and have recently used emergency department or inpatient hospital services. We discussed these same studies and commenters' concerns regarding differences in the patient populations served by OPDs and physician offices in the CY 2026 OPPS/ASC final rule with comment period (90 FR 53819 through 53820).

Commenters also provided additional analyses specific to the imaging without contrast

services included in the CY 2027 proposal. One commenter stated that, based on 2025 Medicare claims data, beneficiaries receiving imaging without contrast services in OPDs were 51 percent more likely than beneficiaries receiving the same services in independent physician offices to be dually eligible for Medicare and Medicaid, 64 percent more likely to be disabled, and 58 percent more likely to have end-stage renal disease. The commenter also stated that OPD beneficiaries receiving these services had greater clinical complexity, including being 50 percent more likely to have five or more complications or comorbidities and 92 percent more likely to have five or more major complications or comorbidities.

Commenters further stated that imaging without contrast services furnished in OPDs may be part of broader, coordinated episodes of care, including pre-operative evaluation, treatment planning, serial imaging for patients receiving complex therapies or cancer treatment, and multispecialty care. Commenters stated that OPDs may provide additional staff, specialized equipment, emergency response capabilities, and immediate access to laboratory, advanced imaging, surgical, and other services that may be important for medically complex beneficiaries. Commenters also noted that physicians may refer higher-risk patients to OPDs because those settings can more readily manage complications or escalation of care.

Commenters noted that these differences demonstrate that OPDs and physician offices are not interchangeable for all beneficiaries and that higher-acuity patients may require additional time, staffing, coordination, and hospital-level resources. Commenters therefore stated that reducing payment for imaging without contrast services in OPDs could adversely affect access to care for medically complex beneficiaries.

Response: We appreciate commenters reiterating their concerns regarding differences in the patient populations served by OPDs and freestanding physician offices and providing additional information specific to imaging without contrast services. As we explained in response to similar comments in the CY 2026 OPPS/ASC final rule with comment period (90 FR 53820), we appreciate that OPDs serve unique patient populations and provide services to

medically complex beneficiaries. However, the data provided by commenters do not demonstrate how these factors necessitate a higher payment for all imaging without contrast services provided in OPDs. While commenters indicate that these patients are more frequently treated in OPDs and, in some cases, may require additional coordination or support, they do not show that OPDs alone are clinically capable of furnishing imaging without contrast services to medically complex patients or that freestanding physician offices and other lower-cost ambulatory settings would be unequipped to safely furnish these same services when clinically appropriate.

As we stated in the CY 2019 OPPS/ASC final rule with comment period (90 FR 53820), we continue to believe shifts in the sites of service described in the preceding paragraphs are inherently unnecessary if the beneficiary can safely receive the same services in a lower-cost setting but instead receives care in a higher-cost setting due to the payment incentives created by the difference in payment amounts. Our policy does not prevent a physician from determining that an OPD is the appropriate setting for a particular beneficiary based on the beneficiary's clinical needs.

Further, the OPPS contains mechanisms to increase payment to providers for complex care. Hospitals can receive outlier payments to help hospitals mitigate financial risks associated with complex and costly procedures that exceed the normal payment amount. We also use complexity adjustments to provide increased payment for certain comprehensive services.

Comment: Some commenters stated that the proposed policy does not appropriately account for the role of physicians in determining whether an imaging service is medically necessary and the appropriate site of service. Commenters stated that physicians, rather than hospitals or outpatient departments, generally order imaging services and that hospitals therefore have limited ability to control the volume of imaging services furnished in their outpatient departments. Commenters stated that reducing payment to the hospital may penalize the facility for utilization that is largely driven by physician clinical judgment.

Commenters further stated that physicians may determine that an OPD is the appropriate site of service for particular beneficiaries based on clinical complexity, comorbidities, availability of specialized equipment or personnel, or the potential need for other hospital resources. Commenters expressed concern that the proposed policy could interfere with or create incentives inconsistent with physicians' clinical judgment regarding the most appropriate setting for their patients.

Response: We thank the commenters for their input. We agree that physicians should determine whether an imaging service is medically necessary and should consider the medical needs of the beneficiary when determining the appropriate setting in which that service should be furnished. We believe that payment should have no influence on what setting of care a physician decides is most appropriate for their patient. Our policy does not limit a physician's ability to order a medically necessary imaging service or prevent a beneficiary from receiving that service in an OPD when that setting is clinically appropriate.

We also disagree that the role of physicians in ordering imaging services makes application of the volume control method to excepted off-campus PBDs inappropriate. Our concern is not with the physician's decision regarding whether a beneficiary requires a particular imaging service. Rather, our concern is with the financial incentives that may affect the setting in which that service is ultimately furnished. The fact that a physician determines that an imaging service is medically necessary does not establish that the service must be furnished in an excepted off-campus PBD or that the higher OPPS payment rate is necessary for that service.

We also do not believe that application of the volume control method depends on an individual hospital having direct control over a physician's decision to order a particular imaging service. The method is intended to address the broader payment structure that creates a systemic financial incentive for services that can safely be furnished in lower-cost ambulatory settings to be furnished in the higher-paid OPD setting and that we believe is a significant driver of unnecessary increases in covered OPD services over time. By aligning payment for the affected

services furnished in excepted off-campus PBDs with the PFS-equivalent payment methodology applicable to non-excepted off-campus PBDs, we are addressing the underlying payment differential that contributes to these site-of-service incentives rather than seeking to influence individual physicians' clinical ordering decisions.

As discussed previously, imaging without contrast services are routinely furnished in freestanding physician offices and non-excepted off-campus PBDs. Where a beneficiary can safely receive the same medically necessary service in a lower-cost setting but instead receives the service in a higher-paid OPD setting because of payment incentives, we consider the resulting increase in covered OPD services unnecessary for purposes of section 1833(t)(2)(F) of the Act. Applying the PFS-equivalent payment rate removes the payment differential while leaving physicians free to determine, based on the beneficiary's clinical needs, whether the hospital outpatient setting is appropriate.

Comment: Several commenters noted that CMS failed to adequately consider other explanations for increases in the volume of imaging without contrast services furnished in hospital outpatient departments. Commenters disagreed that higher OPPS payments are necessarily responsible for hospital acquisitions of physician practices and independent imaging facilities or resulting increases in OPD utilization. Commenters stated that correlation between payment differentials, consolidation, and increased OPD utilization does not establish that the payment differential caused the observed increase.

Similar to comments received in response to the CY 2026 OPPS/ASC proposed rule, commenters stated that physician practices may seek acquisition by or affiliation with hospitals because of financial and operational pressures unrelated to OPPS payment rates. Commenters cited increasing practice expenses, regulatory and administrative burden, workforce shortages, physician burnout, payer mix, and declines in Medicare physician payment as factors contributing to physicians leaving independent practice. Commenters also stated that entities other than hospitals, including commercial insurers and private equity firms, have acquired

physician practices and stated that broader consolidation trends cannot be attributed solely to Medicare site-of-service payment differences.

Commenters also identified other factors that may affect imaging utilization and site-of-service patterns, including changes in clinical practice and technology, beneficiary needs, physician referral patterns, hospital investment in imaging capacity, and changes in the availability of independent imaging facilities. Commenters recommended that CMS account for these factors before concluding that payment differences contribute to unnecessary increases in OPD volume.

Response: We thank the commenters for their input. As discussed earlier in this section, we recognize that multiple factors may affect changes in imaging utilization and the settings in which imaging services are furnished. However, the existence of other factors that may contribute to consolidation or changes in utilization does not mean that the substantial difference between OPPS and PFS payment rates does not also create an incentive to furnish services in the higher-paid setting.

As we explained in response to similar comments in the CY 2026 OPPS/ASC final rule with comment period (90 FR 53819), hospitals did, in large quantities, acquire physician practices and convert them into PBDs, and a financial incentive to make these conversions existed. While physician practices may also be acquired by private equity firms, commercial insurers, or other entities, only acquisition by a hospital can result in services that were previously paid under the PFS being paid at the higher OPPS rate as a result of conversion to a provider-based department. We therefore do not believe that evidence of other causes of physician-practice consolidation eliminates the Medicare payment incentive created by the difference between OPPS and PFS payment rates.

We also acknowledge commenters' concerns regarding financial and operational pressures faced by freestanding physician practices that may encourage association with hospitals and a shift to OPD settings. However, as we stated in the CY 2026 OPPS/ASC final

rule with comment period (90 FR 53819), the OPPS was intended to pay for services provided in the hospital outpatient setting; it has no mandate to subsidize care or the cost of providing that care as a result of broader economic forces or the perceived inadequacy of other forms of payment. To the extent that commenters may believe payment under the PFS is inadequate, as discussed elsewhere in this section, such concerns do not provide a basis for maintaining a higher OPPS payment for services that can safely be furnished in lower-cost settings.

We similarly recognize that changes in clinical practice, technology, beneficiary needs, referral patterns, and the availability of imaging capacity may affect utilization of particular imaging services. However, our determination does not depend on a finding that the OPPS/PFS payment differential is the sole cause of changes in imaging utilization or consolidation. As discussed previously, our additional analyses continue to demonstrate increases in imaging without contrast services furnished in excepted off-campus PBDs, including increases in utilization per FFS beneficiary, and we have considered commenters' specific concerns regarding the timeframe of our analysis, coding changes, individual service trends, changes in the FFS population, inpatient-to-outpatient migration, utilization in non-excepted PBDs, and available counterfactual evidence.

After considering these alternative explanations, we continue to believe that the substantial payment differential between the OPPS and PFS creates a significant financial incentive to furnish imaging without contrast services in the higher-paid OPD setting and is a significant factor contributing to unnecessary increases in the volume of these services furnished in excepted off-campus PBDs. Even if multiple factors affect where imaging services are furnished, we continue to believe that payment should have no influence on what setting of care is selected when a beneficiary can safely receive the same service in a lower-cost setting. Our policy removes the payment incentive that we believe is a substantial cause of unnecessary increases in covered OPD services while preserving the ability of physicians and beneficiaries to use the hospital outpatient setting when clinically appropriate.

Comment: Some commenters raised concerns regarding the direct comparison between OPPS and PFS payment rates for imaging without contrast services. Commenters stated that the OPPS and PFS reflect fundamentally different approaches to valuing and paying for services and stated that there is no basis for substituting payment rates developed under one payment system for rates under the other. Similar to comments received in response to the CY 2026 OPPS/ASC proposed rule, commenters stated that hospital outpatient departments incur costs and maintain capabilities that are not reflected in physician office payment rates, including regulatory and accreditation requirements, staffing and equipment, emergency and standby capacity, and other hospital infrastructure. Commenters stated that these differences make direct comparisons between OPPS and PFS payment rates inappropriate.

Commenters also stated that imaging services furnished in OPDs may require resources that differ from those reflected in PFS payment rates. Commenters cited differences in equipment acquisition and maintenance costs, staffing, quality and safety requirements, and the resources necessary to serve medically complex patients. Commenters stated that OPDs may maintain imaging capacity and specialized staff that allow them to furnish services to higher-acuity patients and respond to complications or other clinical needs. Commenters stated that these additional costs are not adequately reflected in PFS payment rates and that reducing OPPS payment based on PFS rates could adversely affect hospitals' ability to maintain imaging capacity and beneficiary access to care.

Other commenters questioned whether PFS payment rates themselves provide an appropriate benchmark for determining payment under the OPPS. Commenters stated that physician practices have experienced increasing practice expenses and reductions in inflation-adjusted Medicare payment and expressed concern that aligning hospital payment with PFS rates could extend payment inadequacies in the PFS to the hospital outpatient setting. Commenters also cited negative Medicare hospital margins and stated that further reductions in OPPS payment would exacerbate hospitals' existing financial pressures and could impair their ability to

support emergency, standby, and other hospital capabilities. Some commenters stated that site-neutral payment should account for the actual resources required to furnish services across ambulatory settings rather than simply reduce payment to the amount paid in the lowest-cost setting.

Response: We appreciate the commenters' concerns regarding comparisons between OPPS and PFS payment rates. As we stated in the CY 2026 OPPS/ASC final rule with comment period (90 FR 53817), to the extent that similar services can be safely provided in more than one setting, we do not believe it is prudent for the Medicare program to pay more for these services in one setting than another. We believe that differences in payment for the same or similar services can create a payment incentive to provide those services in the higher-cost setting. Because these services can be safely provided in a lower-cost setting, we believe that growth in services paid under the OPPS that results from this payment incentive is unnecessary. Further, we believe that setting OPPS payment at a PFS-equivalent rate is an effective method to control the unnecessary increase in the volume of these services because the payment differential that is driving the site-of-service decision would be removed.

As discussed in the CY 2027 OPPS/ASC proposed rule (91 FR 41912), we also compared OPPS and PFS payment rates using PFS payment rates for the most frequently billed imaging without contrast HCPCS codes furnished by excepted off-campus PBDs and volume-weighted those rates to create a PFS proxy average APC payment rate for imaging without contrast services. Using this approach, we found that, on average, OPPS payment rates for imaging without contrast services furnished in excepted off-campus PBDs were approximately 2.5 times higher than PFS payment rates, while payment rates for these services furnished in non-excepted off-campus PBDs were closely aligned with PFS payment rates. At the APC level, PFS payments ranged from approximately 31 percent to 54 percent of OPPS payments. We believe these findings demonstrate a substantial payment differential between the OPPS and PFS for the imaging without contrast services subject to this policy.

We observed a similar pattern for beneficiary cost sharing. Average beneficiary cost sharing for imaging without contrast services furnished in excepted off-campus PBDs was more than twice the amount for these services when furnished in freestanding physician offices, while beneficiary cost sharing for services furnished in non-excepted off-campus PBDs was closely aligned with beneficiary cost sharing in freestanding physician offices. These differences further support our concern that the payment differential not only creates an incentive to furnish services in the higher-paid setting but also results in higher costs for Medicare beneficiaries.

We appreciate that some hospital outpatient departments may incur costs that physician offices do not. We note that applying the PFS-equivalent payment methodology to these services does not eliminate payment to the hospital for furnishing the service. The hospital continues to receive payment for the facility component of the service under the applicable PFS-equivalent methodology, while the physician or other practitioner may receive separate payment under the PFS for the professional services furnished. Thus, the payment methodology continues to recognize a facility payment for services furnished in the off-campus PBD, although at a lower amount than would otherwise be paid under the OPPS. However, the issue we are addressing here is whether the difference between OPPS payment rates and PFS payment rates for imaging without contrast services distorts the market and incentivizes providers to shift volume to the higher-paying setting unnecessarily. The aspects of the OPD setting identified by commenters, including staffing and equipment, licensing and accreditation requirements, emergency and standby capacity, and the resources associated with caring for medically complex patients, do not change the fact that a specific imaging without contrast service provided in an off-campus provider-based department of a hospital is clinically similar to the provision of that same imaging service when provided in a freestanding physician office. We believe that imaging without contrast services included in this policy can generally be safely performed in the freestanding physician office setting and note that freestanding physician offices also incur costs to adhere to regulatory and safety standards and ensure that they are appropriately equipped to

provide these services. While some hospital outpatient departments may have additional costs that freestanding physician offices do not, hospitals may also have efficiencies that freestanding physician offices do not, such as greater purchasing power, that may offset some of the additional costs identified by commenters. This is consistent with our response to similar comments regarding drug administration services in the CY 2026 OPPS/ASC final rule with comment period (90 FR 53819).

We also acknowledge commenters' concerns regarding the adequacy of payment rates under the PFS. As we stated in the CY 2026 OPPS/ASC final rule with comment period (90 FR 53817), the overall amount of Medicare payments to physicians and other entities made under the PFS is determined by the PFS statute, and the rates for individual services are determined based on the resources involved in furnishing these services relative to other services paid under the PFS. To the extent commenters believe that the PFS rate for a particular service is misvalued relative to other PFS services, commenters may nominate the service for review as a potentially misvalued service under the PFS.

We similarly do not believe that commenters' concerns regarding overall Medicare hospital margins demonstrate that the higher OPPS payment rate must be maintained for the imaging without contrast services subject to this policy. As discussed in the CY 2026 OPPS/ASC final rule with comment period (90 FR 53819), the OPPS was intended to pay for services provided in the hospital outpatient setting; it has no mandate to subsidize care or the cost of providing that care as a result of broader economic forces or the perceived inadequacy of other forms of payment. Our volume control method addresses the payment incentive associated with the particular services subject to the policy rather than the overall financial condition of an individual hospital or the adequacy of Medicare payment across all hospital services.

We therefore continue to believe that applying the PFS-equivalent payment methodology to imaging without contrast services furnished in excepted off-campus PBDs is appropriate. Doing so directly addresses the payment differential that we believe is a significant driver of

unnecessary increases in OPD volume while preserving physicians' ability to determine the clinically appropriate setting for each beneficiary.

Comment: Some commenters raised concerns related to the use of the 40-percent PFS relativity adjuster for the proposed volume control method. Commenters stated that the relativity adjuster does not necessarily produce the payment amount that would otherwise apply under the PFS for individual imaging services. Commenters presented analyses comparing 40 percent of the applicable OPPS payment amount with the PFS technical component payment and stated that, for some imaging services, application of the 40-percent relativity adjuster would result in payment below the applicable PFS technical component amount, while for other services it would result in payment above the PFS technical component amount. Commenters stated that these differences demonstrate that the 40-percent factor does not consistently approximate PFS payment for imaging without contrast services.

Commenters also raised concerns regarding application of the relativity adjuster to imaging services paid through the multiple imaging composite APCs. Commenters stated that the composite APC methodology already reflects payment for multiple imaging services furnished during the same encounter and stated that applying the 40-percent relativity adjuster to the composite APC payment could result in an additional or duplicative payment reduction. Commenters also stated that comparisons between OPPS and PFS payment amounts should account for differences in packaging and other payment policies between the two systems.

Some commenters further stated that certain imaging services under the PFS are subject to the imaging payment cap established by the Deficit Reduction Act of 2005 (DRA) and codified at section 1848(b)(4) of the Act. Commenters stated that the DRA imaging payment cap may contribute to differences between the applicable PFS technical component payment and the payment produced by applying the 40-percent PFS relativity adjuster and recommended that CMS account for these differences when establishing payment for imaging without contrast services under the volume control method.

Several commenters recommended that CMS modify the methodology so that payment would be no less than the applicable PFS technical component amount. Commenters suggested, for example, that CMS pay the greater of 40 percent of the OPPS payment amount or the applicable PFS technical component payment. Commenters stated that such a floor would ensure that hospitals are not paid less for an imaging service than would be paid for the technical component of the same service under the PFS.

Response: We appreciate commenters' concerns regarding the relationship between the 40-percent PFS relativity adjuster and the payment amounts that would otherwise apply under the PFS for particular imaging services. We note, however, that the PFS relativity adjuster itself was established through separate rulemaking and was not proposed for modification in this rulemaking. In the CY 2018 PFS final rule (82 FR 52976), we finalized a PFS relativity adjuster of 40 percent for purposes of establishing payment under the PFS for non-excepted items and services furnished by non-excepted off-campus PBDs. In doing so, we explained that the adjuster was intended to approximate the overall relativity between OPPS and PFS payment rather than reproduce the applicable PFS payment amount for each individual HCPCS code.

As we explained in the CY 2018 PFS final rule (82 FR 53023), the comparison between OPPS and PFS payment varies considerably across services, reflecting, among other things, differences in packaging, bundling, multiple procedure payment reductions, and the mix of services furnished in off-campus PBDs. We therefore recognized that an across-the-board relativity adjuster would necessarily be imprecise and that the actual difference between OPPS and PFS payment for an individual service may be higher or lower than the amount produced by application of the adjuster. We also recognized that PFS payment for some individual services may be lower or higher than the payment amount calculated using the PFS relativity adjuster.

When finalizing the 40-percent factor for CY 2018, we considered an updated analysis showing that the utilization-weighted applicable PFS payment amount for the most frequently billed services in off-campus PBDs was approximately 35 percent of the corresponding OPPS

payment amount. Because we were unable at that time to fully account for differences in packaging between the OPPS and PFS, we finalized a 40-percent relativity adjuster as an upward adjustment to that 35-percent estimate. Thus, the 40-percent factor was not intended to establish exact code-specific PFS payment amounts.

For the CY 2027 imaging policy, our analysis similarly demonstrates variation in the relationship between OPPS and PFS payment across the affected services. As discussed in the CY 2027 OPPS/ASC proposed rule (91 FR 41912), at the APC level, PFS payments for imaging without contrast services ranged from approximately 31 percent to 54 percent of OPPS payments. We believe that this range is consistent with the service-level variation that we anticipated when establishing an overall relativity adjuster. Accordingly, the fact that application of the 40-percent factor may result in payment above the applicable PFS technical component amount for some services and below it for others does not, by itself, demonstrate that use of the existing PFS relativity adjuster is inappropriate for purposes of the volume control method finalized in this rule.

We also disagree that application of the PFS relativity adjuster to imaging services paid through the multiple imaging composite APCs results in an inappropriate duplicative payment reduction. As discussed in the CY 2018 PFS final rule (82 FR 53024), when establishing payment for non-excepted items and services furnished by non-excepted off-campus PBDs, we included applicable OPPS packaging and payment policies, including comprehensive APCs, conditionally and unconditionally packaged items and services, and applicable multiple procedure payment reductions. We explained that retaining these OPPS payment policies was necessary to maintain the integrity of the PFS relativity adjuster because the adjuster is intended, in part, to account for methodological differences between the OPPS and PFS. Accordingly, where imaging services are paid through an applicable multiple imaging composite APC, the composite APC payment amount represents the OPPS payment amount to which the relativity adjuster applies. The methodology was not designed to reconstruct, on a service-by-service

basis, the amount that would be paid under the PFS for each individual service comprising the composite.

We also considered commenters' concerns regarding the DRA imaging payment cap under section 1848(b)(4) of the Act. We recognize that the applicable PFS payment for certain imaging services may be affected by statutory payment limitations and that this may contribute to differences between the applicable PFS technical component payment and the payment produced by applying the 40-percent PFS relativity adjuster. However, this does not alter the purpose or design of the PFS relativity adjuster. As discussed previously, the relativity adjuster was intended to approximate the overall relationship between OPPS and PFS payment and may produce payment amounts that are higher or lower, on a code-by-code basis, than the payment that would otherwise apply under the PFS.

Several commenters recommended that, at a minimum, CMS establish the applicable PFS technical component payment as a floor, such that payment would equal the greater of 40 percent of the OPPS payment amount or the applicable PFS technical component amount. We appreciate commenters' recommendation. However, the PFS relativity adjuster itself was not proposed for modification in this rulemaking. Rather, the proposed volume control method relied on the existing site-specific PFS payment methodology applicable to non-excepted off-campus PBDs, including the existing 40-percent PFS relativity adjuster.

Accordingly, we are not establishing a PFS technical component floor or otherwise modifying the PFS relativity adjuster in this final rule. However, we appreciate commenters' input regarding the relationship between the relativity-adjusted payment amount and the applicable PFS technical component payment. We believe commenters have raised important considerations regarding the continued use and design of the PFS relativity adjuster, including the variation between relativity-adjusted payment amounts and applicable PFS payment amounts for individual services. We intend to continue evaluating whether refinements to the PFS relativity adjuster, or the development of alternative relativity adjusters, may be appropriate and

may consider such changes in future rulemaking.

Comment: Several commenters expressed concern that applying the volume control method to imaging without contrast services could adversely affect beneficiary access to preventive and screening services. Commenters identified several screening services assigned to the imaging without contrast APCs, including low-dose CT for lung cancer screening, CT colonography, abdominal aortic aneurysm (AAA) screening, and DXA bone density testing. Commenters stated that reductions in payment for these services could affect provider capacity and availability and create barriers to beneficiary participation in recommended screening. Some commenters recommended that CMS exempt imaging services that receive an A or B recommendation from the United States Preventive Services Task Force (USPSTF) or are recommended by medical specialty societies, while other commenters recommended that CMS monitor payment adequacy and beneficiary access to preventive imaging following implementation of the policy.

Several commenters raised particular concerns regarding bone mass measurement services. Commenters stated that DXA is an important preventive service used to identify beneficiaries at risk for osteoporosis and fracture and noted that the USPSTF recommends osteoporosis screening for certain populations. Commenters noted that DXA is already underutilized and cited analyses indicating that utilization of DXA among Medicare beneficiaries has declined over the longer term. Commenters stated that reductions in Medicare payment for office-based DXA have contributed to reductions in the number of physician offices furnishing the service and stated that the increase in hospital-based DXA utilization may reflect migration of services from physician offices rather than unnecessary increases in the overall volume of DXA testing. Commenters further stated that reduced access to screening could result in beneficiaries remaining undiagnosed and untreated until after experiencing a fracture, potentially resulting in greater downstream Medicare expenditures.

Commenters also cited prior CMS rulemaking concerning payment for DXA services.

Commenters noted that in the CY 2017 OPPS rulemaking CMS proposed to assign CPT code 77080 to a lower-paying APC but did not finalize that proposal after commenters raised concerns regarding beneficiary access to bone density testing. Commenters stated that although the payment policy proposed for CY 2027 differs from the policy considered in that prior rulemaking, similar concerns regarding the effects of reduced payment on access to preventive bone density screening remain relevant.

Commenters raised similar concerns regarding other preventive imaging services. For example, commenters stated that AAA screening is a preventive service for which increased utilization may be clinically appropriate and cautioned against treating increases in the volume of such screening as unnecessary solely because the service is furnished in an off-campus PBD. Commenters generally stated that CMS should distinguish medically appropriate increases in recommended screening from increases attributable to site-of-service payment incentives.

Response: We appreciate commenters' concerns regarding the application of the volume control method to preventive services, including bone mass measurement, abdominal aortic aneurysm screening, and lung cancer screening services. We recognize the important role that preventive services play in identifying disease at an earlier stage and improving health outcomes for Medicare beneficiaries. However, we do not believe that the preventive nature of a service, by itself, warrants exclusion from the volume control method. The policy finalized in this rule does not change Medicare coverage of these preventive services, applicable eligibility or frequency requirements, or the clinical criteria for determining when these services are appropriate.

We also do not interpret increases in the utilization of preventive services in excepted off-campus PBDs to mean that clinically appropriate screening or preventive care is itself unnecessary. Rather, consistent with the volume control method finalized in this rule, our concern is with an unnecessary increase in the volume of covered OPD services when a clinically appropriate service that can safely be furnished in a lower-cost setting is instead

furnished in the higher-paid OPD setting because of the payment incentive created by the difference in payment amounts.

The preventive and screening nature of these services also does not, in itself, indicate that they require the hospital outpatient setting. Preventive services are generally planned ambulatory services and are frequently ordered or furnished as part of routine physician and primary care. Encouraging beneficiaries to obtain appropriate preventive care does not require Medicare to maintain a higher payment when that care is furnished in an excepted off-campus PBD. We are concerned that substantial differences in Medicare payment across settings may create incentives for preventive services that can safely and appropriately be furnished in freestanding physician offices or other lower-cost ambulatory settings to migrate to the higher-paid OPD setting.

We considered commenters' concerns regarding historical trends in the availability and utilization of DXA services. We recognize that commenters cited evidence of declines in DXA utilization and in the number of freestanding physician offices furnishing DXA over longer historical periods. However, the information submitted by commenters does not demonstrate that maintaining the higher OPPS payment rate for DXA services furnished in excepted off-campus PBDs is necessary to preserve beneficiary access to these services. DXA remains a frequently furnished outpatient service. For example, CPT code 77080 had more than 1.2 million single-frequency claims used in the CY 2027 OPPS rate-setting process, and the number of such claims has exceeded 1.1 million in each of the past five OPPS rate-setting years.

Moreover, our utilization analysis demonstrates a substantial shift in the site of service for CPT code 77080. Between CY 2016 and CY 2025, utilization of CPT code 77080 in excepted off-campus PBDs increased by more than 55 percent, while utilization in freestanding physician offices remained relatively stable. We acknowledge commenters' view that some of this change may reflect historical reductions in physician-office capacity and recognize that multiple factors may contribute to changes in site of service. However, the existence of other

factors does not demonstrate that the OPPS/PFS payment differential has no effect on where DXA services are furnished. As discussed previously, acquisition of a physician practice or imaging facility by a hospital uniquely permits services that otherwise would be paid under the PFS to receive the higher OPPS payment when furnished in an excepted off-campus PBD. We therefore do not believe these historical trends support maintaining a higher OPPS payment simply because DXA is a preventive service.

We also considered commenters' discussion of the CY 2017 OPPS rulemaking regarding the APC assignment for CPT code 77080. In the CY 2017 OPPS/ASC proposed rule, we proposed to assign CPT code 77080 to APC 5521, which would have reduced the OPPS payment for the service from $100.69 in CY 2016 to $63.33 in CY 2017. In response to public comments, we reconsidered the proposed APC assignment. In the CY 2017 OPPS/ASC final rule (81 FR 79629), we assigned CPT code 77080 to APC 5522 based on our analysis of its geometric mean cost and its resource comparability to other services within the imaging APCs. Specifically, we noted that CPT code 77080 had a geometric mean cost of $91.08 and that its assignment to APC 5521 increased the probability of a violation of the 2 times rule when compared with other significant procedures assigned to that APC. We therefore assigned CPT code 77080 to APC 5522, with a final CY 2017 payment rate of $112.69.

That determination addressed a different payment question from the policy finalized in this rule. APC assignments establish the relative payment for services within the OPPS based on the applicable OPPS classification and ratesetting methodology, including the clinical characteristics and relative resource costs of services grouped within an APC. The determination of the appropriate APC assignment for a service is not based on whether the resulting OPPS payment approximates the payment that would otherwise be made for the service under the PFS. Here, we are not reconsidering the appropriate APC assignment for CPT code 77080. Rather, under section 1833(t)(2)(F) of the Act, we are applying a method to control unnecessary increases in the volume of covered OPD services by addressing the payment differential between

excepted off-campus PBDs and lower-cost settings in which these services can safely be furnished.

Application of the volume control method also does not preclude us from reevaluating the APC assignment for CPT code 77080 in future rulemaking. We review APC groups and relative payment weights annually and may revise APC assignments based on changes in medical practice, technology, new cost data, and other relevant information and factors. Accordingly, if future OPPS claims data or other relevant information support a different APC assignment for CPT code 77080, we may consider such a change through future OPPS rulemaking.

For these reasons, we do not believe that preventive services, including DXA and other imaging without contrast services that qualify as Medicare preventive services, should be excluded from the volume control method finalized in this rule.

Comment: Several commenters expressed concern that applying the volume control method to imaging without contrast services could adversely affect beneficiary access to care. Commenters stated that payment reductions could cause hospitals to reduce imaging capacity, discontinue certain services, close off-campus imaging locations, or limit investments in imaging equipment and staffing. Commenters stated that these effects could be particularly significant in rural, low-income, medically underserved, and other communities where freestanding physician offices or freestanding imaging facilities may not have sufficient capacity or may not offer comparable services. Commenters also stated that reduced hospital outpatient imaging capacity could result in longer wait times or travel distances, delayed diagnosis, greater fragmentation of care, and increased reliance on emergency departments or other higher-cost settings.

Some commenters further stated that off-campus PBDs may improve access by locating imaging services closer to where beneficiaries live while maintaining integration with the hospital and other physicians involved in the beneficiary's care. Commenters noted that freestanding physician offices and independent imaging facilities may lack the capital,

equipment, workforce, or operational capacity to absorb imaging services currently furnished in hospital outpatient departments. Commenters therefore recommended that CMS reconsider the proposal, adopt additional access protections, or closely monitor the effects of the policy on service availability, wait times, travel distances, and beneficiary access.

Response: We appreciate commenters' concerns regarding beneficiary access to imaging services. We agree that maintaining access to clinically appropriate imaging is important, particularly in communities where alternative sources of care may be limited. However, we do not believe that the information provided by commenters demonstrates that applying the PFS-equivalent payment rate to imaging without contrast services furnished in excepted off-campus PBDs will generally result in the loss of access to these services.

As discussed previously, imaging without contrast services are routinely furnished in physician offices, freestanding facilities, and non-excepted off-campus PBDs. Our experience with non-excepted off-campus PBDs is particularly relevant because these departments already receive the PFS-equivalent payment rate for applicable services. We also believe that non-excepted off-campus PBDs are relevant to commenters' concerns that some beneficiaries may benefit from receiving imaging in a hospital-affiliated setting with access to hospital clinical resources. The choice of setting is not limited to an excepted off-campus PBD receiving the full OPPS payment rate or a freestanding physician office. Non-excepted off-campus PBDs are also hospital departments and furnish imaging without contrast services while receiving the PFS-equivalent payment rate.

As discussed in the CY 2027 OPPS/ASC proposed rule (91 FR 41911), there are approximately four times as many providers billing the "PN" modifier for non-excepted off-campus PBDs as providers billing the "PO" modifier for excepted off-campus PBDs. Nevertheless, excepted off-campus PBDs continue to account for the substantial majority of combined off-campus PBD volume for many of the highest-volume imaging without contrast services. In CY 2025, excepted off-campus PBDs accounted for approximately 81 percent of

combined PBD volume for HCPCS code 77080, 79 percent for HCPCS code 71046, 79 percent for HCPCS code 93306, and 83 percent for HCPCS code 71250. We believe these patterns are relevant because they demonstrate that, despite a substantially broader base of non-excepted off-campus PBDs furnishing services under the PFS-equivalent payment methodology, utilization of these high-volume services remains disproportionately concentrated in the smaller group of excepted off-campus PBDs receiving the higher OPPS payment.

We recognize that section 603 of the BBA of 2015 established different payment treatment for excepted and non-excepted off-campus PBDs, and the policy finalized in this rule does not alter that statutory framework. Rather, as discussed previously, we are exercising our separate authority under section 1833(t)(2)(F) of the Act to develop a method to control unnecessary increases in the volume of covered OPD services. For purposes of addressing commenters' access concerns, we believe the continued furnishing of imaging without contrast services in non-excepted off-campus PBDs is relevant evidence that these services can be furnished in a hospital-affiliated off-campus setting under the PFS-equivalent payment methodology. Thus, maintaining access to hospital affiliation and hospital clinical resources does not, by itself, demonstrate that the higher OPPS payment applicable to an excepted off-campus PBD is necessary for these services.

We also note that, consistent with our approach in prior rulemaking, we have taken specific access concerns into account in determining the scope of this policy. As discussed later in this section, we are finalizing an exemption for rural SCHs because of their historical treatment under the OPPS, documented additional resource costs, and importance in maintaining access to care in rural communities. In the CY 2026 OPPS/ASC final rule with comment period (90 FR 53822), we similarly recognized that rural SCHs are often the only source of care in their communities and that rural beneficiaries may have fewer alternative sites of care.

We acknowledge that particular communities may differ in the availability of alternative imaging providers and that individual hospitals may make operational decisions in response to

changes in Medicare payment. However, commenters did not demonstrate that freestanding physician offices, freestanding imaging facilities, and non-excepted off-campus PBDs generally lack the capacity to furnish imaging without contrast services or that maintaining the higher OPPS payment rate for all affected services is necessary to preserve beneficiary access. Moreover, our policy does not prevent a beneficiary from receiving imaging in an OPD when that setting is clinically appropriate and does not restrict a physician's ability to determine the appropriate setting of care based on the beneficiary's medical needs.

We will continue to monitor the effects of this change in Medicare payment policy, including changes in the volume and availability of imaging without contrast services and beneficiary access to care. If future data indicate that the policy is creating significant access concerns, we may consider whether additional refinements are appropriate in future rulemaking.

Comment: Several commenters recommended that, if CMS finalizes the volume control method for imaging without contrast services, CMS phase-in the payment reduction, delay implementation, or otherwise provide a transition period. Commenters stated that immediately applying the full PFS-equivalent payment rate could result in a significant reduction in payment for affected services and could give hospitals insufficient time to adjust staffing, equipment, contracts, referral arrangements, and other operational considerations. Some commenters recommended that CMS initially apply a less significant payment reduction and transition to the PFS-equivalent rate over multiple years.

Other commenters recommended that CMS establish hardship protections or other mechanisms to address providers that may experience significant financial or access impacts as a result of the policy. Commenters stated that transition or hardship protections could reduce the risk of service reductions or disruptions in beneficiary access while allowing CMS to evaluate the effects of the policy before fully implementing the payment reduction.

Response: We appreciate commenters' recommendations regarding a phase-in, delayed implementation, or other transition or hardship protections. We do not believe that a phase-in or

delay is necessary for the volume control method finalized in this rule. The policy applies to a defined set of imaging without contrast services furnished in excepted off-campus PBDs, and these same services are routinely furnished in freestanding physician offices and other lower-cost ambulatory settings.

We also believe our experience with non-excepted off-campus PBDs supports implementation of the PFS-equivalent payment rate without a phase-in. Non-excepted off-campus PBDs already receive the PFS-equivalent payment rate for applicable services and continue to furnish imaging without contrast services at substantial volume. We believe this experience demonstrates that imaging without contrast services can continue to be furnished in an off-campus hospital setting under the PFS-equivalent payment methodology.

As discussed later in this section, we are finalizing an exemption for rural SCHs based on their historical treatment under the OPPS, documented additional resource costs, and importance in maintaining access to care in rural communities.

Moreover, a phase-in would continue, during the transition period, the payment differential that we have determined contributes to unnecessary increases in the volume of covered OPD services. The purpose of the volume control method is to remove that payment incentive by applying the PFS-equivalent payment rate to the affected services. We therefore believe that implementing the PFS-equivalent payment rate beginning in CY 2027 is appropriate.

We will continue to monitor the effects of this change in Medicare payment policy, including the volume and availability of imaging without contrast services and beneficiary access to care, and may consider whether additional refinements are appropriate in future rulemaking.

Comment: Some commenters questioned whether the proposed reduction in payment would actually control unnecessary increases in volume. Commenters stated that reducing the payment amount for individual services could create an incentive for hospitals to increase the number of services furnished in off-campus PBDs to offset the reduction in revenue. Commenters stated that CMS therefore had not demonstrated that reducing payment for imaging

without contrast services would result in a reduction in volume rather than simply lower Medicare payment for the same volume or potentially lead to additional utilization.

Commenters pointed to CMS's experience with the sustainable growth rate methodology and other prior discussions of volume control as evidence that reducing unit payment does not necessarily result in lower utilization. Commenters therefore stated that the proposed methodology is not reasonably designed to control unnecessary increases in volume as required under section 1833(t)(2)(F) of the Act.

Response: We thank the commenters for their input. We disagree that the possibility that a provider could respond to a reduction in payment by increasing volume means that our volume control method is not reasonably designed to control unnecessary increases in volume. As we explained in the CY 2026 OPPS/ASC final rule with comment period in response to similar comments (90 FR 53811), our volume control method is specifically designed to address unnecessary increases in OPD volume that result from site-of-service payment differentials. By applying a PFS-equivalent payment rate, the method removes the payment differential that creates an incentive to furnish a service in the higher-paid OPD setting when the same service can safely be furnished in a lower-cost setting.

We recognize that changes in payment may affect provider behavior in different ways. However, the relevant incentive addressed by this policy is the additional Medicare payment available when an imaging without contrast service is furnished in an excepted off-campus PBD rather than in a physician office or non-excepted off-campus PBD. Once payment for the service furnished in the excepted off-campus PBD is aligned with the PFS-equivalent payment applicable in the lower-paid setting, the financial incentive to furnish the service in the excepted off-campus PBD solely because of the higher OPPS payment is removed. We therefore continue to believe that applying the PFS-equivalent payment rate is an appropriate method to control the unnecessary increase in volume attributable to that payment differential.

We also do not believe that commenters' references to the sustainable growth rate (SGR)

methodology lead to a different conclusion. The SGR established an aggregate spending target under the PFS and adjusted physician payment updates based on whether aggregate expenditures exceeded that target. Our volume control method does not establish an aggregate expenditure target or reduce payment in response to providers exceeding a predetermined volume benchmark. Rather, it prospectively addresses a specific payment differential that we have determined is a substantial cause of unnecessary increases in covered OPD services by eliminating that differential for the affected services.

We will continue to monitor utilization following implementation of this policy, as we have done for our clinic visit and drug administration volume control policies. We continue to believe that prospectively applying the PFS-equivalent payment rate to imaging without contrast services furnished in excepted off-campus PBDs is an appropriate method under section 1833(t)(2)(F) of the Act to control unnecessary increases in the volume of covered OPD services.

Comment: Several commenters requested additional information and implementation guidance regarding how the volume control method for imaging without contrast services would be operationalized. Commenters requested that CMS clearly identify the HCPCS codes subject to the policy and explain how changes in HCPCS coding or APC assignments would affect application of the volume control method in future years.

Commenters also requested clarification regarding the treatment of imaging services paid through the multiple imaging composite APCs and encounters involving multiple imaging services. Commenters requested CMS to clarify how the PFS-equivalent payment methodology would apply when imaging without contrast services are furnished together with other imaging services, including services that may not otherwise be subject to the volume control method, and how the policy would interact with existing OPPS packaging and composite payment policies.

Some commenters also requested sufficient implementation guidance and lead time for hospitals to update billing, claims-processing, financial, and other operational systems before the policy takes effect.

Response: We appreciate commenters' requests for additional implementation guidance. As finalized in this rule, the volume control method applies to imaging without contrast services assigned to APCs 5521 through 5524, as well as imaging without contrast services paid through the applicable multiple imaging composite APCs (APCs 8004, 8005, and 8007), when furnished by an off-campus PBD excepted from section 1833(t)(21) of the Act and billed with the "PO" modifier. We identify the applicable HCPCS codes and their APC assignments through the applicable OPPS Addenda, consistent with our usual process for publishing annual OPPS payment information.

We also clarify that this policy does not change the existing OPPS packaging or composite APC policies. Where an imaging without contrast service is otherwise paid through a composite APC under the OPPS, the existing requirements for determining whether the composite payment applies will continue to apply. When the applicable imaging without contrast composite APC is paid for a service furnished by an excepted off-campus PBD, the payment for that composite APC will be subject to the volume control method finalized in this rule. Similarly, existing OPPS packaging rules will continue to determine whether other items and services furnished during the encounter are separately payable or packaged.

The volume control method does not change hospitals' existing requirements for reporting the "PO" modifier for services furnished in excepted off-campus PBDs. Rather, the modifier will continue to identify services furnished by these departments for purposes of applying the appropriate payment methodology. Services furnished in other settings or not otherwise within the scope of the volume control method will continue to be paid under the applicable Medicare payment methodology.

We appreciate commenters' concerns regarding implementation and the need for hospitals to update their billing and operational systems. The policy will be implemented through the annual OPPS payment system and associated claims-processing instructions, consistent with our established processes for implementing annual OPPS payment changes. We

believe these existing mechanisms provide an appropriate framework for communicating the HCPCS and APC information necessary to implement the policy.

After consideration of public comments, we are finalizing our proposal to use our authority under section 1833(t)(2)(F) of the Act to apply an amount equal to the site-specific PFS payment rate for non-excepted items and services furnished by a non-excepted off-campus PBD (the PFS payment rate) for HCPCS codes assigned to the imaging without contrast APCs or paid through the imaging without contrast composite APCs, when provided at an off-campus PBD excepted from section 1833(t)(21) of the Act (departments that bill the modifier "PO" on claim lines) without modification. In addition, we are finalizing our proposal to implement this policy in a non-budget neutral manner without modification. We will monitor the impacts of this policy to ensure that beneficiaries continue to have access to quality care.

9. Exemption for Rural Sole Community Hospitals

As stated previously, we proposed to expand our method to control unnecessary increases in the volume of covered OPD services by paying a PFS-equivalent payment rate for imaging without contrast services furnished in excepted off-campus PBDs. We believe that this policy is an appropriate method for controlling unnecessary volume of imaging without contrast services in excepted off-campus PBDs because beneficiaries can generally safely receive these same services in a lower-cost setting but instead may receive care in a higher-cost setting due to payment incentives. In these cases, we maintain that, similar to the clinic visit volume control policy established in the CY 2019 OPPS/ASC final rule with comment period (83 FR 59004 through 59015) and the drug administration volume control policy established in the CY 2026 OPPS/ASC final rule with comment period (90 FR 53806 through 53821), to the extent similar services can be safely provided in more than one setting, we do not believe it is appropriate for the Medicare program to pay more for these services in one setting than another. We continue to believe the difference in payment for these services is a significant factor in the shift in services from the freestanding physician's office setting to the hospital OPD.

In the CY 2023 OPPS/ASC final rule with comment period (87 FR 72047 through 72051) and the CY 2026 OPPS/ASC final rule with comment period (90 FR 53821 through 53824), we finalized exemptions to our clinic visit and drug administration volume control policies for PBDs of rural SCHs. Under these exemptions, we pay the full OPPS payment rate, rather than the PFS-equivalent rate, when the clinic visit or drug administration service is furnished in excepted PBDs of rural SCHs. In those rules, we explained that rural SCHs have historically received special payment treatment to account for their higher costs and the disproportionately harmful impact that payment reductions could have on them. Because we proposed a volume control payment policy for imaging without contrast services, we have additionally considered whether a similar policy for rural SCHs or other provider types would be appropriate.

a. Special Payment Treatment for Rural SCHs

Across the various Medicare payment systems, CMS has established several special payment provisions for rural providers to ensure access to high quality care for beneficiaries in rural areas. CMS administers several statutory hospital payment designations in which rural or isolated hospitals that meet specified eligibility criteria receive higher reimbursement for hospital services than they otherwise would receive under Medicare's standard payment methodologies. A rural hospital may qualify as a Critical Access Hospital (CAH),[164] Sole Community Hospital (SCH),[165] Rural Emergency Hospital (REH),[166] or Medicare Dependent Hospital[167]—each of which has different eligibility criteria and payment methodologies. With the exception of CAHs, rural hospitals may also qualify as Low Volume Hospitals[168] and Rural Referral Centers (RRCs),[169] which qualify these hospitals for additional payments or exemptions. Not all rural or isolated hospitals receive special payment treatment under the OPPS. For instance, CAHs are

[164] 42 CFR 485.601 through 485.647.
[165] 42 CFR 412.92.
[166] 42 CFR 419.91.
[167] 42 CFR 412.108.
[168] 42 CFR 412.101.
[169] 42 CFR 412.96.

not paid under the OPPS and are reimbursed at 101 percent of reasonable costs for outpatient services.

Rural SCHs are a hospital type that has received special payment treatment under the OPPS to account for their higher costs and the disproportionately harmful impact that payment reductions could have on them. In the CY 2006 OPPS final rule with comment period (70 FR 68556 through 68561), we finalized a payment increase for rural SCHs of 7.1 percent for all services and procedures paid under the OPPS, excluding separately payable drugs and biologicals, items paid at charges reduced to costs, and devices paid under the pass-through payment policy. This policy was adopted under section 1833(t)(13)(B) of the Act, which required the Secretary, by January 1, 2006, to provide for an appropriate adjustment under subparagraph (t)(2)(E) to reflect the higher costs of hospitals in rural areas if the Secretary determined, pursuant to a study required by section 1833(t)(13)(A) of the Act, that the costs to rural hospitals by APC exceeded those costs for hospitals in urban areas. Our analysis revealed that rural SCHs had significantly higher costs per unit than urban hospitals. We have continued to adjust payments for rural SCHs by 7.1 percent each year since 2006. As discussed in section II.E. of this final rule with comment period, for CY 2027 we proposed to continue the current policy of utilizing a 7.1 percent payment adjustment for rural SCHs.

As noted previously, in the CY 2023 OPPS/ASC final rule with comment period (87 FR 72051), we finalized an exemption for clinic visits to our policy to pay the PFS-equivalent rate for the clinic visit service at excepted off-campus PBDs to control unnecessary increases in the volume of covered OPD services. Commenters were generally supportive of this proposal and noted that rural SCHs are typically the chief, if not sole, source of community outpatient care for rural residents and stated that this exemption would be vital to ensuring continued access to the care they need. Some commenters stated that the exemption should be extended to other types of hospitals, including urban SCHs. In that rule, we explained that our analysis did not find that

urban SCHs had the additional resource costs for covered OPD services that rural SCHs have and only finalized applying the clinic visit policy exemption to rural SCHs (87 FR 72049).

Similarly, in the CY 2026 OPPS/ASC final rule with comment period (90 FR 53824), we finalized an exemption for rural SCHs to our policy to pay the PFS-equivalent rate for drug administration services at excepted off-campus PBDs to control unnecessary increases in the volume of covered OPD services. Commenters were again generally supportive of the proposal and emphasized that rural SCHs have higher costs and are important for access in rural areas. Some commenters suggested extending the exemption to other types of hospitals such as urban SCHs, Medicare Dependent Hospitals (MDHs), urban and rural safety-net hospitals, REHs, FQHCs, and all rural hospitals. However, because our historical analysis did not demonstrate that these facilities had the additional resource costs that rural SCHs do, we did not finalize any exemptions beyond our exception for rural SCHs (90 FR 53823).

b. Exemption to Volume Control Payment Policy for Imaging Without Contrast Services Furnished in Off-Campus Provider-Based Departments of Rural SCHs

Earlier in this section, where we proposed the volume control method policy for imaging without contrast services, we stated that to the extent there are lower-cost sites of service available, beneficiaries and the physicians treating them should be able to choose the appropriate care setting and not be encouraged to receive or provide care in settings for which payment rates are higher solely for financial reasons. However, as we have previously noted, many rural providers, and rural SCHs in particular, are often the only source of care in their communities,[170] which means beneficiaries and providers are not choosing between a higher paying off-campus PBD of a hospital and a lower paying freestanding physicians' office setting. The closure of inpatient departments of hospitals and the shortage of primary care providers in rural areas likely further drives utilization to off-campus PBDs in areas where rural SCHs are located.

[170] *https://www.shepscenter.unc.edu/wp-content/uploads/dlm_uploads/2017/11/SCHs_Differences_in_Community_Characteristics.pdf.*

As with clinic visits and drug administration services, we do not believe that rural SCH site-of-service decisions for imaging without contrast services are being driven by differences in payment rates. As we have previously observed, rural areas often experience lower availability of health care professionals and hospitals than urban areas.[171] Hospital closures in rural communities are associated with lower access to health care and worse health outcomes.[172] Access to outpatient services, particularly in rural areas, is vital to keeping beneficiaries from being admitted as an inpatient because beneficiaries in rural settings face unique challenges that impact their health. In the CY 2023 OPPS/ASC final rule with comment period, we explained that we believe that exempting rural SCHs from the clinic visit policy would help to maintain access to care in rural areas by ensuring rural providers are paid for clinic visit services provided at off-campus PBDs at rates comparable to those paid at on-campus departments (87 FR 72049). We extended this exemption to drug administration in the CY 2026 OPPS/ASC final rule with comment period on the same basis (90 FR 53822), and we proposed to extend it to our proposed imaging without contrast policy for similar reasons. Specifically, we proposed to exempt rural SCHs from payment of the site-specific PFS-equivalent payment for imaging without contrast services, as described by APCs 5521 through 5524, 8004, 8005, and 8007, when furnished at an off-campus PBD exempted from section 1833(t)(21) of the Act (departments that bill the modifier ‘‘PO’’ on claim lines). Under the proposed policy, a rural SCH would continue to bill services in APCs 5521 through 5524, 8004, 8005, and 8007 with the “PO” modifier for CY 2027 and the payment rate for such services would continue to be the full OPPS payment without the PFS relativity adjuster.

This exemption would result in higher payments to excepted off-campus PBDs of rural SCHs compared to if rural SCHs were subject to the proposed volume control method. By

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[171] *https://www.gao.gov/assets/gao-21-93.pdf.*

[172] Mills CA, Yeager VA, Unroe KT, Holmes A, Blackburn J. The impact of rural general hospital closures on communities—A systematic review of the literature. *J Rural Health*. 2024; 40:238–248. *https://doi.org/10.1111/jrh.12810.*

exempting rural SCHs, the Medicare payments for these services would remain at the OPPS level. We note, however, that these figures do not represent increases in costs to Medicare or the beneficiaries above the current policy, as our proposed exemption would maintain current payment rates at excepted off-campus PBDs of rural SCHs of 107.1 percent of the OPPS payment rate for these services. These figures are solely for the purpose of comparing potential savings from this policy.

We invited comments on all aspects of the proposed exemption for rural SCHs from the method to control unnecessary volume of imaging without contrast services. Specifically, we requested comments on whether such an exemption was appropriate for rural SCHs; what the impact on SCHs would be, should we finalize the method without an exemption for rural SCHs; and whether we should consider any other hospital types for an exemption to any of the three policies to control unnecessary volume of outpatient services at off-campus PBDs. Additionally, we requested comments on whether the current exemptions for rural SCHs from the method to control unnecessary volume of clinic visit and drug administration services remained appropriate.

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: The majority of commenters supported our proposal to exempt rural Sole Community Hospitals (rural SCHs) from payment of the site-specific Medicare PFS-equivalent payment for any HCPCS codes assigned to the imaging without contrast APCs or paid through the imaging without contrast composite APCs, when furnished at an off-campus PBD excepted from section 1833(t)(21) of the Act (departments that bill the modifier "PO" on claim lines). Several commenters opposed the volume control method generally but stated that should CMS finalize the policy, CMS should also finalize the proposed exemption for rural SCHs. Commenters stated that rural SCHs have higher costs, operate with limited financial and workforce resources, and are important for maintaining access to care in rural areas where

alternative sources of imaging services may be limited. Commenters also stated that applying the volume control method to rural SCHs could result in reduced service availability or require beneficiaries to travel greater distances for care. One commenter opposed a broad exemption for all rural SCHs and recommended that CMS instead target the exemption to independent rural hospitals or hospitals that demonstrate greater financial vulnerability. The commenter stated that some rural SCHs are affiliated with large health systems and may be better positioned to absorb payment reductions than independent hospitals.

Response: We thank the commenters for their support of the proposed exemption for rural SCHs. As discussed in the CY 2027 OPPS/ASC proposed rule (91 FR 41918), and consistent with our historical analysis that indicated rural SCHs have higher costs, we agree that their financial health is vital to ensure continued access to care in rural areas. We acknowledge the nuanced perspective that many commenters took in supporting the proposed exemption while disagreeing with the volume control methodology overall.

We appreciate the commenter's recommendation that any exemption be targeted to independent rural hospitals or hospitals demonstrating greater financial vulnerability. However, as we stated in the CY 2026 OPPS/ASC final rule with comment period (90 FR 53823), we believe the rural SCH designation generally indicates that a hospital has additional costs and is vital for access in rural areas. We do not believe that the exemption should be limited to independent hospitals, as rural SCHs that are part of larger health systems may also face similarly heightened costs. We continue to believe that these considerations support exempting rural SCHs from the volume control method. We intend to continue to monitor costs at rural SCHs and to ensure that this exemption continues to be warranted for our volume control policies.

Comment: Several commenters supported the proposed rural SCH exemption but recommended that CMS extend the exemption to additional types of hospitals and providers. Commenters recommended exemptions for, among others, all rural hospitals, Critical Access

Hospitals (CAHs), Rural Emergency Hospitals (REHs), Medicare Dependent Hospitals (MDHs), Rural Referral Centers, low-volume hospitals, safety-net hospitals, hospitals serving Health Professional Shortage Areas or Medically Underserved Areas, Qualifying Disadvantaged Hospitals, children's hospitals, and other geographically isolated or essential providers. Commenters generally stated that hospitals other than rural SCHs may face similar financial, workforce, and geographic challenges and may likewise be important for maintaining beneficiary access to imaging services in communities where alternative sites of care are limited.

Some commenters also recommended exempting hospitals that have reclassified as rural. Other commenters recommended exempting children's hospitals, noting their generally limited Medicare utilization and expressing concern regarding the potential effects of the policy on pediatric access.

Response: We appreciate commenters' recommendations regarding additional types of hospitals and providers for which they believe further exemptions would be warranted. We note that CAHs and REHs are not subject to the volume control method finalized in this rule, and therefore an exemption for these hospital types is not necessary.

We also appreciate commenters' discussion of rural reclassifications and clarify that the exemption for rural SCHs includes SCHs that have reclassified as rural, consistent with our rural SCH exemptions from the clinic visit and drug administration volume control methods.

We appreciate commenters' recommendation to exempt children's hospitals based on their generally limited Medicare utilization and concerns regarding pediatric access. We recognize the unique role that children's hospitals play in furnishing specialized pediatric care and appreciate commenters' interest in ensuring that Medicare payment policies do not adversely affect access to these services. We also recognize that children's hospitals generally have limited Medicare utilization, which may limit the overall impact of this policy on these hospitals. Based on the information available to us, we do not believe that a separate exemption for children's hospitals is necessary at this time. As discussed previously, the policy does not

prevent a physician from determining that the hospital outpatient setting is clinically appropriate for a particular beneficiary. We will continue to consider the effects of our volume control policies on different types of hospitals and beneficiary access to care and may consider whether additional exemptions are appropriate in future rulemaking.

With respect to the other hospital types suggested by commenters, as we discussed in the CY 2027 OPPS/ASC proposed rule and in prior rulemaking (90 FR 53823), our historical analysis has found that rural SCHs have higher costs, which we believe is appropriate to consider when developing a payment policy such as this. Rural SCHs have historically received special treatment under the OPPS due to these higher costs. As we stated in the CY 2023 OPPS/ASC final rule with comment period (87 FR 72047 through 72051), we believe exempting rural SCHs, which have demonstrated additional resource costs, is appropriate to ensure these hospitals can remain open to serve the beneficiaries who rely on them for their care.

We proposed a narrow exemption largely based upon the historical treatment and documented additional resource costs of rural SCHs under the OPPS. We continue to believe in the underlying principles of the volume control method, and that same rationale continues to justify application of the volume control method for imaging without contrast services to other hospitals subject to this policy. Where differences in payment lead to unnecessary increases in the volume of covered outpatient department services, we remain concerned that shifts in the site of care increase beneficiary cost-sharing liability because Medicare payment rates for the same or similar services are generally higher in hospital outpatient departments than in physician offices.

We share commenters' concerns about maintaining access to care in rural and medically vulnerable communities, including concerns regarding pediatric access. However, we do not believe that commenters provided sufficient reasoning or data to demonstrate that the other hospital types subject to this policy have the additional resource costs that our historical analysis has demonstrated for rural SCHs and therefore should also be exempted from this OPPS payment

policy. We will continue to study access and costs to determine whether further exemptions to the volume control policy are appropriate in future rulemaking.

Comment: Some commenters recommended that CMS use criteria other than hospital type in determining whether a provider should qualify for an exemption. Commenters suggested considering factors such as geographic isolation, the availability of alternative imaging providers, beneficiary travel times, financial vulnerability, local workforce shortages, and the role of a hospital in maintaining access to essential services. Some commenters recommended that CMS monitor the effects of the policy on beneficiary access, including changes in imaging availability, wait times, travel distances, and service volumes, particularly in rural and underserved communities.

Response: We appreciate commenters' thoughtful suggestions regarding alternative criteria for determining whether an exemption may be appropriate. As discussed previously, for purposes of this policy we believe that the rural SCH designation provides an appropriate basis for the exemption because of the historical treatment and documented additional resource costs of rural SCHs under the OPPS. We are not adopting additional exemption criteria at this time. We will, however, consider commenters' suggestions as we continue to evaluate the effects of our volume control policies and whether additional exemptions may be appropriate in future rulemaking.

We also appreciate commenters' concerns regarding beneficiary access. Consistent with our approach to the clinic visit and drug administration volume control policies, we will continue to monitor the effects of this change in Medicare payment policy, including the volume of these types of OPD services and beneficiary access to care, including for beneficiaries with disabilities, and may revisit the policy in future rulemaking.

Comment: Some commenters recommended that CMS exempt certain imaging services or clinical circumstances from the volume control method based on the type of service furnished or the needs of the patient. Several commenters recommended exempting preventive and

screening imaging services from the volume control method based on concerns regarding beneficiary access to recommended screening and early detection services. As discussed previously in this section, commenters specifically identified certain preventive and screening services included in the imaging without contrast APCs and recommended that CMS exclude these services from the policy.

Other commenters recommended exemptions for certain oncology-related imaging services. One commenter requested that CMS exempt diagnostic and procedural imaging directly associated with planned or same-day interventional oncology procedures, including pre- and post-procedural imaging used for treatment planning, procedural guidance, or assessment following a procedure. Other commenters recommended exemptions or other protections for imaging furnished to high-acuity oncology patients or imaging that is integrated with specialty oncology care, stating that these services may require hospital-level clinical infrastructure, specialized staff, immediate access to other hospital resources, or coordination with other services furnished as part of the patient's treatment.

Some commenters also raised concerns that applying the volume control method to imaging without contrast services, while imaging services furnished with contrast or an enhancing agent would not be subject to the policy, could create a payment incentive affecting the use of contrast or enhancing agents. Commenters specifically noted that ultrasound enhancing agents may be clinically appropriate for certain echocardiography services but stated that the decision to use an enhancing agent should be based on the clinical needs of the patient rather than differences in payment. Commenters expressed concern that increased use of enhancing agents in response to payment differences could also increase costs associated with the agent, intravenous access, nursing, and other related resources.

Some commenters more generally recommended exempting imaging furnished as part of a medically complex diagnostic workup, imaging integrated with same-day procedures requiring hospital-level resources, or services that rely on hospital infrastructure or specialty resources.

Commenters stated that these circumstances may involve medically-complex beneficiaries or additional resources that are not available in freestanding imaging facilities or physician offices.

Response: We appreciate the commenters' thoughtful suggestions regarding exemptions for particular imaging services or clinical circumstances. As we stated in the CY 2026 OPPS/ASC final rule with comment period in response to similar recommendations regarding drug administration services (90 FR 53824), we are concerned that exempting a small subset of services from the volume control methodology could inadvertently incentivize an increase in the provision of those services in the higher cost setting of care. Furthermore, we do not believe that commenters have provided a clear clinical justification for exempting certain imaging without contrast services while leaving other imaging without contrast services non-exempted. We believe it would be most transparent to propose any service-specific exceptions through notice-and-comment rulemaking.

We address commenters' recommendations regarding preventive and screening imaging services in detail previously in this section. As discussed there, we recognize the important role that preventive services play in identifying disease at an earlier stage and improving health outcomes for Medicare beneficiaries, but we do not believe that the preventive nature of a service, by itself, warrants exclusion from the volume control method.

We also appreciate commenters' concerns regarding the potential for differences in payment to affect the use of contrast or enhancing agents. We agree that the decision to use a contrast or enhancing agent should be based on the clinical needs of the beneficiary and not on differences in Medicare payment. The volume control method finalized in this rule does not change the clinical criteria for determining when the use of a contrast or enhancing agent is appropriate. As discussed previously, our policy is intended to remove a payment incentive that we believe contributes to unnecessary increases in the volume of covered OPD services, not to influence clinical decisions regarding how an imaging service should be furnished. We will monitor utilization following implementation of this policy and may consider changes in

utilization patterns, including the use of contrast or enhancing agents, as part of our evaluation of the effects of the volume control method.

With respect to commenters' recommendations regarding imaging furnished to high-acuity or medically complex patients, imaging furnished in connection with planned or same-day procedures, or imaging furnished as part of integrated oncology care or other complex episodes of care, we appreciate that OPDs serve unique patient populations and provide services to medically complex beneficiaries. However, we do not believe that these circumstances demonstrate the need for higher payment for all imaging without contrast services furnished to these beneficiaries or in connection with these episodes of care. The fact that an imaging service is furnished on the same day as, or in connection with, another hospital service also does not necessarily establish that the imaging service itself requires the hospital outpatient setting or should be excluded from the volume control method. Our policy does not prevent a physician from determining that an OPD is the appropriate setting for a particular beneficiary based on the beneficiary's clinical needs.

We also are not certain how we would reliably identify the particular patients, services, or clinical circumstances suggested by commenters for purposes of administering an exemption. We appreciate commenters' input and may consider these suggestions in future rulemaking.

Comment: Several commenters discussed the impact of the proposed method to control volume for imaging without contrast services on PPS-exempt cancer hospitals. Commenters noted that payments to PPS-exempt cancer hospitals are subject to the cancer hospital payment adjustment based on a payment-to-cost ratio and stated that reducing OPPS payment for imaging without contrast services could indirectly affect payments to these hospitals through the payment-to-cost ratio methodology.

Response: We appreciate commenters' discussion of the impact of this policy on PPS-exempt cancer hospitals. We note that any reduction in the initial OPPS payment to a PPS-exempt cancer hospital as a result of this policy would lower the hospital's payment-to-cost ratio

and would result in a corresponding increase in the cancer hospital payment adjustment at cost report settlement. We therefore do not believe that the application of the volume control method to imaging without contrast services warrants a separate exemption for PPS-exempt cancer hospitals.

We also recognize that this policy may affect the target payment-to-cost ratio used in determining the cancer hospital payment adjustment because the target payment-to-cost ratio is based on the payment-to-cost ratios of hospitals paid under the OPPS other than PPS-exempt cancer hospitals. We believe the effect of this policy on the target payment-to-cost ratio, through its effect on non-cancer hospitals' payment-to-cost ratios, would be relatively small. Moreover, because we believe the reduced payment for imaging without contrast services furnished by non-cancer hospitals subject to this policy is appropriate, we likewise believe that any resulting effect on the target payment-to-cost ratio is appropriate.

After consideration of public comments, we are finalizing our proposal to exempt rural Sole Community Hospitals (rural SCHs) from payment of the site-specific Medicare PFS-equivalent payment for any HCPCS codes assigned to the imaging without contrast APCs or paid through the imaging without contrast composite APCs, when furnished at an off-campus PBD excepted from section 1833(t)(21) of the Act (departments that bill the modifier "PO" on claim lines). We believe that exempting rural SCHs from the volume control policy for imaging without contrast services will help to maintain access to care in rural areas by ensuring rural providers are paid for imaging without contrast services provided at off-campus PBDs at the same rate paid when the service is furnished in on-campus departments. Finalizing this policy also aligns with the special payment treatment rural SCHs receive under the OPPS. We will continue to monitor the effects of this change in Medicare payment policy.

B. OPPS Payments for SaMS Diagnostic Services

1. Payment for Software as a Medical Service (SaMS)

In recent years, there have been rapid developments in the use of software-based technologies with novel functionalities to support clinical decision-making in the outpatient and physician office settings. New clinical software, which includes clinical decision support software, clinical risk modeling, and computer aided detection (CAD), is becoming increasingly available to providers. These technologies often perform data analysis of diagnostic images from patients, relying on complex algorithms or statistical predictive modeling to aid in the diagnosis or treatment planning of a patient's condition. In previous rulemaking, we have referred to these algorithm-driven services that assist practitioners in making clinical assessments or diagnoses as Software as a Service (SaaS). Unlike prescription digital therapeutics (PDTs), for example PDTs that provide cognitive behavioral therapy to treat substance disorders or chronic insomnia, SaaS technologies as we refer to them do not currently treat illnesses or patient injuries. SaaS is also separate from remote patient monitoring (RPM) and remote therapeutic monitoring (RTM), which are digital healthcare tools for tracking patient data outside traditional office settings (90 FR 49394). For CY 2027, we proposed-a change in terminology. We noted that we now understand that in other industries, the existing SaaS terminology is used for general cloud-based computing service models outside of a health care context, which may cause confusion as we are using it to describe specific services that provide a medical function for purposes of OPPS/ASC Medicare payment policy. To dispel any ambiguity and clarify that distinction, we proposed to change our terminology from SaaS to Software as a Medical Service (SaMS) to refer to software-based technologies that support clinical decision making through algorithmic analysis, including those that provide clinical or diagnostic functionality. We welcomed public comments on the proposed change in terminology.

CMS has been evaluating how to develop a comprehensive and consistent approach to SaMS payment for several years with the novel and evolving nature of these technologies. We have sought public input through two comment solicitations (87 FR 72035 through 87 FR 72036, 89 FR 94129 through 89 FR 94131) and expressed our objective to seek a payment strategy that

aligns with our agency's mission to increase quality, improve health, reduce costs, and strengthen the healthcare system. However, questions remain regarding how best to structure payment for these services. One challenge is that current Medicare Part B payment systems for SaMS, including in the OPPS, are primarily designed to pay for services that rely on material resources, rather than technologies whose value is driven by proprietary algorithms and scalable, non-material costs. This creates difficulties in establishing appropriate valuation methodologies, as the current cost-based system often offers only limited transparency into underlying costs and may not effectively constrain pricing. Another challenge is determining how to account for the various ways in which these technologies are acquired and billed by hospital OPDs, particularly in cases with subscription- or license-based arrangements, as well as per-use or "per-click" fees, which raises concerns regarding program integrity.

As coding for SaMS continues to rapidly increase and technologies evolve, establishing a consistent and timely payment methodology for these services is a priority. New SaMS technologies are continuing to be introduced to the market, each often accompanied by unique CPT codes reflecting their proprietary algorithms or specific characteristics. Interested parties are frequently seeking Medicare payment and coding for SaMS technologies through the new technology APC process or requesting clinical APC assignments. As a result, CMS is continuously assessing and evaluating payment for SaMS through different pathways. As we consider this policy, we want to ensure that we are moving toward a more standardized approach that reduces payment rate variation across similar technologies.

Given the growing need for a comprehensive and tailored payment methodology, as we work to gather additional data to better understand and more fully address the inherent payment challenges in this area, we proposed an interim payment policy for SaMS for CY 2027 while we examine a range of approaches to payment for these kinds of technologies. Specifically, we proposed to assign SaMS technologies to new technology APCs for CY 2027. We proposed to designate 36 HCPCS codes as SaMS services and reassign the proposed designated SaMS

services that are currently paid separately (assigned to status indicator "S") under clinical APCs, to new technology APCs that closely align with their current CY 2026 payment rates. We proposed to assign the separately paid SaMS technologies to new technology APCs because we believed that the existing clinical APC structure did not adequately accommodate SaMS. We believed that the new technology APCs were more appropriate to accommodate SaMS on a temporary basis, as there have historically been placements under the OPPS that allow us to provide consistent payment for new procedures that are not yet reflected in our claims data or for which we lack sufficient clinical information and cost data until we can identify an appropriate clinical APC. In certain circumstances, we have also assigned some services to new technology APCs through rulemaking, even when they have not met the specific regulatory criteria (66 FR 59897 through 59903) or have not applied for new technology APC assignment through the subregulatory process. For example, we have assigned certain services to new technology APCs in special cases where an appropriate clinical APC to which to assign the service does not exist. In the CY 2026 OPPS/ASC final rule with comment period, we maintained the new technology APC assignment for HCPCS codes G2082 and G2083 because we did not believe there was an appropriate clinical APC to which to assign the service (90 FR 53551). This proposed approach of assigning SaMS services to the same APC series would allow CMS to take the first step towards standardization and applying a consistent payment methodology across these services as we consider more comprehensive long-term approaches, including those that may better align payment with clinical outcomes.

We also believed it was important to distinguish SaMS technologies from other services that are assigned to new technology APCs because not all new services assigned to new technology APCs are SaMS technologies. Therefore, we proposed to create a new status indicator under OPPS specifically for SaMS technologies. For CY 2027, we proposed to create status indicator "O1" (Software as a Medical Service, Paid under OPPS; separate APC payment) and assign all services that we proposed to designate as SaMS to status indicator "O1."

Functionally, we proposed for status indicator "O1" to have the same payment specifications as status indicator "S," to allow for separate payment. We requested public comment on this proposal. We also requested public comment regarding whether a new status indicator with the same specification as status indicator "T" (Procedure or service subject to multiple procedure discounting) would provide more appropriate payment for these services while addressing any potential program integrity concerns.

For CY 2027, we proposed to designate the HCPCS codes listed in Table 83 as SaMS technologies. Of these, we proposed to assign 21 HCPCS codes to new technology APCs from clinical APCs, maintaining approximate payment rate continuity with CY 2026 payment, and status indicator "O1". Table 84 provides the list of HCPCS codes and proposed new technology APC and status indicator assignments for CY 2027. For SaMS that are already assigned to new technology APCs for CY 2026, we proposed to continue to assign these services to new technology APCs for CY 2027 while proposing to update the status indicator assignment to "O1" to designate these technologies as SaMS. We refer readers to section III.C. of the proposed rule (91 FR 41803 through 91 FR 41807) for a discussion on our proposals for SaMS technologies that are currently assigned to new technology APCs for CY 2026.

We note that there are a small number of technologies we consider to be SaMS that are currently paid under the OPPS and assigned to an OPPS status indicator of "Q1" (STV-Packaged Codes; Paid under OPPS), indicating that the service is conditionally packaged. Services assigned to an OPPS status indicator of "Q1" will receive packaged payment when furnished with a significant procedure but will be separately paid when the service appears on the claim without a significant procedure. Because services assigned to new technology APCs are exempt from C-APC packaging policies, we did not believe it would be appropriate to propose to assign SaMS HCPCS codes that are currently conditionally packaged for CY 2026 to new technology APCs with status indicator "S" (Procedure or Service, Not Discounted When Multiple) to indicate separate payment. As an alternative, we considered unconditionally packaging SaMS

services that are currently assigned to status indicator "Q1" by proposing to assign the services a status indicator of "N" (Items and Services Packaged into APC Rates). However, we stated that we believe proposing to unconditionally package payment for CY 2027 for SaMS technologies that are currently conditionally packaged under the OPPS may have resulted in interruptions to patient access. Given that we intended for this policy to be a first step towards more comprehensive payment policy changes and sought to minimize disruption, we believed it was more appropriate to propose to maintain the clinical APC and status indicator assignments for these codes. Therefore, for CY 2027, we proposed to maintain the clinical APC and status indicator assignments for SaMS that are currently conditionally packaged under the OPPS.

Similarly, there are other HCPCS codes that describe SaMS assigned to status indicator "E1" (Items, codes, and services not covered by any Medicare outpatient benefit category; statutorily excluded; not reasonable and necessary), status indicator "N" (Items or services packaged into APC rates), or status indicator "M" (Items and services not billable to the FI or MAC). Since these are not separately paid services under the OPPS for CY 2026, for CY 2027, we proposed to maintain the OPPS status indicators to which they are currently assigned.

We provided a table with the various SaMS HCPCS codes that were impacted by our proposals. Table 83 provides the proposed CY 2027 APC and status indicator assignments for codes we proposed to designate as SaMS services and that are currently assigned to clinical APCs or are not separately paid under the OPPS for CY 2026. We referred readers to section III.C. of the proposed rule for a discussion on the proposed CY 2027 payment rates for SaMS codes that are currently assigned to new technology APCs for CY 2026. In addition, we referred readers to Addendum B of the proposed rule for proposed CY 2027 OPPS payment rates and status indicators for HCPCS codes that we proposed to designate as SaMS. We requested comment on our proposals, including the list of HCPCS codes we proposed to designate as SaMS and that we proposed to reassign to new technology APCs for CY 2027, including whether there were any additional HCPCS codes we should consider.

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: Several commenters supported the proposed terminology change from SaaS to SaMS. One commenter explained that the proposed terminology would clarify the distinction between clinical algorithms and generic cloud tooling. A commenter requested that we clarify whether the transition to SaMS is intended solely as a naming convention or whether it reflects broader distinctions regarding the scope, classification, valuation or payment treatment of these technologies.

Response: We thank the commenters for their support. The terminology change from SaaS to SaMS seeks to clarify, as one commenter explained, the distinction between clinical algorithms used to furnish these services and generic cloud tooling.

Based on the comments received, for CY 2027, we are finalizing our proposal to change the terminology for these algorithm-based software services that are paid under Medicare from "SaaS" to "SaMS."

Comment: Many commenters requested clarification regarding the types of services that would be considered SaMS for purposes of this policy. For example, commenters asked whether remote care delivery or non-device clinical decision support (CDS) would be considered SaMS for purposes of separate payment. Similarly, we received comments regarding how CMS will distinguish separately paid software that supports clinical decision making from software that provides broader operational, administrative, or business functions. One commenter specifically requested that we expand our scope of services that we designate as SaMS to include those that perform analyses on structured clinical data conforming to recognized interoperability standards such that super intelligence-enabled comprehensive clinical trial eligibility analysis would be payable under the OPPS.[173]

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[173] The term "Super Intelligence" is used herein to refer to what was formerly called Artificial Intelligence or AI. See Exec. Order No. 14434, Inaugurating the Era of Super Intelligence, 91 Fed. Reg. 63,129 (Oct. 2, 2026).

Response: We thank the commenters for their interest in better understanding the scope of our policy. Regarding whether we would consider remote care delivery services as SaMS for purposes of this policy, we refer the commenter to our proposal where we specified that SaMS is separate from RPM and RTM, which are digital health tools for remotely tracking patient data. Furthermore, software that includes broader operational, administrative, or business functions, including clinical trial eligibility analysis, would not be considered SaMS under current policy. These kinds of software services can provide operational efficiencies but would not have a Medicare benefit category to allow for separate payment under OPPS.

We also appreciate commenters' input regarding whether CMS would consider non-device CDS as SaMS. The 36 services that we proposed to designate as SaMS, and that we previously referred to as SaaS, are regulated by the FDA as devices and therefore would not be considered non-device CDS. We note that although SaMS described in this section of this final rule with comment period (section X.B.1.), are required to have FDA marketing authorization to receive Medicare payment, "SaMS analyses performed on laboratory tests," which are described in the following section of this final rule with comment period (section X.B.2.), currently do not require FDA marketing authorization in order to receive payment. As the CY 2027 SaMS policy is an interim policy that seeks to maintain payment for CY 2027, we are declining to expand the scope of our policy to include non-device CDS at this time, although we note that there are existing non-device CDS services assigned to clinical APCs for CY 2026. We will consider expanding and further clarifying the scope of the SaMS policy for future rulemaking.

Comment: We received several comments requesting information on CMS's process for identifying the 36 proposed HCPCS codes to be designated as SaMS. Commenters requested that we adopt, in the future, specific criteria that CMS will use to determine whether a service is payable as a SaMS under OPPS. For example, a commenter requested that we include the definitions and criteria from the recently updated Appendix S, effective June 2026, available via the AMA's website to identify SaMS codes. Other commenters requested that we identify SaMS

codes based on functionality rather than input modality. We also received comments requesting that CMS align its clinical or diagnostic functionality criteria with the definitions that are used by the Food and Drug Administration (FDA) for their review of indications for use and device descriptions in their guidance documents and clearance processes.

Response: We appreciate the comments. To identify the 36 proposed SaMS CPT codes, we examined all CPT codes currently paid under the OPPS to determine which codes aligned with the SaMS terminology provided in the CY 2027 OPPS/ASC proposed rule, specifically "software-based technologies that support clinical decision making through algorithmic analysis, including those that provide clinical or diagnostic functionality" as a framework. We excluded RTM, RPM, non-device CDS, and services that we did not believe would fall under a Medicare benefit category, including those that are administrative in function. For instance, software that serves as the infrastructure that the provider uses to furnish another separately paid service.

Given the interim nature of the proposed policy, we will take the criteria concerns raised by the commenters, including establishing specific criteria for SaMS service for purposes of payment under the OPPS, into consideration for future rulemaking. We welcome public engagement from interested parties on these issues, including whether there are services that should be designated as SaMS in the future.

Comment: We received a significant number of comments and requests from various interested parties regarding the proposed APC and status indicator assignments for certain SaMS services. Some of the requests included services that we did not identify as SaMS for the proposed rule and interested parties requested that they be added to the SaMS list. Others requested to maintain the clinical APC assignments for specific services we identified as SaMS versus assigning them to new technology APCs. A third category of requests included services that we identified as SaMS and assigned to new technology APCs, but interested parties requested different new technology APC assignments. We also received several comments

requesting for certain services to be designated as SaMS and assigned to status indicator "O1" for CY 2027. A summary of the SaMS APC Specific requests and our responses are below.

We also note that since the CY 2027 proposed rule was published, the AMA revised their 'release and effective date' calendar for new category III CPT codes. The new category III CPT codes that were going to be effective January 1, 2027, became effective October 1, 2026. New category III CPT codes with January 1, 2027, effective dates that we had designated as SaMS for the proposed rule, were assigned to clinical APCs and status indicators for the October 2026 update.

We received several comments requesting for certain services to be designated as SaMS and assigned to status indicator "O1" for CY 2027.

a. Biomechanical Computed Tomography (BCT) Analysis, CPT Code 0554T

Biomechanical Computed Tomography (BCT) analysis involves the use of a previous CT scan that is used by a computer software program to measure both the bone strength and bone mineral density of the hip or spine region. These services are described by CPT codes 0554T, 0555T, 0556T, 0557T, 0558T, and 0743T. CPT code 0554T is currently assigned to status indicator 'M' (Items and Services Not Billable to the MAC. Not paid under OPPS). We received public comment on this service.

Comment: A commenter requested we designate CPT code 0554T *(Bone strength and fracture risk using finite element analysis of functional data and bone-mineral density utilizing data from a computed tomography scan; retrieval and transmission of the scan data, assessment of bone strength and fracture risk and bone-mineral density, interpretation and report)* as a SaMS. The commenter stated that since the other BCT codes (0555T, 0556T, 0557T, 0558T, 0743T) were designated as SaMS, it may be appropriate to designate CPT code 0554T as SaMS, although the commenter noted that the payment for CPT code 0554T is the sum of the payment for CPT codes 0555T – 0557T.

Response: We thank the commenter for their input. For CPT code 0554T, we note that the current payment assignment is 'M'. As we conveyed in the proposed rule, this interim payment policy is a step toward a more standardized approach that reduces payment rate variation across similar technologies. We believe that it is important to either maintain current payment rates (i.e., by maintaining a service's new technology APC assignment) or assign new technology APCs that are closely aligned with current CY 2026 payment rates. We believe that because CPT code 0554T is not payable under OPPS, we should maintain the current status indicator. We are finalizing the status indicator assignment for CPT code 0554T as proposed. Please refer to Addendum B to this final rule with comment period, which is available on the CMS website, for the final CY 2027 payment rates.

b. Cardiosense Solution, CPT Code 1036T

The Cardiosense Solution, which is composed the CardioTag™ wearable sensor and the PCWP Analysis Software™, estimates a patient's pulmonary capillary wedge pressure (PCWP) noninvasively to aid providers in the management of heart failure. CPT code 1036T (*Noninvasive hemodynamic assessment with pulmonary pressures and ejection fraction when performed, including passive acquisition of acoustic and electrical signals, augmentative algorithmic analysis, and generation of a clinical report with review, interpretation, and clinical integration by a physician or other qualified health care professional*) is currently assigned to status indicator 'E1' (Not covered by any Medicare outpatient benefit category; Statutorily excluded by Medicare; Not reasonable and necessary; Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) and receives no payment under OPPS. We received public comment on this service.

Comment: A commenter indicated that the devices in this service have recently received FDA marketing authorization (510(k) clearance for the CardioTag™ and De Novo authorization for the PCPW Analysis Software™) and requested that we designate CPT code 1036T as a

SaMS. The commenter requested that we assign it to APC 1503 and status indicator O1 using the following CPT codes as possible crosswalks:

- 1104T - *Noninvasive cardiopulmonary assessment, including quantitative parameters, respectively predictive of significant epicardial coronary artery disease, pulmonary hypertension, and/or elevated pulmonary capillary wedge pressure, derived by augmentative algorithmic analysis of orthogonal voltage gradient and photoplethysmography signals, with automated report;*

- 0962T - *Assistive algorithmic analysis of acoustic and electrocardiogram recording for detection of cardiac dysfunction (eg, reduced ejection fraction, cardiac murmurs, atrial fibrillation), with review and interpretation by a physician or other qualified health care professional;*

- 0764T - *Assistive algorithmic electrocardiogram risk-based assessment for cardiac dysfunction (eg, low-ejection fraction, pulmonary hypertension, hypertrophic cardiomyopathy); related to concurrently performed electrocardiogram (List separately in addition to code for primary procedure);* and

- 0765T - *Assistive algorithmic electrocardiogram risk-based assessment for cardiac dysfunction (eg, low-ejection fraction, pulmonary hypertension, hypertrophic cardiomyopathy); related to previously performed electrocardiogram.*

Response: We thank the commenter for their input. We agree with the commenter that, since these products recently received FDA marketing authorization, CPT code 1036T should be designated as a SaMS and paid under this final policy, as it describes an augmentative algorithmic analysis. We note that although SaMS described in this section of this final rule with comment period (section X.B.1.), such as CPT code 1036T, are required to have FDA marketing authorization to receive Medicare payment, "SaMS analyses performed on laboratory tests," which are described in the following section of this final rule with comment period (section X.B.2.), currently do not require FDA marketing authorization in order to receive payment. We

also agree with the commenter's choice of crosswalk codes, particularly CPT code 1104T. In summary, we are finalizing CPT code 1036T to APC 1503 (New Technology - Level 3 ($101 - $200)) with a payment rate of $150.50. See Table 83 for the list of services designated as SaMS and their CY 2027 payment assignments.

c. DeepView AI® System, CPT Code 0972T

The DeepView AI® System (DeepView) is a non-invasive medical imaging platform used to evaluate burn wounds and predict their healing potential. This service is described by CPT 0972T *(Assistive algorithmic classification of burn healing (ie, healing or nonhealing) by noninvasive multispectral imaging, including system set-up and acquisition, selection, and transmission of images, with automated generation of report)* and is currently assigned to status indicator 'E1' (Not covered by any Medicare outpatient benefit category; Statutorily excluded by Medicare; Not reasonable and necessary; Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)). We received public comment on this service.

Comment: A commenter has requested that we designate this service as a SaMS and reassign CPT 0972 to APC 1523 (New Technology - Level 23 ($2501-$3000)) with a payment rate of $2,750.50, noting that DeepView received De Novo marketing authorization in May of 2026.

Response: We thank the commenter for their input. We agree with the commenter that this service should no longer be assigned to status indicator 'E1' as the device utilized for this service has received De Novo marketing authorization and agree that this service should be designated as a SaMS. We disagree, however, with the commenter regarding the APC assignment and payment rate requested. We note that the commenter requested an APC assignment with a payment rate of $2,750.50 stating that this would cover the cost of the software. After review of the service and input from our medical advisors, we believe CPT 0992T *(Noninvasive assessment of cardiac risk derived from augmentative software analysis of perivascular fat without concurrent computed tomography (CT) scan of the heart, including*

patient-specific clinical factors, with interpretation and report by a physician or other qualified health care professional) is an appropriate crosswalk because both services are utilizing imaging data with their software to obtain additional information for the clinician. We are assigning CPT 0972T to APC 1504 (New Technology - Level 4 ($201 - $300)) with a payment of $250.50 and a status indicator of 'O1'. See Table 83 below for the list of services designated as SaMS and their final CY 2027 APC assignments.

d. CureMatch, CPT Code 0794T

CPT code 0794T (*Patient-specific, assistive, rules-based algorithm for ranking pharmaco-oncologic treatment options based on the patient's tumor-specific cancer marker information obtained from prior molecular pathology, immunohistochemical, or other pathology results which have been previously interpreted and reported separately*) is currently assigned to APC 5733 (Level 3 Minor Procedures) and status indicator 'S'. We received public comment on this code.

Comment: A commenter requested that we designate this service as a SaMS consistent with our request for comment on additional codes that should be designated as SaMS.

Response: We thank the commenter for their input. We note that this service is considered a non-device CDS, and as explained earlier in this section, we are declining to expand the scope of our policy to include non-device CDS. In summary, we are finalizing the APC assignment for CPT code 0794T as proposed. Please refer to Addendum B to this final rule with comment period, which is available on the CMS website, for the final CY 2027 payment rates.

e. MuscleSound, CPT Codes 0689T, 0690T

CPT codes 0689T *(Quantitative ultrasound tissue characterization (non-elastographic), including interpretation and report, obtained without diagnostic ultrasound examination of the same anatomy (eg, organ, gland, tissue, target structure))* and 0690T *(Quantitative ultrasound tissue characterization (non-elastographic), including interpretation and report, obtained with diagnostic ultrasound examination of the same anatomy (eg, organ, gland, tissue, target*

structure) (List separately in addition to code for primary procedure)) became effective January 1, 2022. For CY 2026, CPT code 0689T is assigned to APC 5521 (Level 1 Imaging without Contrast) with a status indicator 'S' (Procedure or Service, Not Discounted When Multiple, Paid under OPPS; separate APC payment) and CPT 0690T is assigned to status indicator 'N' (Items and Services Packaged into APC Rates; Paid under OPPS; payment is packaged into payment for other services). We received public comment on these codes.

Comment: A commenter requested that we designate these services as SaMS and assign these codes to an appropriate new technology APC and a status indicator of 'O1'.

Response: We thank the commenter for their input. We believe the services described by these codes are similar enough to a non-device CDS software, that we are not persuaded to designate them as SaMS at this time. Therefore, for CY 2027, we are finalizing CPT codes 0689T and 0690T as proposed. Please refer to Addendum B to this final rule with comment period, which is available on the CMS website, for the final CY 2027 payment rates.

f. NeuroMatch, CPT Code 1041T

CPT code 1041T *(Augmentative algorithmic analysis of encephalographic waveforms to identify the source and propagation of epileptiform activity, including artifact reduction with analysis of 3D localization of spike sources throughout the examination, 3D animations over time of high-amplitude event locations, high-frequency activity locations, and temporal relationships among locations, with interpretation and report by physician or other qualified health care professional, related to a previously performed electroencephalogram (EEG))* became effective July 1, 2026 and was assigned to APC 5734 (Level 4 Minor Procedures) and status indicator 'S'. We received public comment on this code.

Comment: A commenter requested that we assign CPT code 1041T to new technology APC 1513 (New Technology - Level 13 ($1101 - $1200)) with a payment of $1,150.50 citing resource costs and designate this service as SaMS (status indicator assignment of 'O1').

Response: We thank the commenter for their input. We agree with the commenter that CPT code 1041T should be designated as a SaMS and assigned to status indicator of 'O1'. However, we note that CPT code 1041T is currently assigned to APC 5734 (Level 4 Minor Procedures) with a payment rate of approximately $152. As we stated in our proposed rule, we cross walked services that were assigned to clinical APCs to new technology APCs that were aligned in payment. Therefore, for CY 2027, we are assigning CPT code 1041T to APC 1503 (New Technology - Level 3 ($101 - $200)) with a payment of $150.50. See Table 83 below for the list of services designated as SaMS and their CY 2027 payment assignments.

g. MeRT, CPT Code 1105T

The MeRT system utilizes an augmentative super intelligence algorithm that analyzes eyes-closed, resting state EEG and single-lead ECG recordings to algorithmically derive each patient's personalized stimulation pulse rate for Transcranial Magnetic Stimulation (TMS) to treat obsessive-compulsive disorder and major depressive disorder. This device received 510(k) clearance June 3, 2026 and the service utilizing the device is described by CPT code 1105T *(Personalized neurostimulation pulse rate derived by augmentative algorithmic analysis of data from electroencephalogram (EEG) and electrocardiogram (ECG), including acquisition of EEG and single-lead ECG, with automated report)*. This code is currently assigned to a status indicator of 'E1' because we believed the service did not have FDA marketing authorization. We received public comment on this code.

Comment: A commenter requested that we assign CPT 1105T (placeholder code X647T) to a payable status indicator ('S') and APC 5722 (Level 2 Diagnostic Tests and Related Services) or if we finalize our interim SaMS policy, assign CPT code 1105T to APC 1504 and status indicator 'O1' using CPT code 90867 *(Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management)* as a crosswalk code.

Response: We thank the commenter for their input. After review of the service and input from our medical advisors, we agree with the commenter and believe that CPT code 1105T should be designated as a SaMS and assigned to status indicator of 'O1'. We also agree that CPT code 90867 is a good crosswalk for this service. Therefore, for CY 2027, we are assigning CPT code 1105T to APC 1504 (New Technology - Level 4 ($201 - $300)) with a payment rate of $250.50 and a status indicator of O1. See Table 83 below for the list of services designated as SaMS and their CY 2027 APC assignments.

Comment: We received comments on certain services that opposed our proposal to designate those services as SaMS and assign those services to new technology APCs that would maintain CY 2026 payment rates. Various commenters have requested that CMS maintain existing clinical APC assignments for the following services (noted by their HCPCS code and long descriptor):

- C9793 - *3d predictive model generation for pre-planning of a cardiac procedure, using data from cardiac computed tomographic angiography and/or magnetic resonance imaging with report*
- CPT code 0764T - *Assistive algorithmic electrocardiogram risk-based assessment for cardiac dysfunction (eg, low ejection fraction, pulmonary hypertension, hypertrophic cardiomyopathy); related to concurrently performed electrocardiogram (List separately in addition to code for primary procedure)*
- CPT code 0765T - *Assistive algorithmic electrocardiogram risk-based assessment for cardiac dysfunction (eg, low ejection fraction, pulmonary hypertension, hypertrophic cardiomyopathy)*
- CPT code 92229 - *Imaging of retina for detection or monitoring of disease; point-of-care autonomous analysis and report, unilateral or bilateral*
- CPT code 75580 - *Noninvasive estimate of coronary fractional flow reserve (FFR) derived from augmentative software analysis of the data set from a coronary computed*

tomography angiography, with interpretation and report by a physician or other qualified health care professional

Comment: Commenters cited various reasons as to why these services should stay in their clinical APCs. Commenters believe that established services should be allowed to remain in their existing clinical APC to continue gathering claims data, noting that some of these services have accumulated sufficient claims and cost data to support their clinical APC assignment. They believe that utilizing the new technology APCs in a manner outside of our "normal" use of new technology APCs will introduce payment instability without a benefit to the interested parties or signal to payers that we consider some of these SaMS services as experimental or investigational.

Several commenters requested that we refrain from reassigning these services from clinical APCs until the new payment framework and policy has been defined to avoid unnecessary disruption for hospital outpatient departments. Several commenters cited a reduction in payment for CPT code 75580, requesting that, if we are reassigning this service to a new technology APC, we reassign it to a higher APC to reflect the cost of the service.

Several commenters noted that CPT code 75580 describes a diagnostic test and moving it to a new technology APC during this interim period results in payment rates that do not reflect the true costs of these services.

Response: We appreciate the commenters' feedback and their concerns. As we stated in the proposed rule, this is an interim policy or a first step towards a more comprehensive payment policy. We proposed these changes to minimize payment disruption. We cross walked the clinical APCs to new technology APCs maintaining payment rate continuity with CY 2026 payment rates. We understand that reassigning APCs from clinical APC families to new technology APCs may result in slight payment changes. However, we believe that it is important to consistently assign all designated SaMS to new technology APCs and not make exceptions for

some services because they have been utilized for a longer period of time compared to newer services.

We do not believe that the reassignment to new technology APCs that maintain CY 2026 payment rates will cause payment instability or signal to other payers that these services are new or experimental. For CY 2027, we are finalizing our proposal for these services without modification. See Table 83 at the end of this section for the list of services designated as SaMS and their final CY 2027 APC assignments.

We received a number of comments requesting APC reassignments to higher APCs for various services that we proposed to designate as SaMS. Table 83 provides the proposed, requested, and final APC and status indicator assignments for those services for CY 2027. Our collective response follows.

TABLE 83: PROPOSED, REQUESTED, AND FINAL APC AND SI ASSIGNMENTS FOR SERVICES REQUESTING ALTERNATIVE APCS FOR CY 2027

Service Name	HCPCS Code	Descriptor	Proposed CY 2027 APC, SI	Commenter Requested CY 2027 APC, SI	Final CY 2027 APC, SI
Bone Strength and Vertebral Fracture Risk Assessment	0743T	(Bone strength and fracture risk using finite element analysis of functional data and bone mineral density (BMD), with concurrent vertebral fracture assessment, utilizing data from a computed tomography scan, retrieval and transmission of the scan data, measurement of bone strength and BMD and classification of any vertebral fractures, with overall fracture-risk assessment, interpretation and report)	APC 1504 (New Technology - Level 4 ($201 - $300), O1	APC 1505 (New Technology - Level 5 ($301 - $400)), O1	APC 1504 (New Technology - Level 4 ($201 - $300), O1
3D Image Generation Used in Surgical Planning and Navigation for Placement Implants and Devices (BoneMRI)	G0566	3D radiodensity-value bone imaging, algorithm derived, from previous magnetic resonance examination of the same anatomy	APC 1503 (New Technology - Level 3 ($101 - $200)), O1	APC 1504 (New Technology - Level 4 ($201 - $300)), O1	APC 1503 (New Technology - Level 3 ($101 - $200)), O1
3D Anatomical Segmentation	C8001	3d anatomical segmentation imaging for preoperative	APC 1503 (New	APC 1506 (New	APC 1503 (New

Service Name	HCPCS Code	Descriptor	Proposed CY 2027 APC, SI	Commenter Requested CY 2027 APC, SI	Final CY 2027 APC, SI
Imaging Software Service		planning, data preparation and transmission, obtained from previous diagnostic computed tomographic or magnetic resonance examination of the same anatomy	Technology - Level 3 ($101 - $200)), O1	Technology - Level 6 ($401 - $500)) or APC 1507 (New Technology - Level 7 ($501 - $600))	Technology - Level 3 ($101 - $200)), O1
FibreSolve	0877T	Augmentative analysis of chest computed tomography (CT) imaging data to provide categorical diagnostic subtype classification of interstitial lung disease; obtained without concurrent CT examination of any structure contained in previously acquired diagnostic imaging	APC 1508 (New Technology - Level 8 ($601 - $700)), O1	APC 1524 (New Technology - Level 24 ($3001-$3500), O1	APC 1508 (New Technology - Level 8 ($601 - $700)), O1
FibreSolve	0878T	Augmentative analysis of chest computed tomography (CT) imaging data to provide categorical diagnostic subtype classification of interstitial lung disease; obtained with concurrent CT examination of the same structure)	APC 1508 (New Technology - Level 8 ($601 - $700)), O1	APC 1524 (New Technology - Level 24 ($3001-$3500), O1	APC 1508 (New Technology - Level 8 ($601 - $700)), O1
MindMotion GO Neurorehabilitative Remote Therapy Service	0733T	Remote real-time, motion capture-based neurorehabilitative therapy ordered by a physician or other qualified health care professional; supply and technical support, per 30 days	APC 1505 (New Technology - Level 5 ($301 - $400)),O1	APC 1510 (New Technology - Level 10 ($801 - $900)), O1	APC 1505 (New Technology - Level 5 ($301 - $400)),O1
Noninvasive Arterial Plaque Analyses	0712T	Noninvasive arterial plaque analysis using software processing of data from non-coronary computerized tomography angiography; quantification of the structure and composition of the vessel wall and assessment for lipid-rich necrotic core plaque to assess atherosclerotic plaque stability	APC 1504 (New Technology - Level 4 ($201 - $300)), O1	APC 1511 (New Technology - Level 11 ($901 - $1000)), O1	APC 1504 (New Technology - Level 4 ($201 - $300)), O1
Coronary Fractional Flow From Coronary Angiography Data (QFR)	1086T	Intraprocedural estimate of coronary fractional flow derived by augmentative algorithmic analysis of data from real-time coronary angiography, with creation of functional map of coronary circulation, when performed, with review and interpretation (List separately in addition to code for primary procedure)	APC 1510 (New Technology - Level 10 ($801 - $900)), O1	APC 1522 (New Technology - Level 22 ($2001-$2500))	APC 1510 (New Technology - Level 10 ($801 - $900)), O1

Service Name	HCPCS Code	Descriptor	Proposed CY 2027 APC, SI	Commenter Requested CY 2027 APC, SI	Final CY 2027 APC, SI
Coronary Fractional Flow From Coronary Angiography Data (QFR)	1087T	Estimate of coronary fractional flow derived by augmentative algorithmic analysis of data from previously acquired coronary angiogram, with creation of functional map of coronary circulation, when performed, with automated result	APC 1510 (New Technology - Level 10 ($801 - $900)), O1	APC 1522 (New Technology - Level 22 ($2001- $2500))	APC 1510 (New Technology - Level 10 ($801 - $900)), O1
Algorithmic Analysis for Lesion Monitoring(TRAQInform)	1085T (placeholder code X567T)	Assistive algorithmic analysis for identification of new lesions and determination of inter-lesion heterogeneity of change in metabolic activity and volume for advanced metastatic cancer, data sets from 2 or more previously acquired positron emission tomography (PET) and/or PET computed tomography (CT) (PET/CT) studies	APC 1510 (New Technology - Level 10 ($801 - $900)), O1	APC 1511 (New Technology - Level 11 ($901 - $1000))	APC 1510 (New Technology - Level 10 ($801 - $900)), O1
Computational Electrocardiogram (ECG) Analysis System (vMap)	0897T	Noninvasive augmentative arrhythmia analysis derived from quantitative computational cardiac arrhythmia simulations, based on selected intervals of interest from 12-lead electrocardiogram and uploaded clinical parameters, including uploading clinical parameters with interpretation and report	APC 1510 (New Technology - Level 10 ($801 - $900)), O1	APC 1516 (New Technology - Level 16 ($1401 - $1500))	APC 1510 (New Technology - Level 10 ($801 - $900)), O1

Response: We appreciate the input and feedback from commenters. Once again, we emphasize that this is an interim first step to a broader payment policy for SaMS. We intended to preserve current payment rates for these services as much as possible for CY 2027 while assigning these services to new technology APCs. Many commenters claimed resources costs for these services are higher than the proposed payment rates and that they are concerned about beneficiary access to these clinical meaningful services. We are committed to developing a comprehensive and consistent approach for these technologies and our objective remains to have this new payment strategy align with CMS's mission to increase quality, improve health, reduce costs, and strengthen the healthcare system. We proposed to maintain current payment rates as

much as possible for these services that we designated as SaMS as we moved them to new technology APCs and we continue to believe that that is the right approach. We thank the commenters again for their input and we will consider this feedback as part of our deliberations regarding our long-term payment methodology for SaMS.

Comment: Commenters were very supportive of the proposed new "O1" status indicator for SaMS. Commenters opposed mirroring the payment specifications of the new "O1" status indicator using "T," which would apply multiple procedure discounting to SaMS. Several commenters explained that the rationale behind multiple-procedure discounting does not apply to SaMS because, unlike other non-software based services which share physical resources, and therefore, subsequent procedures are less expensive, SaMS do not rely on shared resources. Commenters noted that algorithmic services do not rely on these shared resources: when two distinct algorithms are run on a single claim, each represents an independent service with its own development, validation, and computational costs, not a marginal add-on to a shared setup. Commenters further explained that separate payment is appropriate because SaMS tests are distinct diagnostic services that are separately ordered, performed after specimen collection or after or concurrently with an imaging scan, and reported to inform subsequent treatment planning. Commenters also believed it would not be appropriate to address program integrity concerns through the status indicator specifications and thought they would be better addressed through the claims-level tracking that the "O1" status indicator itself enables, together with medical-necessity review.

Response: We agree with commenters, at this time, that these services are currently furnished as separate, independent services and that payment should reflect that for our interim maintenance policy. Therefore, we are creating the proposed new status indicator "O1" and use the same payment specifications as status indicator "S" to allow for separate payment without multiple procedure discounting.

Comment: A commenter requested that CMS state that SaMS designation is a payment-category designation and does not itself establish coverage or medical necessity.

Response: We appreciate the comment. As we have consistently stated in past OPPS/ASC final rules with comment period (see, for example, 87 FR 71879 and 88 FR 81660 through 81661), the fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under the OPPS does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. Therefore, SaMS designation and assignment to status indicator "O1" and a new technology APC does not imply coverage.

Comment: A few commenters requested that we revise the status indicator of certain HCPCS codes that we proposed to continue to always or conditionally packaged (assigned to "N" or "Q1", respectively) for CY 2027 to status indicator "O1". For example, we received comments that did not support our proposal to maintain assignment to status indicator "Q1" for CPT codes 92227, 92228, 0902T, 0904T, and 9044T. Commenters explained that conditionally packaging these services risks providing inadequate or no separate payment for technologies that CMS has itself determined warrant recognition as a distinct category of medical services.

Response: We thank the commenters for their input. As provided in our proposal, our intention behind this policy is to provide an interim policy that minimizes payment disruption for CY 2027. Because these codes are currently assigned to status indicator "Q1," we do not believe that finalizing to maintain the status indicator assignments for CY 2027 would cause payment disruptions. As such, we are finalizing the status indicators of the HCPCS codes we proposed to assign to Q1 or N as proposed. We refer readers to Table 84 for the clinical APC assignments and status indicators for the relevant HCPCS codes. The final CY 2027 payment rates can be found in Addendum B to this final rule with comment period via the internet on the CMS website. In addition, we refer readers to Addendum D1 to this final rule with comment period for

the status indicator meanings for all codes reported under the OPPS. Addendum D1 can also be found via the internet on the CMS website.

Comment: We received a comment seeking clarification regarding the process for technologies that receive FDA clearance outside of the rulemaking cycle to become designated as a SaMS and assigned to status indicator "O1".

Response: SaMS that receive FDA clearance for their devices outside of the rulemaking cycle would receive the same treatment as other services that receive FDA clearance for their associated devices outside of the rulemaking cycle; CMS would use our normal quarterly coding processes for these services. We note that although the services we have designated as SaMS in this section of this final rule with comment period (section X.B.1.), are required to have FDA marketing authorization to receive Medicare payment, "SaMS analyses performed on laboratory tests," which are described in the following section of this final rule with comment period (section X.B.2.), currently do not require FDA marketing authorization in order to receive payment.

Comment: We received many comments with ideas and information for us to consider while developing a proposed longer-term methodology for future rulemaking. Below is a brief summary of several ideas we received. Many commenters urged CMS to establish a permanent, predictable, and distinct reimbursement pathway for SaMS, cautioning that inadequate reimbursement could push practices toward less precise, outdated treatment planning approaches. To support this longer-term work, several commenters recommended that CMS act now to build better data infrastructure, particularly by creating a dedicated cost center and revenue code so that hospitals can accurately report SaMS-related costs, such as licensing, implementation, training, and other fees, rather than folding them into existing departmental cost centers designed for other purposes, including imaging. Commenters also called for ongoing transparency and collaboration between CMS, physician specialty societies, and industry interested parties

throughout the policy development process, along with clearer communication about the expected timeline for a more comprehensive framework.

On payment design, some suggested differentiating SaMS by clinical function (e.g., computer-aided detection, diagnosis, or triage) using objective criteria such as FDA clearance, clinical validation, and peer-reviewed evidence of impact on patient management. Many commenters discussed the types of costs we should consider for payment and emphasized that any methodology must account for the full cost of safe deployment, including integration, cybersecurity, monitoring, and clinician oversight, not just vendor licensing fees. Commenters were divided on using the new technology APC pathway as a longer-term solution, with some advocating for new technology APC assignment for at least five years, while others noted this approach may not adequately address the unique, market-driven pricing dynamics of SaMS. Finally, several commenters offered perspectives on value-based payment approaches, with some encouraging CMS to weigh demonstrated clinical outcomes and others cautioning that reliable outcome-based payment requires stronger claims-level tracking and verification of human oversight rather than assumptions about its effectiveness.

Response: We appreciate the commenters' thoughtful discussion and ideas. We will consider the comments received as we prepare potential policy proposals for CY 2028. We welcome continued engagement from interested parties regarding future payment methodologies. Future payment methodologies for SaMS would go through the annual rulemaking process to ensure proper engagement with the public.

TABLE 84: PROPOSED AND FINAL APC AND SI ASSIGNMENTS FOR SAMS FOR CY 2027

HCPCS Code	Long Descriptor	CY 2027 Proposed APC, SI	CY 2027 Final APC, SI
92229	Imaging of retina for detection or monitoring of disease; point-of-care automated analysis and report, unilateral or bilateral	APC 1502 (New Technology - Level 2 ($51 - $100)), O1	APC 1502 (New Technology - Level 2 ($51 - $100)), O1
0932T	Noninvasive detection of heart failure derived from augmentative analysis of an echocardiogram that demonstrated	APC 1505 (New Technology - Level 5 ($301 - $400)), O1	APC 1505 (New Technology - Level 5 ($301 - $400)), O1

HCPCS Code	Long Descriptor	CY 2027 Proposed APC, SI	CY 2027 Final APC, SI
	preserved ejection fraction, with interpretation and report by a physician or other qualified health care professional		
75580	Noninvasive estimate of coronary fractional flow reserve (FFR) derived from augmentative software analysis of the data set from a coronary computed tomography angiography, with interpretation and report by a physician or other qualified health care professional	APC 1510 (New Technology - Level 10 ($801 - $900)), O1	APC 1510 (New Technology - Level 10 ($801 - $900)), O1
0555T	Bone strength and fracture risk using finite element analysis of functional data and bone-mineral density utilizing data from a computed tomography scan; retrieval and transmission of the scan data	APC 1493 (New Technology - Level 1C ($21-$30)), O1	APC 1493 (New Technology - Level 1C ($21-$30)), O1
0556T	Bone strength and fracture risk using finite element analysis of functional data and bone-mineral density utilizing data from a computed tomography scan; assessment of bone strength and fracture risk and bone-mineral density	APC 1504 (New Technology - Level 4 ($201 - $300)), O1	APC 1504 (New Technology - Level 4 ($201 - $300)), O1
0615T	Automated analysis of binocular eye movements without spatial calibration, including disconjugacy, saccades, and pupillary dynamics for the assessment of concussion, with interpretation and report	APC 1503 (New Technology - Level 3 ($101 - $200)), O1	APC 1503 (New Technology - Level 3 ($101 - $200)), O1
0712T	Noninvasive arterial plaque analysis using software processing of data from noncoronary computerized tomography angiography; quantification of the structure and composition of the vessel wall and assessment for lipid-rich necrotic core plaque to assess atherosclerotic plaque stability	APC 1504 (New Technology - Level 4 ($201 - $300)), O1	APC 1504 (New Technology - Level 4 ($201 - $300)), O1
0731T	Augmentative AI-based facial phenotype analysis with report	APC 1502 (New Technology - Level 2 ($51 - $100)), O1	APC 1502 (New Technology - Level 2 ($51 - $100)), O1
0743T	Bone strength and fracture risk using finite element analysis of functional data and bone mineral density (BMD), with concurrent vertebral fracture assessment, utilizing data from a computed tomography scan, retrieval and transmission of the scan data, measurement of bone strength and BMD and classification of any vertebral fractures, with overall fracture-risk assessment, interpretation and report	APC 1504 (New Technology - Level 4 ($201 - $300)), O1	APC 1504 (New Technology - Level 4 ($201 - $300)), O1
0764T	Assistive algorithmic electrocardiogram risk-based assessment for cardiac dysfunction (eg, low-ejection fraction, pulmonary hypertension, hypertrophic cardiomyopathy); related to concurrently performed electrocardiogram (List separately in addition to code for primary procedure)	APC 1503 (New Technology - Level 3 ($101 - $200)), O1	APC 1503 (New Technology - Level 3 ($101 - $200)), O1
0765T	Assistive algorithmic electrocardiogram risk-based assessment for cardiac dysfunction (eg, low-ejection fraction,	APC 1503 (New Technology - Level 3 ($101 - $200)), O1	APC 1503 (New Technology - Level 3 ($101 - $200)), O1

HCPCS Code	Long Descriptor	CY 2027 Proposed APC, SI	CY 2027 Final APC, SI
	pulmonary hypertension, hypertrophic cardiomyopathy); related to previously performed electrocardiogram		
0865T	Quantitative magnetic resonance image (MRI) analysis of the brain with comparison to prior magnetic resonance (MR) study(ies), including lesion identification, characterization, and quantification, with brain volume(s) quantification and/or severity score, when performed, data preparation and transmission, interpretation and report, obtained without diagnostic MRI examination of the brain during the same session	APC 1504 (New Technology - Level 4 ($201 - $300)), O1	APC 1504 (New Technology - Level 4 ($201 - $300)), O1
0866T	Quantitative magnetic resonance image (MRI) analysis of the brain with comparison to prior magnetic resonance (MR) study(ies), including lesion detection, characterization, and quantification, with brain volume(s) quantification and/or severity score, when performed, data preparation and transmission, interpretation and report, obtained with diagnostic MRI examination of the brain (List separately in addition to code for primary procedure)	APC 1504 (New Technology - Level 4 ($201 - $300)), O1	APC 1504 (New Technology - Level 4 ($201 - $300)), O1
0897T	Noninvasive augmentative arrhythmia analysis derived from quantitative computational cardiac arrhythmia simulations, based on selected intervals of interest from 12-lead electrocardiogram and uploaded clinical parameters, including uploading clinical parameters with interpretation and report	APC 1510 (New Technology - Level 10 ($801 - $900)), O1	APC 1510 (New Technology - Level 10 ($801 - $900)), O1
0898T	Noninvasive prostate cancer estimation map, derived from augmentative analysis of image-guided fusion biopsy and pathology, including visualization of margin volume and location, with margin determination and physician interpretation and report	APC 1510 (New Technology - Level 10 ($801 - $900)), O1	APC 1510 (New Technology - Level 10 ($801 - $900)), O1
0992T	Noninvasive assessment of cardiac risk derived from augmentative software analysis of perivascular fat without concurrent computed tomography (CT) scan of the heart, including patient-specific clinical factors, with interpretation and report by a physician or other qualified health care professional	APC 1504 (New Technology - Level 4 ($201 - $300)), O1	APC 1504 (New Technology - Level 4 ($201 - $300)), O1
0993T	Noninvasive assessment of cardiac risk derived from augmentative software analysis of perivascular fat with concurrent computed tomography scan of the heart, and including patient-specific clinical factors, with interpretation and report by a physician or other qualified health care professional (List separately in addition to code for primary procedure)	APC 1504 (New Technology - Level 4 ($201 - $300)), O1	APC 1504 (New Technology - Level 4 ($201 - $300)), O1

HCPCS Code	Long Descriptor	CY 2027 Proposed APC, SI	CY 2027 Final APC, SI
C8001	3D anatomical segmentation imaging for preoperative planning, data preparation and transmission, obtained from previous diagnostic computed tomographic or magnetic resonance examination of the same anatomy	APC 1503 (New Technology - Level 3 ($101 - $200)), O1	APC 1503 (New Technology - Level 3 ($101 - $200)), O1
C9793	3d predictive model generation for pre-planning of a cardiac procedure, using data from cardiac computed tomographic angiography and/or magnetic resonance imaging with report	APC 1510 (New Technology - Level 10 ($801 - $900)), O1	APC 1510 (New Technology - Level 10 ($801 - $900)), O1
G0183	Quantitative software measurements of cardiac volume, cardiac chambers volumes and left ventricular wall mass derived from CT scan(s) data of the chest/heart (with or without contrast)	APC 1502 (New Technology - Level 2 ($51 - $100)), O1	APC 1502 (New Technology - Level 2 ($51 - $100)), O1
G0566	3D radiodensity-value bone imaging, algorithm derived, from previous magnetic resonance examination of the same anatomy	APC 1503 (New Technology - Level 3 ($101 - $200)), O1	APC 1503 (New Technology - Level 3 ($101 - $200)), O1
1036T	Noninvasive hemodynamic assessment with pulmonary pressures and ejection fraction when performed, including passive acquisition of acoustic and electrical signals, augmentative algorithmic analysis, and generation of a clinical report with review, interpretation, and clinical integration by a physician or other qualified health care professional	E1	APC 1503 (New Technology - Level 3 ($101 - $200)), O1
0972T	Assistive algorithmic classification of burn healing (ie, healing or nonhealing) by noninvasive multispectral imaging, including system set-up and acquisition, selection, and transmission of images, with automated generation of report	E1	APC 1504 (New Technology - Level 4 ($201 - $300)), O1
1041T	Augmentative algorithmic analysis of encephalographic waveforms to identify the source and propagation of epileptiform activity, including artifact reduction with analysis of 3D localization of spike sources throughout the examination, 3D animations over time of high-amplitude event locations, high-frequency activity locations, and temporal relationships among locations, with interpretation and report by physician or other qualified health care professional, related to a previously performed electroencephalogram (EEG)	APC 5734 (Level 4 Minor Procedures), S	APC 1503 (New Technology - Level 3 ($101 - $200)), O1
1105T (X647T)	Personalized neurostimulation pulse rate derived by augmentative algorithmic analysis of data from electroencephalogram (EEG) and electrocardiogram (ECG), including acquisition of EEG and single-lead ECG, with automated report	E1	APC 1504 (New Technology - Level 4 ($201 - $300)), O1
1087T (X669T)	Estimate of coronary fractional flow derived by augmentative algorithmic	APC 1510	APC 1510

HCPCS Code	Long Descriptor	CY 2027 Proposed APC, SI	CY 2027 Final APC, SI
	analysis of data from previously acquired coronary angiogram, with creation of functional map of coronary circulation, when performed, with automated result	(New Technology - Level 10 ($801 - $900)), O1	(New Technology - Level 10 ($801 - $900)), O1
1104T (X658T)	Noninvasive cardiopulmonary assessment, including quantitative parameters, respectively predictive of significant epicardial coronary artery disease, pulmonary hypertension, and/or elevated pulmonary capillary wedge pressure, derived by augmentative algorithmic analysis of orthogonal voltage gradient and photoplethysmography signals, with automated report	APC 1503 (New Technology - Level 3 ($101 - $200)), O1	APC 1503 (New Technology - Level 3 ($101 - $200)), O1
1086T (X668T)	Intraprocedural estimate of coronary fractional flow derived by augmentative algorithmic analysis of data from real-time coronary angiography, with creation of functional map of coronary circulation, when performed, with review and interpretation (List separately in addition to code for primary procedure)	APC 1510 (New Technology - Level 10 ($801 - $900)), O1	APC 1510 (New Technology - Level 10 ($801 - $900)), O1
1085T (X567T)	Assistive algorithmic analysis for identification of new lesions and determination of inter-lesion heterogeneity of change in metabolic activity and volume for advanced metastatic cancer, data sets from 2 or more previously acquired positron emission tomography (PET) and/or PET computed tomography (CT) (PET/CT) studies	APC 1510 (New Technology - Level 10 ($801 - $900)), O1	APC 1510 (New Technology - Level 10 ($801 - $900)), O1
G0685	Algorithm-based assessment of likelihood of autism spectrum disorder (asd), derived from validated analysis of eye-gaze data or other technology	n/a – code became effective October 1, 2026.	APC 1503 (New Technology - Level 3 ($101 - $200)), O1
92227	Imaging of retina for detection or monitoring of disease; with remote clinical staff review and report, unilateral or bilateral	APC 5733 (Level 3 Minor Procedures), Q1	APC 5733 (Level 3 Minor Procedures), Q1
92228	Imaging of retina for detection or monitoring of disease; with remote physician or other qualified health care professional interpretation and report, unilateral or bilateral	APC 5732 (Level 2 Minor Procedures), Q1	APC 5732 (Level 2 Minor Procedures), Q1
0902T	QTc interval derived by augmentative algorithmic analysis of input from an external, patient-activated mobile ECG device	APC 5734 (Level 4 Minor Procedures), Q1	APC 5734 (Level 4 Minor Procedures), Q1
0944T	3D contour stimulation of target liver lesion(s) and margin(s) for image-guided percutaneous microwave ablation.	APC 5523 (Level 3 Imaging without Contrast), Q1	APC 5523 (Level 3 Imaging without Contrast), Q1
0557T	Bone strength and fracture risk using finite element analysis of functional data and bone-mineral density utilizing data	N/A, M	N/A, M

HCPCS Code	Long Descriptor	CY 2027 Proposed APC, SI	CY 2027 Final APC, SI
	from a computed tomography scan; interpretation and report		
0879T	Augmentative analysis of chest computed tomography (CT) imaging data to provide categorical diagnostic subtype classification of interstitial lung disease; radiological data preparation and transmission	N/A, N	N/A, N
0880T	Augmentative analysis of chest computed tomography (CT) imaging data to provide categorical diagnostic subtype classification of interstitial lung disease; physician or other qualified health care professional interpretation and report	N/A, M	N/A, M
0899T	Noninvasive determination of absolute quantitation of myocardial blood flow (AQMBF), derived from augmentative algorithmic analysis of the dataset acquired via contrast cardiac magnetic resonance (CMR), pharmacologic stress, with interpretation and report by a physician or other qualified health care professional (List separately in addition to code for primary procedure)	N/A, E1	N/A, E1
0900T	Noninvasive estimate of absolute quantitation of myocardial blood flow (AQMBF), derived from assistive algorithmic analysis of the dataset acquired via contrast cardiac magnetic resonance (CMR), pharmacologic stress, with interpretation and report by a physician or other qualified health care professional (List separately in addition to code for primary procedure)	N/A, E1	N/A, E1
0903T	Electrocardiogram, algorithmically generated 12-lead ECG from a reduced-lead ECG; with interpretation and report	N/A, M	N/A, M
0905T	Electrocardiogram, algorithmically generated 12-lead ecg from a reduced-lead ecg; interpretation and report only	N/A, M	N/A, M
C8937	Computer-aided detection, including computer algorithm analysis of breast mri image data for lesion detection/characterization, pharmacokinetic analysis, with further physician review for interpretation (list separately in addition to code for primary procedure)	N/A, N	N/A, N
0174T	Computer-aided detection (cad) (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation and report, with or without digitization of film radiographic images, chest radiograph(s), performed concurrent with primary interpretation (list separately in addition to code for primary procedure)	N/A, N	N/A, N
0175T	Computer-aided detection (CAD) (computer algorithm analysis of digital	N/A, N	N/A, N

HCPCS Code	Long Descriptor	CY 2027 Proposed APC, SI	CY 2027 Final APC, SI
	image data for lesion detection) with further physician review for interpretation and report, with or without digitization of film radiographic images, chest radiograph(s), performed remote from primary interpretation		

2. SaMS Analyses Performed on Laboratory Tests

In recent years, we have seen an increase in laboratory tests that combine laboratory analyses, such as genomic sequencing or immunoassays, with computer algorithms to produce a clinical test result. The AMA CPT Editorial Panel created a category called Multi-Analyte Assays with Algorithmic Analysis (MAAA's), to categorize test codes that combined laboratory analyses with computer algorithms to generate clinical information. More recently, however, we are seeing the development of distinct algorithmic analyses alone with distinct CPT codes.

For example, when the genomic sequencing of an individual is performed, this sequencing will likely only need to be performed once by a laboratory. However, once the genomic sequence has been generated, the subsequent algorithmic analyses of that sequence data can be performed an infinite number of times to produce a wide range of results and/or diagnostic or risk-related information. These secondary analyses of original genomic sequences can be proprietary and unique to a single laboratory but could also be conducted at a range of settings. For purposes of this final rule with comment period, we are referring to subsequent stand-alone algorithmic analyses as "SaMS analyses performed on laboratory tests".

As discussed in the proposed rule, currently, certain SaMS analyses performed on laboratory tests are treated as clinical diagnostic laboratory tests (CDLTs) and paid under the Clinical Laboratory Fee Schedule (CLFS) (91 FR 41925). Section 1861(s) of the Act specifies items and services included as "medical and other health services" under Part B, including diagnostic X-ray tests, diagnostic laboratory tests, and other diagnostic tests as described in section 1861(s)(3) of the Act. Sections 1833(h) and 1834A of the Act and the implementing regulations at 42 CFR part 414, subpart G, set forth the CLFS rate setting methodologies for

CDLTs. We stated in the proposed rule that we do not believe it is appropriate to consider these secondary algorithmic analyses, when performed alone, to be CDLTs or establish CLFS payment rates for these analyses because we believe these secondary algorithmic analyses may not currently require laboratory services or entities, regulated by CLIA, to perform them. Our position is that the secondary analyses, which have distinct CPT codes,[174] are "other diagnostic tests" under section 1861(s)(3) of the Act as opposed to "diagnostic laboratory tests." As noted previously, Medicare will not pay for CDLTs on the CLFS unless they are furnished by laboratories that meet applicable certification requirements. Tests that examine materials derived from the human body are assigned to and paid under the CLFS only when furnished by such certified laboratories in accordance with 42 CFR 410.32(d). Because SaMS analyses performed on laboratory tests are downstream evaluations of the data generated by a prior laboratory test, which are described by distinct CPT codes, an entity that performs only algorithmic analyses of previously sequenced data may not meet the definition of a "laboratory" under 42 CFR 493.2 or qualify for payment under CLFS. We believe SaMS that evaluate data generated by a prior laboratory test should not be treated as CDLTs for Medicare payment purposes.

As discussed in the proposed rule, we are also concerned that paying for these analyses based on existing CLFS payment methodologies may create significant vulnerabilities for the Medicare program, due to the lack of data transparency and CDLTs not being subject to beneficiary cost-sharing or budget neutrality. 42 CFR 414.508 outlines the rate setting methodologies CMS uses to set payment rates for new tests on the CLFS. Under § 414.508(b), CMS determines the payment amount based on either crosswalking or gapfilling methodologies until applicable information is available to establish a payment amount under the methodology described in § 414.507(b). Crosswalking is used if it is determined that a new CDLT is comparable to an existing test, multiple existing test codes, or a portion of an existing test code.

[174] We note that the AMA has created Category III CPT codes that describe secondary algorithmic analyses performed on laboratory tests. *https://www.ama-assn.org/system/files/cpt-category3-codes-long-descriptors.pdf.*

Gapfilling is used when no comparable existing CDLT is available. Public consultation for payment for a new clinical diagnostic laboratory test is required in determining payment amounts, receiving public comments and recommendations (and data on which the recommendations are based) as well as recommendations from the Medicare Advisory Panel on Clinical Diagnostic Laboratory Tests (CDLTs) per § 414.506. A significant challenge to the rate setting process for CMS is receiving transparent data from laboratories outlining resource costs of a test, particularly for the algorithmic portions of tests that are combined with other analytes. In the past, laboratories have explained to CMS that the algorithmic components of laboratory tests are highly proprietary and details cannot be shared. Thus, CMS has worked with the limited information available on the details of methods or resources for the algorithmic portions of tests or analyses and has thus far relied on other laboratory methods provided in the CPT descriptor (i.e. NGS sequencing, RT-PCR, or DNA methylation analysis). As CMS has gathered more information on SaMS analyses performed on laboratory tests, we now believe that since these analyses are entirely computer-based, comparison based on laboratory methodologies is not appropriate. We believe that these analyses are substantially similar to other SaMS already paid under the OPPS. Additionally, in contrast to the OPPS, the CLFS generally does not include beneficiary cost-sharing or budget neutrality adjustments, which limits transparency regarding pricing and creates challenges for ensuring appropriate valuation of these services.

CMS has an interest in ensuring that services that are fundamentally similar are paid for and treated in the same way, regardless of the setting of care in which the service is furnished. Since we believe SaMS perform algorithmic analyses on previously generated data, we believe SaMS analyses performed on laboratory tests are substantively similar to other SaMS technologies that are currently paid under the OPPS. Accordingly, we believe that whether the SaMS performs algorithmic analyses of an imaging test (e.g. CT scan) or whether it performs an algorithmic analysis on data generated from a laboratory test, all algorithmic analyses should be

treated consistently from a payment perspective. We believe that this uniform approach for SaMS technologies would promote stability and predictability in payment for similar services.

Finally, we note that CMS and CDC issued a Request for Information (RFI) on July 16, 2026, regarding CLIA regulations, the results of which may be used to help inform the agencies as to what types of action, if any, should be taken to update the existing CLIA regulations through future comment and rulemaking (91 FR 43586). The RFI closed for comments on September 15, 2026. CMS may refine SaMS payment and policies based on RFI responses and make changes in future rulemaking.

For CY 2027, as an interim first step to address concerns described above, we proposed to assign 10 HCPCS codes describing various SaMS analysis performed on laboratory tests to new technology APCs under the OPPS, using the latest available CLFS data to crosswalk to new technology APCs with payment rates that closely approximate the current CY 2026 CLFS payment rates for these codes. We note that SaMS analyses performed on laboratory tests would not currently require FDA marketing authorization in order to receive payment under OPPS. SaMS payment policies may be refined in future rulemaking. We explained that the proposed payment rates for SaMS performed on prior laboratory tests cannot be expected to align exactly with current CLFS payment rates because assignment to new technology APCs is based on established cost bands rather than individual test-specific payment amounts. For example, if a HCPCS code is currently paid $430.17 under the CLFS, the appropriate new technology APC assignment under this proposal would be APC 1506 (New Technology - Level 6 ($401 - $500)), which has a standardized payment rate of $450.50, rather than receiving a payment rate that exactly matches the current CLFS amount. We noted that, under this proposal, SaMS analyses performed on laboratory tests would be paid separately by being assigned to new technology APCs with the newly proposed status indicator “O1” (Software as a Medical Service, Paid under OPPS; separate APC payment) for CY 2027.. These 10 HCPCS codes were identified based on the CPT descriptor for the code. We noted that, if there were no laboratory

methods included in the code descriptor, and only an algorithmic analysis was described, we identified the code as a SaMS analysis performed on a laboratory test. We invited public comment on this proposed list and any other similar analyses that should be removed from the CLFS and paid under the OPPS.

In addition, for CY 2027 and subsequent years, we proposed to assign any new SaMS analyses performed on laboratory test codes to new technology APCs for payment under the OPPS. We requested public comment on these proposals, including the list of 10 HCPCS codes that we identified as SaMS analyses performed on laboratory tests and any additional HCPCS codes that we should designate as SaMS analyses performed on laboratory tests and pay under the OPPS rather than the CLFS. We stated that CMS may finalize a policy that includes such payment for additional HCPCS codes in the final rule based on public comment.

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: Some commenters, including large cancer treatment centers, supported our proposal to establish a payment methodology for software-based analyses performed on laboratory tests distinct from the underlying laboratory test. These commenters supported migrating software-based analyses performed on laboratory tests from payment under the CLFS to payment under the OPPS and agreed that such analyses are better characterized as "other diagnostic tests." Commenters added that this policy correctly recognizes algorithmic re-analysis of previously obtained data as a separately payable clinical service. In addition, commenters expressed support for establishing a consistent, cross-setting payment framework for algorithmic analyses, citing that this policy seeks to adapt and evolve with changing healthcare environments. The commenters noted that it is especially critical that this payment policy evolve to reflect the value and resource costs of these technologies.

Response: We thank the commenters for their support and note that we will consider these comments as we continue to refine this payment policy.

Comment: Some commenters, including independent laboratories, supported our proposal but requested that CMS develop the payment methodology transparently, and ensure the payment for algorithm-driven services rests on evidence of clinical benefit. Commenters requested that CMS establish a payment mechanism for these services when the patient is not seen in a hospital outpatient department, noting that as proposed, the framework would leave no payment mechanism for a substantial share of medically necessary testing. Commenters also requested that CMS assign substantively comparable specimen-based algorithmic analyses to consistent new technology APCs and state the basis for APC assignment, and that CMS establish a defined, confidential process through which laboratories may submit cost and clinical outcomes data to support valuation as CMS develops a more comprehensive payment methodology. One commenter supported the proposal but requested that CMS defer changes to CLFS payment for algorithm-only laboratory analyses until the necessary coding, regulatory, and operational infrastructure has been established.

Response: We appreciate the suggestion to be transparent and thoughtful in the implementation of this policy. We believe that publicly proposing this policy in the proposed rule, inviting comments, and addressing those comments in this rule has made this process transparent. We also appreciate the recommendation to evaluate the clinical benefit of SaMS analyses performed on laboratory tests. We remind readers that our goal in this rulemaking cycle is to establish the category of SaMS analyses performed on laboratory tests and the general payment mechanism for those services under the OPPS. Regarding a request to establish a separate confidential process through which laboratories may submit cost and clinical data, we remind commenters that we are available to meet with interested parties where information may be shared with CMS. However, because payment rates are finalized through the notice-and-comment rulemaking process, which requires providing the underlying reasoning for our proposals and final policy, establishing a separate confidential process would not be compatible with the existing rulemaking process. Further, finalizing this policy would not eliminate

Medicare payment for these services, or prohibit certain facilities from billing Medicare, but rather, it would define how these services would be paid under the OPPS. For the purposes of maintaining stability, particularly for the HCPCS codes we proposed to remove from the CLFS and place in an APC category, we chose to assign APC levels based on the CY 2026 CLFS payment rates to avoid any considerable payment disruption. As we continue to develop this policy, we will consider possible methods for evaluating the APC assignment for new SaMS analyses performed on laboratory tests. We do not believe that it is appropriate to delay the movement of SaMS analyses performed on laboratory tests from the CLFS to the OPPS, given the speed at which SaMS technologies are developing and the goal of having a consistent policy across payment systems for similar services. These services will be paid for under existing and well-established Medicare payment mechanisms, depending on the place of service (that is, hospital outpatient departments or physician offices).

Comment: A few commenters, specifically large laboratory associations, requested that we not finalize the policy as proposed. Commenters generally believed that CMS should engage with the laboratory community more closely prior to finalizing payment changes for SaMS analyses performed on laboratory tests. Commenters specifically expressed concerns that the proposed policy could inadvertently create duplicate or inconsistent payment pathways and fragment integrated laboratory services by separating algorithmic analyses from the laboratory responsible for validation, quality, clinical interpretation, and reporting. Several commenters expressed concerns regarding the implications of introducing beneficiary cost sharing for services that generally are not subject to cost sharing under the CLFS if this policy were to be finalized. One commenter explained that, if CMS is concerned about unregulated software vendors billing Medicare, CMS should condition Medicare payment for designated SaMS laboratory services on performance by a CLIA-certified, appropriately accredited laboratory.

Response: We acknowledge the commenters' concerns, and we will continue to consider them while we implement the policy. Regarding cost sharing, we acknowledge that while cost

sharing shifts some costs to beneficiaries, it also encourages greater efficiency by providers and more economical delivery of medically necessary services, which would contain unnecessary growth in Medicare spending long-term to the benefit of both Medicare and beneficiaries.

We disagree with concerns that this final policy would fragment integrated laboratory services, as this policy would apply to HCPCS codes that already recognize a distinct SaMS analysis component. To ensure that this policy impacts HCPCS codes describing the secondary analyses only, we requested public comment on the list of HCPCS codes we proposed to designate as SaMS analyses performed on laboratory tests. As discussed further below, based on public comments received, HCPCS codes describing integrated services, meaning those codes that describe both the wet lab and SaMS secondary analyses, were not finalized for payment under this policy for CY 2027. These HCPCS codes would continue to be paid under the CLFS.

Concerns about billing and regulations regarding vendors of SaMS analyses are outside of the scope of this final rule with comment period.

While we understand the commenters' concerns, we believe that the proposed policy provides a uniform payment pathway for SaMS that should be implemented for CY 2027. We continue to maintain that paying for SaMS analyses performed on laboratory tests under the CLFS may create significant vulnerabilities for the Medicare program, due to the challenges in receiving transparent data regarding the algorithms themselves and CDLTs on the CLFS generally not being subject to beneficiary cost-sharing or budget neutrality. As mentioned above, we believe SaMS technologies generally should be treated and paid for consistently across the Medicare program because these algorithm-based services are functionally equivalent, despite differences in the type of clinical service or data. For example, both SaMS currently paid under the OPPS and SaMS analyses performed on laboratory tests perform algorithm-based analyses on existing data. We anticipate that resource costs may be similar between these kinds of services. For SaMS analyses performed on laboratory tests, assigning them to new technology APCs under the OPPS means similar algorithm-based services will be billed and paid for under

the same payment system. We will continue to engage the broader laboratory community in further dialogue as we consider potential refinements to this policy in future rulemaking.

Comment: Some commenters, especially large laboratory associations, asked CMS to not finalize its proposal to reassign SaMS analyses performed on prior laboratory tests to new technology APCs under the OPPS and to continue paying for these as CDLTs on the CLFS. A few commenters urged CMS to exempt current and future software-based laboratory tests from this proposed policy and only designate the proposed tests as SaMS analyses performed on laboratory tests.

Response: We appreciate these comments but believe it is important for SaMS-based technologies to be treated consistently across the Medicare program, rather than establishing distinct payment policies for similar SaMS depending on whether the analysis is performed on an imaging service or on a laboratory test.

Comment: Commenters generally expressed concern that the proposed framework to distinguish SaMS analyses performed on laboratory tests from other laboratory tests would be challenging to apply in practice. Commenters stated that these services have generally been classified and paid as CDLTs under the CLFS, reflecting longstanding treatment from CMS, the AMA CPT process, and the FDA. Commenters expressed concern regarding using CPT code descriptors to determine which HCPCS codes should be designated as a SaMS analyses performed on a laboratory test since descriptors do not always indicate whether activities, such as slide preparation or immunostaining, are included in the reported service. Commenters explained that although SaMS analyses performed on laboratory tests are defined as being both separate from specimen examination and entirely computer-based, several of the examples CMS identified appear to involve wet lab components, creating uncertainty regarding how the criteria would be operationalized, and that as a result, interested parties may face difficulty determining whether a given service qualifies as a purely algorithmic analysis or should continue to be treated as a laboratory test including wet lab processes. Commenters requested that CMS provide

additional guidance and examples to support consistent classification and payment for these services.

Response: Medicare utilizes the description of services as provided by the HCPCS code descriptors in determining appropriate payment. For the proposed policy, we identified services listed on the CLFS that indicated algorithmic analysis in the CPT long descriptor and in the description of intraservice work (as provided by AMA in its valuation of CPT codes) and proposed to treat those services as SaMS analyses performed on laboratory tests. Specifically, we considered code descriptors that included phrases such as "augmentative algorithmic analysis" or "previously established sequence," as we believed that these indicated that the code described SaMS analyses performed on laboratory tests. We requested public comments on the proposed list of codes, understanding that we may have inadvertently omitted certain codes or included codes that do not solely describe subsequent, computer-based analyses as intended.

We appreciate the comments regarding the proposed list of codes. In this final rule with comment period, we have removed a few HCPCS codes from the proposed list, based on an additional understanding of the code descriptors and public comments received, but we retained the HCPCS codes that contained phrases such as "augmentative algorithmic analysis" or "previously established sequence" which we discuss in further detail below. We believe that the finalized list of HCPCS codes being reassigned from the CLFS to new technology APCs under the OPPS is limited to those that are entirely computer-based secondary analyses and do not include specimen examination performed as part of the wet lab component.

Comment: Commenters requested that CMS include additional specificity into the SaMS definition to ensure that technologies and services with meaningful differences, such as algorithm-only laboratory-developed tests, laboratory Software as a Medical Device, and imaging Software as a Medical Device, are not treated as equivalent for payment purposes. One commenter proposed that CMS limit the services included in this policy to algorithmic reanalysis of a prior laboratory test's reported results, and exclude any service that examines a patient's

specimen, physical or digitized, or that measures a defined analyte from that specimen.

Response: We appreciate the commenters' input. We remind readers that our goal in this rulemaking cycle is to establish the category of SaMS analyses performed on laboratory tests and the general payment mechanism for those services under the OPPS, noting that payment alignment is a priority for these technologies. Given the interim nature of the policy, we will take the definitional concerns raised by the commenters, including incorporating additional specificity regarding differences in SaMS service for purposes of Medicare payment, into consideration for future rulemaking. We welcome public engagement from interested parties on these issues, including whether there are services that should be designated as SaMS in the future.

Comment: Some commenters, particularly large laboratory associations, disagreed with the premise underlying our proposal, explaining that the diagnostic testing process as a whole, not the physical location where the final computational step occurs, is what defines a clinical diagnostic laboratory test. These commenters did not agree that the absence of a new wet lab step converts a patient-specific computational analysis of laboratory-derived data into something other than laboratory testing and argued that treating the final analytical step as severable from the laboratory service that produced the underlying data misconstrues how these tests are developed, validated, and clinically interpreted. Relatedly, these commenters requested that CMS confirm in the final rule that a test including a laboratory assay measuring an analyte from the specimen remains a CDLT paid under the CLFS, and that specimen preparation, staining, and digitization are not the "prior laboratory test" on which SaMS designation depends.

Response: We disagree with these commenters that the location of the final analytical step is immaterial to the payment classification of these services. While we recognize that the underlying specimen collection, sequencing, or other data-generating steps may require laboratory services, the algorithmic analysis at issue here is a separate step that is performed on data that has already been generated, and may not necessarily require access to the specimen or

laboratory equipment. The fact that a service has historically been billed and paid as a single, integrated CDLT on the CLFS does not mean that each component of that service must continue to be paid as such, particularly where the analytical component is distinguishable from the data-generating component as provided by the HCPCS code descriptor, both in the resources required to perform it and in the manner in which its costs are incurred. Accordingly, we are finalizing our proposal to treat the algorithmic analysis as an "other diagnostic test" distinct from the underlying laboratory test for purposes of OPPS payment. We will take the definitional concerns regarding SaMS into consideration for future rulemaking.

Comment: Several commenters urged CMS to coordinate this policy with the pending CLIA RFI issued by CMS and the CDC on July 16, 2026, regarding the appropriate level of CLIA oversight of "dry lab" facilities that perform computational analyses without a traditional wet-lab component, so that the two efforts do not produce conflicting outcomes.[175] Commenters noted that CMS and the CDC are actively considering, through that RFI, whether CLIA certification is required to furnish these types of services, and argued that it is premature for CMS to conclude in this rule that such services are not "laboratory" services for payment purposes before that RFI is complete. Commenters requested that CMS defer any changes to this OPPS payment policy pending the outcome of the CLIA RFI, given the potential for the policies under consideration there to directly conflict with the proposal at issue here. One commenter separately requested that CMS clarify that CLIA's scope includes facilities that produce and examine information obtained through analysis of materials derived from the human body.

Response: We appreciate these comments. We plan to coordinate and collaborate across the relevant agencies to ensure oversight and payment policies are consistent.

Comment: Commenters requested that CMS confirm it does not intend, in addressing the

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[175] *https://www.federalregister.gov/documents/2026/07/16/2026-14358/request-for-information-clinical-laboratory-improvement-amendments-of-1988-clia-regulations*.

Medicare billing of SaMS analyses performed on laboratory tests, to change the regulatory structure under which laboratories and the tests they provide are governed. Commenters noted that the proposal could be read to create ambiguity on this point and requested that CMS include the following clarifying statement in the final rule: that algorithmic interpretation of specimen-derived pathology data, performed within or under arrangement with a CLIA-certified laboratory, remains subject to CLIA.

Response: This policy does not seek to make changes to the requirements governing CLIA-certified laboratories. We consider these algorithmic analyses as "other diagnostic tests" that are performed on an underlying laboratory test. This policy seeks to provide consistency in paying for all SaMS algorithmic analyses under new technology APCs in the OPPS. We will take the regulatory concerns raised by commenters, including incorporating additional specificity regarding SaMS services and CLIA, into consideration for future rulemaking. We welcome public engagement from interested parties on these issues.

Comment: We received comments regarding the specific list of HCPCS codes we proposed to designate as SaMS laboratory analyses. Commenters generally agreed that the following CPT codes describe algorithmic analyses and may be designated as SaMS laboratory analyses:

- 0510U - *Oncology (pancreatic cancer), augmentative algorithmic analysis of 16 genes from previously sequenced rna whole transcriptome data, reported as probability of predicted molecular subtype*
- 0512U - *Oncology (prostate), augmentative algorithmic analysis of digitized whole-slide imaging of histologic features for microsatellite instability (msi) status, formalin-fixed paraffin embedded (ffpe) tissue, reported as increased or decreased probability of msi-high (msi-h)*
- 0513U - *Oncology (prostate), augmentative algorithmic analysis of digitized whole-slide imaging of histologic features for microsatellite instability (msi) and*

homologous recombination deficiency (hrd) status, formalin fixed paraffin-embedded (ffpe) tissue, reported as increased or decreased probability of each biomarker

- 0418U - *Oncology (breast), augmentative algorithmic analysis of digitized whole slide imaging of 8 histologic and immunohistochemical features, reported as a recurrence score*
- 0376U - *Oncology (prostate cancer), image analysis of at least 128 histologic features and clinical factors, prognostic algorithm determining the risk of distant metastases, and prostate cancer-specific mortality, includes predictive algorithm to androgen deprivation-therapy response, if appropriate*

Response: We thank the commenters for their support. We are finalizing our proposals to assign CPT codes 0510U, 0512U, 0513U, 0418U, and 0376U to new technology APCs for payment under the OPPS as SaMS analyses performed on laboratory tests. Please refer to Table 85 for the list of services we are finalizing as SaMS analyses performed on laboratory tests.

Comment: We received a comment noting that CPT codes 81417 and 81427 both describe post-sequencing data analysis but were not included in the proposed list of CPT codes to designate as SaMS analyses performed on laboratory tests for purposes of payment under the OPPS.

We also received a comment noting that CPT codes 81417 (*Exome (eg, unexplained constitutional or heritable disorder or syndrome); re-evaluation of previously obtained exome sequence (eg, updated knowledge or unrelated condition/syndrome*) and 81427 (*Genome (eg, unexplained constitutional or heritable disorder or syndrome); re-evaluation of previously obtained genome sequence (eg, updated knowledge or unrelated condition/syndrome)*) both describe post-sequencing data analysis but were not included in the proposed list of CPT codes to designate as SaMS analyses performed on laboratory tests for purposes of payment under the OPPS.

Response: We thank the commenter for bringing these codes to our attention. We agree

that CPT codes 81417 and 81427 codes should be designated as SaMS analyses performed on laboratory tests for purposes of payment under the OPPS because they provide a secondary or subsequent stand-alone algorithmic analysis of a previously obtained exome or genome sequence. Therefore, for CY 2027, we are finalizing assigning CPT code 81417 to APC 1505 (New Technology - Level 5 ($301 - $400)) and 81427 to APC 1522 (New Technology - Level 22 ($2001-$2500)).

Comment: Some commenters asserted that certain codes that we proposed to designate as SaMS analyses performed on tests performed on laboratory tests for payment under the OPPS should not be finalized as proposed because they possess, or may possess, wet lab components. Per the commenters, the following CPT codes have wet lab components:

- 0511U – *Oncology (solid tumor), tumor cell culture in 3d microenvironment, 36 or more drug panel, reported as tumor-response prediction for each drug*
- 81416 – *Exome (eg, unexplained constitutional or heritable disorder or syndrome); sequence analysis, each comparator exome (eg, parents, siblings) (list separately in addition to code for primary procedure)*

Similarly, a commenter opposed finalizing CPT code 0414U (*Oncology (lung), augmentative algorithmic analysis of digitized whole slide imaging for 8 genes (alk, braf, egfr, erbb2, met, ntrk1-3, ret, ros1), and kras g12c and pd-l1, if performed, formalin-fixed paraffin-embedded (ffpe) tissue, reported as positive or negative for each biomarker*) as a SaMS analysis performed on a laboratory test for payment under the OPPS because the service includes a wet lab component if performed, as designated in the descriptor. A commenter opposed similarly designating CPT code 0220U (*Oncology (breast cancer), image analysis with artificial intelligence assessment of 12 histologic and immunohistochemical features, reported as a recurrence score*) as a SaMS analysis performed on a laboratory test because the code is ambiguous on whether it includes wet lab steps. One commenter pointed out that CPT code 0208U (*Oncology (medullary thyroid carcinoma), mrna, gene expression analysis of 108 genes,*

utilizing fine needle aspirate, algorithm reported as positive or negative for medullary thyroid carcinoma) was deleted effective January 1, 2022, and therefore, should not be included on the final list for payment under the OPPS.

Response: We agree with commenters that CPT codes 0511U and 81416 both involve wet lab analyses as outlined in each CPT descriptor, and therefore, should not be assigned to new technology APCs for payment under the OPPS. Since the code descriptors integrate both the wet lab and secondary algorithmic analyses, rather than only the computer-based secondary analyses component, we agree to not designate CPT codes 0511U and 81416 as SaMS analyses performed on laboratory tests. These HCPCS codes would continue to be paid under the CLFS.

However, we do not agree with commenters that CPT code 0414U should be paid under the CLFS, as the descriptor characterizes the service as an augmentative algorithmic analysis. Commenters pointed out that the descriptor allows for additional analysis "if performed," if, for example, a slide needs to be redone for the purpose of the analysis. However, our understanding is that the "if performed" language does not indicate that the algorithmic analysis is optional, but instead refers to the optional analysis of additional biomarkers. Therefore, we are finalizing assignment of CPT code 0414U to a new technology APC for payment under the OPPS as proposed.

Regarding CPT code 0220U, we similarly disagree with the commenters that the code descriptor is ambiguous on whether a wet lab component is included. The descriptor cites "image analysis with artificial intelligence," which we believe is similar to other SaMS laboratory analyses of existing images or slides.

Finally, we appreciate the comment noting that CPT code 0208U was deleted and agree that it should not be included on the final list for payment under the OPPS.

Comment: We received comments regarding the proposed APC assignments for the services we proposed to designate as SaMS analyses performed on laboratory tests. Some commenters supported crosswalking codes from the CLFS to new technology APCs as proposed,

maintaining CY 2026 CLFS payment rates. Some commenters disagreed with the proposed new technology APC assignment for certain HCPCS codes. For example, one commenter requested that we reassign CPT codes 1063T (*Oncology (bladder), augmentative algorithmic analysis of histomorphologic features in digitized slides from formalin-fixed paraffin-embedded (FFPE) bladder cancer tissue (high-grade, non-muscle invasive), with clinicopathologic variables entered by the qualified health care professional; algorithm-derived parameters reported as prognostic of recurrence and progression, including hematoxylin and eosin staining of tissue sections, and digitization of glass microscope slides, when performed*) and 1064T (*Oncology (bladder), augmentative algorithmic analysis of histomorphologic features in digitized slides from formalin-fixed paraffin-embedded (FFPE) bladder cancer tissue (high-grade, non-muscle invasive), with clinicopathologic variables entered by the qualified health care professional; algorithm-derived parameters reported as predictive of response to Bacillus Calmette-Guérin (BCG) therapy, including hematoxylin and eosin staining of tissue sections, and digitization of glass microscope slides, when performed*) to APC 1509 (New Technology - Level 9 ($701 - $800)) rather than APC 1542 (New Technology - Level 5 ($301 - $400)) based on resource costs and similarities to other services we proposed to assign to APC 1509. Commenters also requested that CMS assign substantively comparable specimen-based algorithmic analyses to consistent new technology APC bands, state the basis on which band assignments are made, and establish a mechanism for correcting assignments that are inconsistent with those made for comparable services.

Response: We thank the commenters for their input. We agree with commenters that CPT codes 1063T and 1064T are similar to CPT code 1097T, for which we proposed, and are finalizing, assignment to APC 1509. Therefore, we are finalizing assigning CPT codes 1063T and 1064T to APC 1509 (New Technology - Level 9 ($701 - $800)) based on public comments received. Regarding the process for assigning and correcting assignments for comparable SaMS analyses performed on laboratory tests to new technology APCs, we remind the commenters that

the notice-and-comment rulemaking is an available and appropriate process for requesting initial payment assignments and subsequent payment changes.

Comment: Commenters supported CMS's proposal to base new technology APC payment for these codes on existing CLFS payment rates, using the latest available CLFS data to crosswalk codes to new technology APCs at rates that closely approximate current CLFS payment levels.

Response: We thank the commenters for their support. We agree that CY 2026 CLFS rates for algorithmic analyses, which were the latest available CLFS rates at the time that the proposed rule was drafted, should be maintained with the implementation of this interim policy. We believe it is appropriate to use the current CLFS payment rates for CY 2026, as proposed, to align with the payment policy for SaMS described in the prior section which similarly finalized the proposed payment rates.

Comment: Commenters requested that CMS confirm that superintelligence enabled diagnostic analyses performed in CLIA-certified independent laboratories after the hospital encounter are eligible for separate payment under the OPPS framework. Commenters further requested that CMS permit laboratories to bill Medicare for these services when developed as laboratory-developed tests, noting that if such tests are not billable by laboratories under the Medicare Physician Fee Schedule, laboratories would effectively be prohibited from directly billing and receiving payment for services they perform.

Response: As we stated in the proposed rule, the services that we designate as SaMS, specifically SaMS analyses performed on laboratory tests, will be assigned to new technology APCs and a status indicator of ‘O1’ to indicate that these services are SaMS for payment purposes and paid for under the OPPS. We refer readers to the CY 2027 PFS final rule for discussion on how SaMS analyses performed on laboratory tests will be paid under PFS.

Comment: A commenter requested that CMS confirm the applicable date of service for algorithm-only laboratory analyses, noting that if such services are classified as "other diagnostic

tests" rather than clinical diagnostic laboratory tests, the laboratory date of service policy would not apply.

Response: We confirm that because we are classifying SaMS analyses performed on laboratory tests as "other diagnostic tests" under section 1861(s)(3) of the Act, they would not be subject to the date of service policy as outlined in 42 CFR 414.510.

Comment: Regarding CMS's proposed definition of status indicator "O1," a commenter requested that CMS avoid applying a multiple-procedure payment reduction to algorithm-only analyses, explaining that such services do not meet the criteria typically underlying that reduction because each algorithm is typically a distinct, independently developed and validated analytic service answering a distinct clinical question.

Response: We agree. We refer readers to the earlier discussion in this section regarding the payment specifications for status indicator "O1," which we are finalizing to treat as "S" (Procedure or Service, Not Discounted When Multiple) to allow for separate payment without multiple procedure discounting.

After consideration of public comments, we are finalizing our proposal for CY 2027 to reassign certain HCPCS codes describing SaMS analyses performed on laboratory tests that are currently paid under the CLFS to new technology APC assignments under the OPPS. However, we are finalizing the proposed code list with certain modifications, based on public comments received. In total, for CY 2027, we are finalizing to assign 14 SaMS analyses performed on laboratory tests to new technology APCs. Additionally, we are finalizing our proposal for CY 2027 and subsequent years, to assign any new SaMS analyses performed on laboratory test codes to new technology APCs for payment under the OPPS. We note that this is an interim first step to address the concerns regarding the proliferation of SaMS analyses performed on laboratory tests. We intend to continue to engage with the laboratory community on these finalized changes, and acknowledge the definitional concerns regarding SaMS services and the applicable payment and regulatory frameworks. We will consider expanding and further clarifying the scope of the

policy through future rulemaking.

Refer to Table 85 for the final new technology APC and status indicator assignments for SaMS analyses performed on laboratory tests for CY 2027. The final CY 2027 payment rates can be found in Addendum B to this final rule with comment period via the internet on the CMS website. In addition, we refer readers to Addendum D1 to this final rule with comment period for the status indicator meanings for all codes reported under the OPPS. Addendum D1 can also be found via the internet on the CMS website.

TABLE 85: FINAL NEW TECHNOLOGY APC AND SI ASSIGNMENTS FOR SAMS ANALYSES PERFORMED ON LABORATORY TESTS FOR CY 2027

HCPCS Code	Long Descriptor	CY 2027 Proposed New Technology APC, SI	CY 2027 Final New Technology APC, SI
0510U	Oncology (pancreatic cancer), augmentative algorithmic analysis of 16 genes from previously sequenced rna whole transcriptome data, reported as probability of predicted molecular subtype	APC 1506 (New Technology - Level 6 ($401 - $500)), O1	APC 1506 (New Technology - Level 6 ($401 - $500)), O1
0512U	Oncology (prostate), augmentative algorithmic analysis of digitized whole-slide imaging of histologic features for microsatellite instability (msi) status, formalin-fixed paraffin embedded (ffpe) tissue, reported as increased or decreased probability of msi-high (msi-h)	APC 1509 (New Technology - Level 9 ($701 - $800)), O1	APC 1509 (New Technology - Level 9 ($701 - $800)), O1
0513U	Oncology (prostate), augmentative algorithmic analysis of digitized whole-slide imaging of histologic features for microsatellite instability (msi) and homologous recombination deficiency (hrd) status, formalin fixed paraffin-embedded (ffpe) tissue, reported as increased or decreased probability of each biomarker	APC 1509 (New Technology - Level 9 ($701 - $800)), O1	APC 1509 (New Technology - Level 9 ($701 - $800)), O1
0414U	Oncology (lung), augmentative algorithmic analysis of digitized whole slide imaging for 8 genes (alk, braf, egfr, erbb2, met, ntrk1-3, ret, ros1), and kras g12c and pd-l1, if performed, formalin-fixed paraffin-embedded (ffpe) tissue, reported as positive or negative for each biomarker	APC 1509 (New Technology - Level 9 ($701 - $800)), O1	APC 1509 (New Technology - Level 9 ($701 - $800)), O1
0418U	Oncology (breast), augmentative algorithmic analysis of digitized whole slide imaging of 8 histologic and immunohistochemical features, reported as a recurrence score	APC 1509 (New Technology - Level 9 ($701 - $800)), O1	APC 1509 (New Technology - Level 9 ($701 - $800)), O1
0220U	Oncology (breast cancer), image analysis with artificial intelligence assessment of 12 histologic and immunohistochemical features, reported as a recurrence score	APC 1509 (New Technology - Level 9 ($701 - $800)), O1	APC 1509 (New Technology - Level 9 ($701 - $800)), O1

0376U	Oncology (prostate cancer), image analysis of at least 128 histologic features and clinical factors, prognostic algorithm determining the risk of distant metastases, and prostate cancer-specific mortality, includes predictive algorithm to androgen deprivation-therapy response, if appropriate	APC 1509 (New Technology - Level 9 ($701 - $800)), O1	APC 1509 (New Technology - Level 9 ($701 - $800)), O1
81417	Exome (eg, unexplained constitutional or heritable disorder or syndrome); re-evaluation of previously obtained exome sequence (eg, updated knowledge or unrelated condition/syndrome)	N/A, A	APC 1505 (New Technology - Level 5 ($301 - $400)), O1
81427	Genome (eg, unexplained constitutional or heritable disorder or syndrome); re-evaluation of previously obtained genome sequence (eg, updated knowledge or unrelated condition/syndrome)	N/A, A	APC 1522 (New Technology - Level 22 ($2001-$2500)), O1
1106T (placeholder code X623T)	Oncology (breast), augmentative algorithmic analysis of histomorphologic features in digitized hematoxylin and eosin stained slides from formalin-fixed paraffin-embedded (FFPE) breast cancer tissue, algorithm-derived parameters reported as 5-year and 10-year risks of distant metastasis, including digitization of glass microscope slides and hematoxylin and eosin staining of tissue sections, when performed	APC 1509 (New Technology - Level 9 ($701 - $800)), O1	APC 1509 (New Technology - Level 9 ($701 - $800)), O1
1107T (placeholder code X624T)	Oncology (prostate), augmentative algorithmic analysis of histomorphologic features in digitized hematoxylin and eosin stained slide(s) from formalin-fixed paraffin-embedded (FFPE) prostate cancer tissue, algorithm-derived parameters reported as 10-year risk of distant metastasis and prostate cancer specific mortality, including hematoxylin and eosin staining of tissue sections and digitization of glass microscope slides, when performed	APC 1509 (New Technology - Level 9 ($701 - $800)), O1	APC 1509 (New Technology - Level 9 ($701 - $800)), O1
1097T (placeholder code X614T)	Oncology (pancreas), augmentative algorithmic analysis of histomorphologic features in digitized slides from formalin-fixed paraffin-embedded pancreatic cancer tissue, algorithm-derived parameters reported as prediction of response to fluorouracil backbone versus gemcitabine backbone chemotherapy, including hematoxylin and eosin staining of tissue sections and digitization of glass microscope slides, when performed	APC 1509 (New Technology - Level 9 ($701 - $800)), O1	APC 1509 (New Technology - Level 9 ($701 - $800)), O1
1063T (placeholder code X568T)	Oncology (bladder), augmentative algorithmic analysis of histomorphologic features in digitized slides from formalin-fixed paraffin-embedded (FFPE) bladder cancer tissue (high-grade, non-muscle invasive), with clinicopathologic variables entered by the qualified health care professional; algorithm-derived parameters reported as prognostic of recurrence and progression, including hematoxylin and eosin staining of tissue sections, and digitization of glass microscope slides, when performed	APC 1542 (New Technology - Level 5 ($301 - $400)), O1 ($350.50)	APC 1509 (New Technology - Level 9 ($701 - $800)), O1

1064T (placeholder X569T)	Oncology (bladder), augmentative algorithmic analysis of histomorphologic features in digitized slides from formalin-fixed paraffin-embedded (FFPE) bladder cancer tissue (high-grade, non-muscle invasive), with clinicopathologic variables entered by the qualified health care professional; algorithm-derived parameters reported as predictive of response to Bacillus Calmette-Guérin (BCG) therapy, including hematoxylin and eosin staining of tissue sections, and digitization of glass microscope slides, when performed	APC 1542 (New Technology - Level 5 ($301 - $400)), O1 ($350.50)	APC 1509 (New Technology - Level 9 ($701 - $800)), O1

3. Summary of CY 2027 SaMS Final Payment Policies

In summary, for CY 2027, we are finalizing the following interim payment policies. First, we are finalizing a terminology change from SaaS to SaMS to more accurately describe algorithm-based software services. Second, we are creating a new status indicator "O1" (Software as a Medical Service, paid under OPPS; separate APC payment) to designate SaMS that are payable under the OPPS. Third, we are finalizing assignment of all SaMS assigned to status indicator "O1" to a new technology APC. For CY 2027, we are maintaining the payment rates consistent for SaMS assigned to status indicator "O1" from CY 2026 OPPS rates. In addition, we are finalizing our proposal to use the term "SaMS analyses performed on laboratory tests" to describe stand-alone algorithmic analyses of data generated by a prior laboratory test. Although the services we have designated as SaMS in section X.B.1. of the final rule with comment period are required to have FDA marketing authorization to receive Medicare payment, "SaMS analyses performed on laboratory tests do not currently require FDA marketing authorization in order to receive payment under OPPS. While these secondary analyses are currently paid for under the CLFS as "diagnostic laboratory tests" under section 1861(s)(3), (16), and (17) of the Act, for CY 2027, we are finalizing our position that these services are "other diagnostic tests" and, therefore, will be paid under OPPS under section 1861(s)(3) of the Act. Specifically, we are finalizing payment for 14 SaMS analyses performed on laboratory tests from the CLFS to the OPPS by assigning the codes to new technology APCs that align with current CY 2026 CLFS payment rates.

C. Adjustment for Cost-of-Living in Alaska and Hawaii

We have heard from a variety of interested parties about the particularly difficult cost environment facing hospitals located in Alaska and Hawaii. These challenges stem from the unique circumstances of those geographies, including dependency on outside goods and components, remote locations and transportation challenges, and other factors inherent to providing healthcare in these non-contiguous States.

A review of the available cost report data used in OPPS ratesetting highlights these issues. We stated in the proposed rule that we observed a number of hospitals in Alaska and Hawaii with payment-to-cost ratios (PCRs) that range from 0.6 to 0.7, significantly below the average PCR for OPPS hospitals of 0.89 used as an initial target for the cancer hospital adjustment discussed in section II.F. of the proposed rule. In addition, the overall ancillary cost-to-charge ratios for several hospitals located in these States are higher than average, indicating that there are higher costs relative to what those hospitals charge for the outpatient services they provide compared to other OPPS hospitals.

Under the IPPS, section 1886(d)(5)(H) of the Act provides discretionary authority to the Secretary to make adjustments as the Secretary deems appropriate to take into account the unique circumstances of hospitals located in Alaska and Hawaii. To account for higher non-labor-related costs for these two States in the IPPS, we apply an adjustment factor to the nonlabor-related portion of the standardized amount for hospitals in Alaska and Hawaii. For FY 2011 and in prior fiscal years, we used the most recent cost-of-living adjustment (COLA) factors obtained from the U.S. Office of Personnel Management (OPM) website at *https://www.opm.gov/policy-data- oversight/pay-leave/pay-systems/ nonforeign-areas/#url=COLA-Rates* to update this nonlabor portion.

In the FY 2013 IPPS/LTCH PPS final rule, we established a methodology to update the COLA factors for Alaska and Hawaii that were published by the U.S. OPM every 4 years (coinciding with the update to the labor-related share of the IPPS market basket), beginning in

FY 2014. We refer readers to the FY 2013 IPPS/LTCH PPS proposed and final rules for additional background and a detailed description of this methodology (77 FR 28145 through 28146 and 77 FR 53700 through 53701, respectively). In the FY 2022 IPPS/LTCH PPS final rule (86 FR 45546 through 45547), we updated the COLA factors published by OPM for 2009 (as these are the last COLA factors OPM published prior to transitioning from COLAs to locality pay) using the methodology that we finalized in the FY 2013 IPPS/LTCH PPS final rule and Consumer Price Indices (CPIs) data through 2020. Based on the policy finalized in the FY 2013 IPPS/LTCH PPS final rule, we utilized these COLA factors for FYs 2022 through 2025 to adjust the nonlabor-related portion of the standardized amount for hospitals located in Alaska and Hawaii.

As we discussed in the proposed rule, in general, under the IPPS methodology, we updated the 2009 OPM COLA factors by a comparison of the growth in the CPIs for the areas of Urban Alaska and Urban Hawaii, relative to the growth in the CPI for the average U.S. city as published by the Bureau of Labor Statistics (BLS). We used the comparison of the growth in the overall CPI relative to the growth in the CPI for those areas to update the COLA factors for all areas in Alaska and Hawaii, respectively, because BLS publishes CPI data for only Urban Alaska and Urban Hawaii. Using the respective CPI commodities index and CPI services index, and using the approximate commodities/services shares obtained from the IPPS market basket, we created reweighted CPIs for each of the respective areas to reflect the underlying composition of the IPPS market basket nonlabor-related share. Lastly, we exercised our discretionary authority to adjust payments to hospitals in Alaska and Hawaii by including the statutorily mandated cap of 25 percent that was applied when determining OPM's COLA factors. (For additional information, refer to the FY 2022 IPPS/LTCH PPS final rule (86 FR 45546 through 45547).

As discussed in the FY 2027 IPPS/LTCH PPS proposed rule, effective for FY 2027, we proposed to adjust non-labor related costs for hospitals located in Alaska and Hawaii, using the Overseas Cost-of-Living Allowance (OCOLA) data published by the Department of Defense

(DOD). Starting with the FY 2027 payment year, we also proposed to no longer cap the IPPS COLA factors at 25 percent. We refer readers to the FY 2027 IPPS/LTCH PPS proposed rule for further discussion of the proposed changes to the methodology for calculating the IPPS COLA factors for FY 2027 (91 FR 19813 through 19814).

As discussed in the FY 2027 IPPS/LTCH PPS final rule, after consideration of public comments, we finalized our proposed methodology to use the DOD OCOLAs to determine the COLA factors, to no longer cap these OCOLA-based COLA factors at 25 percent, and to continue to update the COLA factors in conjunction with the labor-related share of the IPPS market basket. However, given concerns raised by commenters, in particular that the OCOLA data may not reflect some of the high costs directly affecting Hawaii, for any locality area where the COLA factors would decrease using the DOD OCOLA data, we stated that we will maintain the COLA factors that were in place for FY 2022 through FY 2026. Therefore, we finalized the use of the DOD OCOLAs to determine the COLAs for each of the designated OPM areas in Alaska and for the designated OPM areas for County of Hawaii and County of Kauai and to no longer cap these OCOLA-based COLA factors at 25 percent. For the areas of City and County of Honolulu and County of Maui and County of Kalawao, given that the DOD OCOLA data would result in a decrease in the COLA factor, we finalized to maintain the current COLA factors of 1.25. Table H-01 of the FY 2027 IPPS/LTCH PPS final rule lists the finalized IPPS COLA factors for FY 2027 for the OPM designated areas of Alaska and Hawaii (91 FR 50389).

While higher labor-related costs for these two States are taken into account under the OPPS through the adoption of the IPPS hospital wage index and associated wage index policies, the nonlabor portion of OPPS payment is not currently adjusted to address higher nonlabor costs in these States as is addressed in the IPPS through the COLA policy. We have historically adopted the IPPS wage index and wage index policies under the OPPS, most recently in the CY 2026 OPPS/ASC final rule with comment period (90 FR 53494 through 53498). As discussed in section II.C of the proposed rule, we proposed to continue to adopt the IPPS wage index and

wage index policies under the CY 2027 OPPS and also continue to believe that using the IPPS wage index as the source of an adjustment factor for the OPPS is reasonable and logical, given the inseparable, subordinate status of the HOPD within the hospital overall. We think this same logic would apply to adopting the IPPS COLA policy for hospital outpatient services in Alaska and Hawaii, as additional nonlabor costs that apply to hospital inpatient services provided in these States likely also apply to hospital outpatient services in these States. Further, not addressing the discrepancy between the IPPS and OPPS adjustment to account for nonlabor related costs would potentially continue a disincentive to provide services in the hospital outpatient setting due to the adjustment only applying to inpatient services.

Based on our review of the costs of providing outpatient services in these States and our general practice of applying consistent policies across the inpatient and outpatient hospital settings where possible, we proposed to use the equitable adjustment authority provided by section 1833(t)(2)(E) of the Act to propose to apply the IPPS COLA factors to the nonlabor share of OPPS payment amounts for hospitals located in Alaska and Hawaii for CY 2027 and future years. We note that for OPPS payments for which there is no wage adjustable portion, we proposed to apply the COLA to the full OPPS payment, as would be the case for status indicator assignments of "G," "H," "K," "R," and "U".

As noted earlier in this section, in the FY 2027 IPPS/LTCH PPS proposed rule we proposed several changes to the current COLA methodology including using the OCOLA data published by the DOD for the FY 2027 factors as well as to remove the cap of 25 percent (91 FR 19813 through 19814). Consistent with our historical practice of aligning OPPS payment methodologies with those of the IPPS where appropriate, we proposed to adopt the IPPS COLA factors as finalized in the FY 2027 IPPS/LTCH PPS final rule as the CY 2027 OPPS COLA factors for hospitals located in Alaska and Hawaii. As previously discussed in this section, Table H-01 of the FY 2027 IPPS/LTCH PPS final rule lists the IPPS COLA factors finalized for FY 2027 for the OPM designated areas of Alaska and Hawaii (91 FR 50389).

Under the OPPS, section 1833(t)(2)(E) of the Act grants the Secretary the authority to establish equitable adjustments as necessary, and we proposed to use that authority to establish a COLA for outpatient hospital services provided in Alaska and Hawaii that mirrors the COLA provided for inpatient hospital services provided in these States. Associated with this proposed policy, we also proposed to add conforming regulation text changes by adding subsection (l) to § 419.43. This new subsection describes the cost-of-living adjustment to the nonlabor portion of the OPPS payment amounts for hospitals located in Alaska and Hawaii. Finally, we noted that under our authority at section 1833(t)(2)(E) of the Act this adjustment would be budget neutral, and stated that the associated budget neutrality adjustment is discussed in section II.B. of the proposed rule.

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: Several commenters supported the proposal to establish a COLA for hospital outpatient services furnished in Alaska and Hawaii. Several commenters requested that CMS finalize the proposal without delay and align the outpatient adjustment with the final IPPS COLA factors.

Response: We thank the commenters for their support.

Comment: One commenter stated that the proposed rule did not clearly identify the full set of payable services to which the COLA applies. The comment asked whether the adjustment is limited to status indicators G, H, K, R, and U or also applies to H1, J1, J2, K1, P, S, T, V, and other payable indicators.

Response: We appreciate the request for clarification. For OPPS payments that include a wage-adjustable portion, the COLA would apply to the nonlabor-related portion of the payment after the applicable wage adjustment is determined. This would apply to OPPS payments associated with final status indicators “J1,” “J2,” “O1,” “P,” “S,” “T,” and “V.”

For OPPS payments for which there is no wage-adjustable portion, including payments for services assigned status indicators "G," "H," "H1," "K," "K1," "R," "S1," and "U," the COLA would apply to the full OPPS payment amount. We are clarifying this distinction because these payments do not contain a separately identified labor-related portion to which the hospital wage index would otherwise apply.

Comment: A commenter requested that CMS implement the OPPS COLA in a manner that avoids unintended reductions for hospitals affected by the revised FY 2027 IPPS methodology. The commenter noted that, in the FY 2027 IPPS final rule, CMS maintained the existing payment levels for some of the areas in Hawaii and asked that CMS do the same the OPPS.

Response: In the FY 2027 IPPS/LTCH PPS final rule (91 FR 50389), we are maintaining the COLA factors that were in place for FY 2022 through FY 2026 for City and County of Honolulu, County of Maui, and County of Kalawao for FY 2027. Under our proposal, the same IPPS COLA factors as finalized in the FY 2027 IPPS/LTCH PPS final rule would be adopted as the CY 2027 OPPS COLA factors for hospitals located in Alaska and Hawaii. We refer readers to Table H-01 of the FY 2027 IPPS/LTCH PPS final rule, which lists the IPPS COLA factors finalized for FY 2027 for the OPM designated areas of Alaska and Hawaii (91 FR 50389).

Comment: A commenter supported the proposed COLA but encouraged CMS to continue evaluating alternative data sources that may more accurately reflect healthcare-specific costs in Alaska and Hawaii. The commenter suggested that CMS consider state-level cost-of-living measures, healthcare-specific inflation indexes, construction costs, transportation costs, utility costs, and supply-chain measures.

Response: We appreciate the commenter's recommendations concerning potential alternative data sources. For CY 2027, we believe it is appropriate to use the COLA factors

finalized under the FY 2027 IPPS because doing so provides consistency between the inpatient and outpatient hospital payment systems.

We refer readers to the FY 2027 IPPS/LTCH PPS final rule, where we invited feedback and suggestions regarding any additional data sources that could be used to develop the COLA factors (91 FR 50388).

Comment: One commenter believed that the COLA would establish an asymmetry in which hospitals receiving low wages would contribute to financing the COLA through OPPS budget neutrality without receiving comparable recognition for their geographic circumstances. The commenter asked CMS to explain this difference or provide more substantial relief through modifying budget neutrality for the OPPS wage-index transitional exception to specifically apply to hospitals above the 75th percentile of wage indexes.

Response: We appreciate the commenter's concerns but do not agree that the COLA and wage-index policies create the asserted asymmetry. The hospital wage index and COLA apply to address different cost categories and payment portions. The wage index is used to adjust the portion of the OPPS payment that is labor-related to account for different geographic levels of hospital wage costs. The COLA is designed to adjust the portion of payments not related to labor costs, so as to account for the distinct nonlabor costs of furnishing services in Alaska and Hawaii.

The presence of a nonlabor COLA for Alaska and Hawaii thus does not indicate that the wage-index methodology is failing to recognize geographic variation in labor costs elsewhere. Hospitals outside Alaska and Hawaii continue to receive wage index and other geographic adjustments applicable to them under both the IPPS and OPPS.

Section 1833(t)(2)(E) of the Act mandates that equitable adjustments are made in a budget-neutral manner, requiring that associated changes do not affect estimated aggregate OPPS expenditures. We do not believe that it is appropriate to budget neutralize specifically to hospitals with wage indexes above the 75th percentile. Developing wage index budget neutrality

in this manner would result in different wage indexes between the IPPS and OPPS, we believe that it is important to maintain alignment of the IPPS and OPPS wage indexes,

We therefore do not believe that establishing the COLA in the OPPS necessitates implementation of an additional wage index adjustment or altering the calculation of budget neutrality with regards to the wage index and its associated adjustments. For a detailed discussion of the wage index, please see section II.C. of this final rule with comment period.

Comment: Commenters agreed that circumstances in Alaska and Hawaii lead to higher non-labor costs, but stated that rural communities in other States also have geographic barriers to access care, shortages of health care workers, long travelling distances, transportation limitations, and other access limitations. One commenter stated, in general, that CMS allow for regional variation for cost-of-living.

Response: The OPPS addresses certain geographic differences through other payment policies, including application of the hospital wage index to the labor-related portion of the OPPS payment, the rural sole community hospital adjustment, geographic reclassification, and the out-migration adjustment. The OPPS COLA policy serves a narrower purpose. It recognizes the unique non-labor costs experienced by hospitals in the two non-contiguous states, Alaksa and Hawaii, and aligns the OPPS treatment of those costs with the longstanding IPPS policy.

After consideration of the public comments and for the reasons discussed, we are finalizing our proposal to apply the finalized IPPS COLA factors to the non-labor portion of OPPS payment for hospitals located in Alaska and Hawaii for CY 2027 and future years. We are also finalizing the proposed conforming regulation text changes at 42 CFR 419.43(l) and the associated budget neutrality adjustment as discussed in section II.B. of this final rule with comment period.

D. Provision of Cardiac Rehabilitation (CR), Intensive Cardiac Rehabilitation (ICR) and Pulmonary Rehabilitation (PR) Services to Hospital Outpatients in Their Homes Via Audio and Video Real-Time Communications Technology

Section 6211(a) of the Consolidated Appropriations Act, 2026 (CAA, 2026) (Pub. L. 119-75, February 3, 2026), amended section 1861(eee)(2)(A)(ii) of the Act to allow for the provision of cardiac rehabilitation (CR), intensive cardiac rehabilitation (ICR) and pulmonary rehabilitation (PR) services to hospital outpatients in their homes via audio and video real-time communications technology (excluding audio-only), through December 31, 2027.

Section 6211(b) of CAA, 2026, authorizes the Secretary to implement the amendment made by section 6211(a) via program instruction or otherwise. Consistent with that authority, we have issued sub-regulatory guidance relating to the provision of CR, ICR and PR services to hospital outpatients in their homes via audio and video real-time communications technology. This guidance is available at *https://www.cms.gov/medicare/coverage/telehealth.*

We received several comments in response to our notice of the posting of sub-regulatory guidance relating to the provision of CR, ICR and PR services to hospital outpatients in their homes via audio and video real-time communications technology.

Comment: Three commenters expressed support for the sub-regulatory guidance. One of these commenters stated that they supported policies that appropriately expand access to clinically appropriate rehabilitation services while maintaining patient safety and quality of care. Another stated that they appreciated the agency recognizing cardiac rehabilitation and related services being allowed for hospital outpatients in their homes via audio/video real-time communications through December 31, 2027 and providing clarity via the updated FAQ.

Response: We thank commenters for their support.

Comment: One commenter stated that there has been uncertainty in recent years as to whether Supervised Exercise Therapy (SET) for peripheral artery disease (PAD) continues to require direct supervision. The commenter requested that CMS clarify in the final rule whether SET for PAD is subject to direct or general supervision. If CMS's determination is that direct supervision continues to be required, the commenter urged CMS to allow the direct supervision

requirement for SET to be satisfied through a virtual presence, consistent with the approach CMS has adopted for CR, PR, and ICR services.

Response: SET for PAD continues to require direct supervision. The National Coverage Determination (NCD) 20.35,[176] which is entitled Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD), requires that SET be furnished "under the direct supervision of a physician (as defined in 1861(r)(1)), physician assistant, or nurse practitioner/clinical nurse specialist (as identified in 1861(aa)(5)) who must be trained in both basic and advanced life support techniques." We will take the commenter's suggestion to allow the direct supervision requirement for SET to be satisfied through virtual presence under consideration for future rulemaking.

Comment: One commenter stated that they recognized and appreciated the legislative action taken by Congress to extend authorization for the provision of telehealth pulmonary rehabilitation, cardiac rehabilitation and intensive cardiac rehabilitation through December 31, 2027, and further appreciated the non-regulatory guidance and Q&A document that CMS has developed to explain appropriate billing and documentation of pulmonary rehabilitation services provided in the outpatient setting. However, the commenter expressed concern about reduced patient access to PR services resulting from "low Medicare reimbursement levels" and noted their comments made to previous rulemaking requesting PR services be placed in the same APC as CR (APC 5771). The commenter additionally expressed concern about some virtual only pulmonary rehabilitation programs not fully adhering to guideline-based PR recommendations and requested a meeting with CMS to ensure that "future growth in virtual only PR follows evidence-based guidelines."

Response: We thank the commenter for their input. As we do every year, we will monitor the claims data and reevaluate the APC assignment for PR services in the next rulemaking cycle to determine if a more appropriate APC assignment is warranted. Meetings

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[176] *https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=371*.

with the Division of Outpatient Care at CMS can be requested via the OPPS mailbox at OutpatientPPS@cms.hhs.gov.

Comment: One commenter requested that CMS eliminate the physician supervision requirement for Certified Registered Nurse Anesthetists (CRNAs) under the critical access hospital and rural emergency hospital conditions of participation and the ambulatory surgical conditions for coverage.

Response: We thank the commenter for their input; however, this comment is out of scope for purposes of this OPPS/ASC final rule with comment period.

XI. CY 2027 OPPS Payment Status and Comment Indicators

A. CY 2027 OPPS Payment Status Indicator Definitions

Payment status indicators (SIs) that we assign to HCPCS codes and APCs serve an important role in determining payment for services under the OPPS. They indicate whether a service represented by a HCPCS code is payable under the OPPS or another payment system and whether particular OPPS policies apply to the code.

For CY 2027 and subsequent years, we proposed to create a new status indicator for software as a medical service that is paid separately under the OPPS (91 FR 41929). Under the OPPS, software as a medical service that is paid separately would be assigned a status indicator of "O1" – **(**Software as a Medical Service, paid under OPPS; separate APC payment**)**. Further discussion of the final payment policy for SaMS can be found in section X.B. of this final rule with comment period.

For CY 2027 and subsequent years, we also proposed to revise the current definition of status indicator "E2" to comply with the drug invoice policy. Further discussion of the drug invoice payment policy can be found in section V.B.2.c. of this final rule with comment period.

We did not propose to make any other changes to the existing definitions of status indicators for 2027.

We solicited public comments on the proposed definitions of the OPPS payment status indicators for CY 2027.

We did not receive any public comments on the proposed definitions of new status indicator "O1" or revised status indicator "E2", and therefore, we are finalizing the proposed definitions of status indicators "O1" and "E2" without modification for CY 2027.

The final definitions and payment statuses of status indicators "O1" and "E2" can be found in Table 87 of this final rule with comment period.

We refer readers to section X.B of this final rule with comment period for discussion on the payment specifications for status indicator "O1".

TABLE 87: FINAL DEFINITIONS AND PAYMENT STATUSES OF STATUS INDICATORS O1 AND E2

Final Status Indicator	Final Descriptor	Final OPPS Payment Status
O1	Software as a Medical Service	Paid under OPPS; separate APC payment.
E2	Items and Services: For which pricing information and claims data are not available.	Not paid by Medicare when submitted on outpatient claims (any outpatient bill type). Exception: claims under drug invoice pricing policy are contractor priced.

The complete list of CY 2027 payment status indicators and their definitions is displayed in Addendum D1 to this final rule with comment period, which is available on the CMS website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices*. The CY 2027 payment status indicator assignments for APCs and HCPCS codes are shown in Addendum A and Addendum B, respectively, to this final rule with comment period, which are available on the CMS website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices*.

B. CY 2027 Comment Indicator Definitions

We proposed to use four comment indicators for the CY 2027 OPPS. These comment indicators, "CH", "NC", "NI", and "NP", are in effect for CY 2026; and we proposed to continue their use in CY 2027. The CY 2027 OPPS comment indicators are as follows:

- "CH"—Active HCPCS code in current and next calendar year, status indicator and/or APC assignment has changed; or active HCPCS code that will be discontinued at the end of the current calendar year.

- "NC"—New code for the next calendar year or existing code with substantial revision to its code descriptor in the next calendar year, as compared to current calendar year for which we requested comments in the CY 2026 OPPS/ASC proposed rule; final APC assignment; comments will not be accepted on the final APC assignment for the new code.

- "NI"—New code for the next calendar year or existing code with substantial revision to its code descriptor in the next calendar year, as compared to current calendar year, interim APC assignment; comments will be accepted on the interim APC assignment for the new code.

- "NP"—New code for the next calendar year or existing code with substantial revision to its code descriptor in the next calendar year, as compared to current calendar year, APC assignment; comments will be accepted on the APC assignment for the new code.

We solicited public comments on our proposed definitions of the OPPS comment indicators for CY 2027.

We did not receive any public comments on this provision, and therefore, we are finalizing those definitions without modification for CY 2027. The definitions of OPPS comment indicators for CY 2027 are listed in Addendum D2 to this final rule with comment period, which is available on the CMS website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices*.

XII. MedPAC Recommendations

The Medicare Payment Advisory Commission (MedPAC) was established under section 1805 of the Act in large part to advise the U.S. Congress on issues affecting the Medicare program. As required under the statute, MedPAC submits reports to Congress no later than March and June of each year that present its Medicare payment policy recommendations. The March report typically provides discussion of Medicare payment policy across different payment systems and the June report typically discusses selected Medicare issues. We are including this section to make interested parties aware of certain MedPAC recommendations for the OPPS and ASC payment systems as discussed in its March 2026 report.

Comments received from MedPAC for other OPPS or ASC payment system policies are discussed in the applicable sections of this final rule with comment period.

A. OPPS Payment Rates Update

The March 2026 MedPAC "Report to the Congress: Medicare Payment Policy", recommended that the Congress update Medicare OPPS payment rates by the amount specified in current law. We refer readers to the March 2026 report for a complete discussion of this recommendation.[177] We appreciate MedPAC's recommendation and, as discussed further in section II.B. of this final rule with comment period, we are finalizing our proposal to increase the OPPS payment rates by the amount specified in current law.

B. Medicare Safety Net Index

In the March 2026 MedPAC "Report to the Congress: Medicare Payment Policy", MedPAC stated that their recommended update to IPPS and OPPS payment rates under current law may not be sufficient to ensure the financial viability of some Medicare safety-net hospitals with a poor payer mix. MedPAC recommended that Congress redistribute the current Medicare safety-net payments (disproportionate share hospital and uncompensated care payments) using the MedPAC-developed Medicare Safety-Net Index (MSNI) for hospitals. In addition, MedPAC recommended adding $1 billion to this MSNI pool of funds to help maintain the financial viability of Medicare safety-net hospitals and recommended to the Congress transitional approaches for an MSNI policy. The FY 2027 IPPS/LTCH final rule with comment period (91 FR 49570) provides additional information regarding statutory requirements for disproportionate share hospital and uncompensated care payments. We look forward to working with Congress on these matters.

[177] Medicare Payment Advisory Committee. March 2026 Report to the Congress. Chapter 3: Hospital inpatient and outpatient services, pp.61-96. Available at *https://www.medpac.gov*.

XIII. Updates to the Ambulatory Surgical Center (ASC) Payment System

A. Background, Legislative History, Statutory Authority, and Prior Rulemaking for the ASC Payment System

For a detailed discussion of the legislative history and statutory authority related to payments to ASCs under Medicare, we refer readers to the CY 2012 OPPS/ASC final rule with comment period (76 FR 74377 through 74378) and the June 12, 1998 proposed rule (63 FR 32291 through 32292). For a discussion of prior rulemaking on the ASC payment system, we refer readers to the CYs 2012 to 2026 OPPS/ASC final rules with comment period (76 FR 74378 through 74379; 77 FR 68434 through 68467; 78 FR 75064 through 75090; 79 FR 66915 through 66940; 80 FR 70474 through 70502; 81 FR 79732 through 79753; 82 FR 59401 through 59424; 83 FR 59028 through 59080; 84 FR 61370 through 61410; 85 FR 86121 through 86179; 86 FR 63761 through 63815; 87 FR 72054 through 72096; 88 FR 81900 through 81961; 89 FR 94309 through 94367; and 90 FR 53834 through 53916).

B. ASC Treatment of New and Revised Codes

1. Background on Process for New and Revised HCPCS Codes

We update the lists and payment rates for covered surgical procedures and covered ancillary services in ASCs in conjunction with the annual proposed and final rulemaking process to update the OPPS and the ASC payment systems (§ 416.173; 72 FR 42535). We base ASC payment and policies for most covered surgical procedures, drugs, biologicals, and certain other covered ancillary services on the OPPS payment policies, and we use quarterly change requests (CRs) to update services paid for under the OPPS. We also provide quarterly update CRs for ASC covered surgical procedures and covered ancillary services throughout the year (January, April, July, and October). We release new and revised Level II HCPCS codes and recognize the release of new and revised CPT codes by the American Medical Association (AMA) and make these codes effective (that is, the codes are recognized on Medicare claims) via these ASC quarterly update CRs. We recognize the release of new and revised Category III CPT codes in

the July and January CRs. We note however, that in early August of this year, the AMA updated their 'release and effective date' schedule for Category III CPT codes. The Category III CPT codes will no longer be released only twice a year. Category III CPT codes will be released April 1 with an effective date of July 1, July 1 with an effective date of October 1, and October 1 with an effective date of January 1.[178] These codes will be recognized in the July, October, and January CRs. These updates implement newly created and revised Level II HCPCS and Category III CPT codes for ASC payments and update the payment rates for separately paid drugs and biologicals based on the most recently submitted ASP data. New and revised Category I CPT codes, except vaccine codes, are released only once a year, and are implemented only through the January quarterly CR update. New and revised Category I CPT vaccine codes are released twice a year and are implemented through the January and July quarterly CR updates. We refer readers to Table 41 in the CY 2012 OPPS/ASC proposed rule for an example of how this process is used to update HCPCS and CPT codes, which we finalized in the CY 2012 OPPS/ASC final rule with comment period (76 FR 42291; 76 FR 74380 through 74384).

In our annual updates to the ASC list of covered surgical procedures and covered ancillary services, we undertake a review of excluded surgical procedures, new codes, and codes with revised descriptors, to identify any that we believe meet the criteria for designation as ASC covered surgical procedures or covered ancillary services. Updating the lists of ASC covered surgical procedures and covered ancillary services, as well as their payment rates, in association with the annual OPPS rulemaking cycle, is particularly important because the OPPS relative payment weights and, in some cases, payment rates, are used as the basis for the payment of many covered surgical procedures and covered ancillary services under the revised ASC

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[178] See the AMA's website for the complete schedule. *https://www.ama-assn.org/system/files/category-3-early-release.pdf*.

payment system. This joint update process ensures that the ASC updates occur in a regular, predictable, and timely manner.

Payment for ASC procedures, services, and items are generally based on medical billing codes, specifically, HCPCS codes, that are reported on ASC claims. The HCPCS is divided into two principal subsystems, referred to as Level I and Level II. Level I is comprised of CPT (Current Procedural Terminology) codes, a numeric and alphanumeric coding system maintained by the AMA, and includes Category I, II, and III CPT codes. Level II of the HCPCS, which is maintained by CMS, is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes. Together, Level I and II HCPCS codes are used to report procedures, services, items, and supplies under the ASC payment system. Specifically, we recognize the following codes on ASC claims:

- Category I CPT codes, which describe surgical procedures, diagnostic and therapeutic services, and vaccine codes;
- Category III CPT codes, which describe new and emerging technologies, services, and procedures; and
- Level II HCPCS codes (also known as alpha-numeric codes), which are used primarily to identify drugs, devices, supplies, temporary procedures, and services not described by CPT codes.

We finalized a policy in the August 2, 2007 ASC final rule (72 FR 42533 through 42535) to evaluate each year all new and revised Category I and Category III CPT codes and Level II HCPCS codes that describe surgical procedures, and to make preliminary determinations during the annual OPPS/ASC rulemaking process regarding whether or not they meet the criteria for payment in the ASC setting as covered surgical procedures and, if so, whether or not they are office-based procedures. In addition, we identify new and revised codes as ASC covered ancillary services based upon the final payment policies of the revised ASC payment system. In prior rulemakings, we refer to this process as recognizing new codes. However, this process has

always involved the recognition of new and revised codes. We consider revised codes to be new when they have substantial revision to their code descriptors that necessitate a change in the current ASC payment indicator. To clarify, we refer to these codes as new and revised in this final rule with comment period.

We have separated our discussion later in this section of the preamble based on when the codes are released and whether we proposed to solicit public comments in the proposed rule (and respond to those comments in this CY 2027 OPPS/ASC final rule with comment period) or whether we will be soliciting public comments in the CY 2027 OPPS/ASC final rule with comment period (and responding to those comments in the CY 2028 OPPS/ASC final rule with comment period).

2. April 2026 HCPCS Codes Proposed Rule Comment Solicitation

For the April 2026 update, there were no new CPT codes; however, there were several new Level II HCPCS codes. In the April 2026 ASC quarterly update (Transmittal 13704, dated April 7, 2026, CR 14445), we added several new Level II HCPCS codes to the list of covered ancillary services. Table 64 (New Level II HCPCS Codes for ASC Covered Surgical Procedures and Ancillary Services Effective April 1, 2026) of the CY 2027 OPPS/ASC proposed rule (91 FR 41932 through 41933), listed the new Level II HCPCS codes that were implemented April 1, 2026. These new codes that were effective April 1, 2026, were assigned to comment indicator "NP" in Addendum BB to the CY 2027 OPPS/ASC proposed rule to indicate that the codes were assigned to interim APC assignments. In addition, we note that the ASC addenda (AA, BB, DD1, DD2, EE, and FF) listed below, as well as other relevant addenda discussed later in this section of the preamble, are available via the internet on the CMS website, specifically, at *https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-regulations-and-notices*.

- ASC Addendum AA: ASC Covered Surgical Procedures for CY 2027 (Including Surgical Procedures for Which Payment is Packaged),

- ASC Addendum BB: ASC Covered Ancillary Services Integral to Covered Surgical Procedures for CY 2027 (Including Ancillary Services for Which Payment is Packaged),
- ASC Addendum DD1: Proposed ASC Payment Indicators (PI) for CY 2027,
- ASC Addendum DD2: ASC Comment Indicators (CI) for CY 2027,
- ASC Addendum EE: Surgical Procedures to be Excluded from Payment in ASC for CY 2027, and
- ASC Addendum FF: ASC Device Offset Percentages for CY 2027, and
- Addendum O: Long Descriptors for New Category I CPT Codes, Category III CPT Codes, C-codes, and G-Codes Effective January 1, 2027.

We invited public comments on the proposed interim payment indicators for the new HCPCS codes that were recognized as ASC covered ancillary services in April 2026 through the quarterly update CRs, as listed in Table 88 (New Level II HCPCS Codes for ASC Covered Surgical Procedures and Ancillary Services Effective April 1, 2026). The new codes that were effective April 1, 2026, were assigned to comment indicator ‘‘NP’’ in ASC Addendum BB to the CY 2027 OPPS/ASC proposed rule to indicate that the codes were assigned to interim payment indicators and comments would be accepted on their interim assignments. Comments related to office-based designations or device-intensive status designations for new Level II HCPCS codes that were implemented in April 2026 can be found in sections XIII.C.3.b. and XIII.C.3.c. of this final rule with comment period. We note in prior years we included the final ASC payment indicators in the coding tables in the preamble, but because we include the same information in the ASC addenda, we have not included them in Table 88. Therefore, readers are advised to refer to the ASC addenda for the final ASC payment indicators and payment rates for all codes reported under the ASC payment system. The list of ASC payment indicators and definitions used under the ASC payment system can be found in the ASC addenda. We note that the ASC

addenda (AA, BB, DD1, DD2, EE, and FF) and OPPS Addendum O are available via the internet on the CMS website.

TABLE 88: NEW LEVEL II HCPCS CODES FOR ASC COVERED SURGICAL PROCEDURES AND ANCILLARY SERVICES EFFECTIVE APRIL 1, 2026

April 2026 HCPCS Code	CY 2027 HCPCS Code	Long Descriptor
A2040	A2040	Microlyte painguard, per square centimeter
A2041	A2041	Foundation drs+ duo, per square centimeter
A2042	A2042	Foundation drs+ solo, per square centimeter
A2043	A2043	Biobrane, per square centimeter
A2044	A2044	Biobrane glove, each
A2045	A2045	Novashield or novogen wound matrix, per square centimeter
C1743	C1743	Scaffold, endovascular non-coronary, resorbable drug eluting, with delivery system (implantable)
C8007	C8007	Open implantation of hypoglossal nerve neurostimulator array and pulse generator, not requiring an insertion of a separate distal respiratory sensor electrode or electrode array
C8008	C8008	Revision or replacement of hypoglossal nerve neurostimulator array including connection to existing pulse generator
C8009	C8009	Removal of hypoglossal nerve neurostimulator array and pulse generator
C8010	1091T	Percutaneous placement of permanent common carotid embolic protection device, including all system components and imaging guidance; bilateral
C8011	C8011	Open implantation of hypoglossal nerve(s) neurostimulator electrode array(s) and receiver, including external power source and all system components
C8012	C8012	Revision or replacement of hypoglossal nerve(s) neurostimulator electrode array(s) and receiver
C8013	C8013	Removal of hypoglossal nerve(s) neurostimulator electrode array(s) and receiver
C9818	C9818	Suzetrigine, oral, 1 mg
G0681	G0681	Application of a premarket approval (pma), 510(k), 361 human cells, tissues or cellular and tissue-based products (hct/p) non-sheet form skin substitute for a wound surface area up to 100 sq cm; first 25 sq cm or less of wound surface area
G0682	G0682	Application of a premarket approval (pma), 510(k), 361 human cells, tissues or cellular and tissue-based products (hct/p) non-sheet form skin substitute for a wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (list separately in addition to code for primary procedure)
G0683	G0683	Application of a premarket approval (pma), 510(k), 361 human cells, tissues or cellular and tissue-based products (hct/p) non-sheet form skin substitute graft for a wound surface greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children
G0684	G0684	Application of a premarket approval (pma), 510(k), 361 human cells, tissues or cellular and tissue-based products (hct/p) non-sheet form skin substitute graft for a wound surface greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area or part thereof, or each additional 1% of body area of infants and children, or part thereof (list separately in addition to code for primary procedure)
J0463	J0463	Injection, atropine sulfate (fresenius and therapeutically equivalent), 0.01 mg
J1098	J1098	Articaine ophthalmic, 8% solution, 0.4 mL
J1164	J1164	Injection, diltiazem hydrochloride in 0.72% sodium chloride, 0.5 mg
J1553	J1553	Injection, immune globulin (yimmugo), 100 mg

April 2026 HCPCS Code	CY 2027 HCPCS Code	Long Descriptor
C9145	J8502	Injection, aprepitant (aponvie), 1 mg
J9183	J9183	Gemcitabine intravesical system, 225 mg
J9277	J9277	Injection, pembrolizumab, 1 mg and berahyaluronidase alfa-pmph
C9308	J9278	Injection, carboplatin (avyxa), 1 mg
C9307	J9601	Injection, linvoseltamab-gcpt, 1 mg
Q4418	Q4418	Biolab membrane wrap flow, per square centimeter (add-on, list separately in addition to primary procedure)
Q4419	Q4419	Biolab membrane wrap lite flow, per square centimeter (add-on, list separately in addition to primary procedure)
Q4421	Q4421	Biolab membrane wrap solo, per square centimeter (add-on, list separately in addition to primary procedure)
Q4422	Q4422	A/c wrap, per square centimeter (add-on, list separately in addition to primary procedure)
Q4423	Q4423	Biolab tri-membrane wrap flow, per square centimeter (add-on, list separately in addition to primary procedure)
Q4424	Q4424	Revive ft, per square centimeter (add-on, list separately in addition to primary procedure)
Q4425	Q4425	Revive tl, per square centimeter (add-on, list separately in addition to primary procedure)
Q4426	Q4426	Dermabind tl + or dermabind tl x, per square centimeter (add-on, list separately in addition to primary procedure)
Q4427	Q4427	Dermabind dl n or dermabind dl + or dermabind dl x, per square centimeter (add-on, list separately in addition to primary procedure)
Q4428	Q4428	Dermabind sl n or dermabind sl + or dermabind sl x, per square centimeter (add-on, list separately in addition to primary procedure)
Q4429	Q4429	Dermabind ch n or dermabind ch x, per square centimeter (add-on, list separately in addition to primary procedure)
Q4435	Q4435	Renati membrane, per square centimeter (add-on, list separately in addition to primary procedure)
Q4436	Q4436	Renati ac membrane, per square centimeter (add-on, list separately in addition to primary procedure)
Q4437	Q4437	Revival ac, per square centimeter (add-on, list separately in addition to primary procedure)
Q4438	Q4438	Pretect, per square centimeter (add-on, list separately in addition to primary procedure)
Q4439	Q4439	Instagraft, per square centimeter (add-on, list separately in addition to primary procedure)
Q4440	Q4440	Curamatrix, per square centimeter (add-on, list separately in addition to primary procedure)
Q5162	Q5162	Injection, denosumab-nxxp (bildyos/bilprevda), biosimilar, 1 mg

3. July 2026 HCPCS Codes Proposed Rule Comment Solicitation

In the July 2026 ASC quarterly update (Transmittal R13836, Change Request 14522, June 24, 2026), we added several separately payable CPT and Level II HCPCS codes to the list of covered surgical procedures and covered ancillary services. Table 65 (New HCPCS Codes for ASC Covered Surgical Procedures and Ancillary Services Effective July 1, 2026) of the CY

2027 OPPS/ASC proposed rule (91 FR 41934), displayed the new HCPCS codes that were effective July 1, 2026.

We invited public comments on the proposed payment indicators for these Level II HCPCS codes, and indicated that the proposed comment indicators, payment indicators, and payment rates for these codes were listed in Addendum AA and Addendum BB of the proposed rule. These new codes that were effective July 1, 2026, were assigned to comment indicator ‘‘NP’’ in ASC Addendum AA and Addendum BB to the CY 2027 OPPS/ASC proposed rule to indicate that the codes were assigned to interim payment indicators and comments would be accepted on their interim assignments. We further stated that we proposed to finalize the payment indicators in this final rule with comment period. We note in prior years we included the final ASC payment indicators in the coding preamble tables, however, because the same information can be found in Addendum AA and Addendum BB, we are no longer including them in Table 89. Therefore, readers are advised to refer to the ASC addenda for the final ASC payment indicators and payment rates for all codes reported under the ASC payment system.

Comments related to office-based designations or device-intensive status designations for new CPT and Level II HCPCS codes that were added to the list of covered surgical procedures and ancillary services implemented in July 2026 can be found in sections XIII.C.3.b. and XIII.C.3.c. of this final rule with comment period.

TABLE 89: NEW HCPCS CODES FOR ASC COVERED SURGICAL PROCEDURES AND COVERED ANCILLARY SERVICES EFFECTIVE JULY 1, 2026

July 2026 HCPCS Code	CY 2027 HCPCS Code	Long Descriptor
0730T	0730T	Trabeculotomy by laser, including optical coherence tomography (OCT) guidance
A9574	A9574	Injection, ferumoxytol, 1 mg
C1609	C1609	Vertebral device, motion-preserving, with screw fixation
C8014	C8014	Cystourethroscopy, with ureteroscopy and/or pyeloscopy, with lithotripsy, including use of a suction enabled ureteral access sheath, with irrigation (if performed)
C9310	C9310	Injection, leucovorin calcium (avyxa), 1 mg
J0528	J0528	Injection, fosfomycin disodium, 20 mg
J1289	J1289	Injection, narsoplimab-wuug, 1 mg
J1577	J1577	Injection, immune globulin (qivigy), 100 mg

July 2026 HCPCS Code	CY 2027 HCPCS Code	Long Descriptor
J2361	J2361	Injection, depemokimab-ulaa, 1 mg
J2789	J2789	Riboflavin 5'-phosphate, ophthalmic solution (epioxahd/epioxa), up to 2 mL
J7176	J7176	Injection, human fibrinogen - chmt (fesilty), 1 mg
J9062	J9062	Injection, amivantamab 5 mg and hyaluronidase-lpuj
J9232	J9232	Injection, docetaxel (hospira), not therapeutically equivalent to j9171, 1 mg
Q5098	Q5098	Injection, ustekinumab-srlf (imuldosa), biosimilar, 1 mg
Q5164	Q5164	Injection, ustekinumab-hmny (starjemza), biosimilar, 1 mg
Q5165	Q5165	Injection, denosumab-mobz (oziltus), biosimilar, 1 mg
Q5166	Q5166	Injection, denosumab-desu (osvyrti/jubereq), biosimilar, 1 mg
Q5167	Q5167	Injection, denosumab-qbde (enoby/xtrenbo), biosimilar, 1 mg
Q5168	Q5168	Injection, ranibizumab-leyk (nufymco), biosimilar, 0.1 mg
Q5169	Q5169	Injection, pegfilgrastim-unne (armlupeg), biosimilar, 0.5 mg
Q5170	Q5170	Injection, aflibercept-boav (eydenzelt), biosimilar, 1 mg
Q5171	Q5171	Injection, denosumab-mobz (boncresa), biosimilar, 1 mg

4. October 2026 HCPCS Codes Final Rule Comment Solicitation

For CY 2027, consistent with our established policy, we proposed in the CY 2027 OPPS/ASC proposed rule (91 FR 41934) that the HCPCS codes that will be effective October 1, 2026, would be flagged with comment indicator ‘‘NI’’ in Addendum BB to this final rule with comment period to indicate that we have assigned the codes an interim ASC payment status for CY 2027. In the October 2026 ASC quarterly update (Transmittal 13983, Change Request 14634, dated October 8, 2026), we added separately payable Level I and II HCPCS codes to the list of covered surgical procedures and covered ancillary services. Table 90 lists the codes that were effective October 1, 2026. We are inviting public comments on this final rule with comment period on the interim payment indicators, which will be finalized in the CY 2028 OPPS/ASC final rule with comment period. We note these codes will be subject to comment in the CY 2028 OPPS/ASC proposed rule with comment period, which will be finalized in the CY 2028 OPPS/ASC final rule with comment period.

TABLE 90: NEW HCPCS CODES FOR ASC COVERED SURGICAL PROCEDURES AND ANCILLARY SERVICES EFFECTIVE OCTOBER 1, 2026

October 2026 HCPCS Code	CY 2027 HCPCS Code	CY 2027 Long Descriptor
1054T	1054T	Focused non-shock wave ultrasonic propulsion of residual stone fragment(s) post-lithotripsy, unilateral, including ultrasound guidance, fragment(s) less than or equal to 5 mm
1056T	1056T	Cochlear infusion of pharmacologic agent (ie, gene therapy vector), including mastoidectomy, labyrinthotomy, and repair of fenestrations
1062T	1062T	Artificial insemination, transcervical intratubal, unilateral or bilateral, including imaging guidance
1069T	1069T	Mechanical extremity (ie, hands and feet) cryocompression; individual glove and boot supplies with initial measurement, fitting, and therapy education
1070T	1070T	Mechanical extremity (ie, hands and feet) cryocompression; individual glove and boot placement, initiation of cooling pre-chemotherapy and continuing through chemotherapy administration
1081T	1081T	Microvascular anastomosis between a lymph node and a vein, including robot assistance, when performed; initial anastomosis
1084T	1084T	Implantation of scaffolding allograft to reinforce the suprachoroidal space
1091T	1091T	Placement of permanent common carotid artery filter, percutaneous, bilateral, including ultrasound guidance, when performed
1092T	1092T	Implantation of acellular scaffold (eg, hyaluronan), knee, single implant; into chondral defect, open
1093T	1093T	Implantation of acellular scaffold (eg, hyaluronan), knee, single implant; into a chondral or osteochondral defect, arthroscopic
A9613	A9613	Piflufolastat f 18 (pylarify truvu), diagnostic, 1 millicurie
C9311	C9311	Injection, eplontersen, 1 mg (code may be used for medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered)
C9312	C9312	Injection, trabectedin (apotex), not therapeutically equivalent to J9362, 0.01 mg
C9313	C9313	Injection, pivekimab sunirine-pvzy, 0.01 mg
C9310	J0655	Injection, leucovorin calcium (avyxa), 1 mg
J0871	J0871	Injection, daptomycin (endo), not therapeutically equivalent to j0878, 1 mg
J1757	J1757	Injection, tividenofusp alfa-eknm, 1 mg
J1818	J1818	Injection, pegzilarginase-nbln, 0.05 mg
J9186	J9186	Injection, etoposide (avyxa), 1 mg
J9191	J9191	Injection, fluorouracil (avyxa), 10 mg
J9362	J9362	Injection, trabectedin, 0.01 mg
Q5172	Q5172	Injection, filgrastim-laha (filkri), biosimilar, 1 microgram
A2046	A2046	Dermisphere hdrt, per square centimeter (add-on, list separately in addition to primary procedure)
A2047	A2047	Lacertamatrix, per square centimeter (add-on, list separately in addition to primary procedure)
A2048	A2048	Puraply mz, per milligram
A2049	A2049	Theracor, per square centimeter (add-on, list separately in addition to primary procedure)
A2050	A2050	Fibrillar collagen wound dressing, per milligram
Q4207	Q4207	Carbon life, per square centimeter (add-on, list separately in addition to primary procedure)
Q4223	Q4223	Dermabind sl optic, per square centimeter (add-on, list separately in addition to primary procedure)
Q4243	Q4243	Amchomatrix, per square centimeter (add-on, list separately in addition to primary procedure)

5. January 2027 HCPCS Codes

a. New Level II HCPCS Codes Final Rule Comment Solicitation

As has been our practice in the past, we include those HCPCS codes that are effective January 1 in this final rule with comment period, thereby updating the ASC payment system for the calendar year. In contrast, most Level II HCPCS codes effective January 1 are not released until November and therefore are not available for inclusion in the proposed rule. The G-codes listed in Addendum O to this final rule with comment period (which were also included in the proposed rule) are an exception. We assigned interim payment statuses to the Level II HCPCS codes that were not available for inclusion in the proposed rule and identify them with comment indicator "NI" in ASC Addendum AA and Addendum BB to this final rule with comment period to indicate that we are assigning them an interim payment status, which is subject to public comment. Therefore, as we stated in the CY 2027 OPPS/ASC proposed rule, these Level II HCPCS codes that will be effective January 1, 2027, are included in this final rule with comment period and will also be released to the public through the January 2027 ASC Update CR and the CMS HCPCS website. We are inviting public comments in this final rule with comment period on the payment indicator assignments, which would be finalized in the CY 2028 OPPS/ASC final rule with comment period. Similar to the codes effective October 1, 2026, these new Level II HCPCS codes that will be effective January 1, 2027 will be subject to comment in the CY 2028 OPPS/ASC proposed rule, which would be finalized in the CY 2028 OPPS/ASC final rule with comment period.

b. CPT Codes Proposed Rule Comment Solicitation

For the CY 2027 ASC update, we received the CPT codes that will be effective January 1, 2027, from the AMA in time to be included in this final rule with comment period; however, the AMA subsequently announced a new 'release and effective date' schedule for Category III CPT codes. As a result, the Category III CPT codes that were previously assigned a January 1, 2027 effective date by the AMA, became effective October 1, 2026.

The new, revised, and deleted CPT codes can be found in ASC Addendum AA and Addendum BB to the CY 2027 OPPS/ASC proposed rule, which are available via the internet on the CMS website. We note that the new and revised CPT codes are assigned to comment indicator ‘‘NP’’ in ASC Addendum AA and Addendum BB of the CY 2027 OPPS/ ASC proposed rule to indicate that the code is new for the calendar year 2027, or the code is an existing code with substantial revision to its code descriptor in calendar year 2027 as compared to the current calendar year with a proposed payment indicator assignment. We stated that we would accept comments and finalize the payment indicators in this final rule with comment period. Further, we remind readers that the CPT code descriptors that appeared in Addendum AA and Addendum BB are short descriptors and do not describe the complete procedure, service, or item described by the CPT code. Therefore, we included the 5-digit placeholder codes and their long descriptors for the new CY 2027 CPT codes in Addendum O to the CY 2027 OPPS/ASC proposed rule (which is available via the internet on the CMS website) so that the public could comment on our proposed payment indicator assignments. The 5-digit placeholder codes were listed in Addendum O to the CY 2027 OPPS/ASC proposed rule, specifically under the column labeled ‘‘CY 2027 OPPS/ASC Proposed Rule 5-Digit Placeholder Code.’’ We also stated that we would include the final CPT code numbers in this CY 2027 OPPS/ASC final rule with comment period. Comments related to office-based designations or device-intensive status designations for new CPT codes that were added to the list of covered surgical procedures and ancillary services implemented in January 2027 can be found in sections XIII.C.3.b. and XIII.C.3.c. of this final rule with comment period.

Finally, in Table 91, we summarize our process for updating codes through our ASC quarterly update CRs, seeking public comments, and finalizing the treatment of these new codes under the ASC payment system.

TABLE 91: COMMENT AND FINALIZATION TIMEFRAMES FOR NEW AND REVISED ASC-RELATED HCPCS CODES

ASC Quarterly Update CR	Type of Code	Effective Date	Comments Sought	When Finalized
April 2026	HCPCS (CPT and Level II codes)	April 1, 2026	CY 2027 OPPS/ASC proposed rule	CY 2027 OPPS/ASC final rule with comment period
July 2026	HCPCS (CPT and Level II codes)	July 1, 2026	CY 2027 OPPS/ASC proposed rule	CY 2027 OPPS/ASC final rule with comment period
October 2026	HCPCS (CPT and Level II codes)	October 1, 2026	CY 2027 OPPS/ASC final rule with comment period	CY 2028 OPPS/ASC final rule with comment period
January 2027	CPT Codes	January 1, 2027	CY 2027 OPPS/ASC proposed rule	CY 2027 OPPS/ASC final rule with comment period
	Level II HCPCS Codes	January 1, 2027	CY 2027 OPPS/ASC final rule with comment period	CY 2028 OPPS/ASC final rule with comment period

6. ASC Payment and Comment Indicators

a. Background

In addition to the payment indicators that we introduced in the August 2, 2007 ASC final rule, we created final comment indicators for the ASC payment system in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66855). We created Addendum DD1 to define ASC payment indicators that we use in Addenda AA and BB to provide payment information regarding covered surgical procedures and covered ancillary services, respectively, under the revised ASC payment system. The ASC payment indicators in Addendum DD1 are intended to capture policy-relevant characteristics of HCPCS codes that may receive packaged or separate payment in ASCs, such as whether they were on the ASC CPL prior to CY 2008; payment designation, such as device-intensive or office-based, and the corresponding ASC payment methodology; and their classification as separately payable ancillary services, including radiology services, brachytherapy sources, OPPS pass-through devices, corneal tissue acquisition services, drugs or biologicals, NTIOLs, or qualifying nonopioid devices.

We also created Addendum DD2 that lists the ASC comment indicators. The ASC comment indicators included in Addenda AA and BB to the proposed rules and final rules with

comment period serve to identify, for the revised ASC payment system, the status of a specific HCPCS code and its payment indicator with respect to the timeframe when comments will be accepted. The comment indicator ''NI'' is used in the OPPS/ASC final rule with comment period to indicate new codes for the next calendar year for which the interim payment indicator assigned is subject to comment. The comment indicator ''NI'' also is assigned to existing codes with substantial revisions to their descriptors such that we consider them to be describing new services, and the interim payment indicator assigned is subject to comment, as discussed in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60622). The comment indicator ''NP'' is used in the OPPS/ASC proposed rule to indicate new codes for the next calendar year for which the proposed payment indicator assigned is subject to comment. The comment indicator ''NP'' also is assigned to existing codes with substantial revisions to their descriptors, such that we consider them to be describing new services, and the proposed payment indicator assigned is subject to comment, as discussed in the CY 2016 OPPS/ASC final rule with comment period (80 FR 70497). The ''CH'' comment indicator is used in Addenda AA and BB to the proposed rule (these addenda are available via the internet on the CMS website) to indicate that the payment indicator assignment has changed for an active HCPCS code in the current year and the next calendar year, for example, if an active HCPCS code is newly recognized as payable in ASCs or an active HCPCS code is discontinued at the end of the current calendar year. The ''CH'' comment indicators that are published in the final rule with comment period are provided to alert readers that a change has been made from one calendar year to the next, but do not indicate that the change is subject to comment.

In the CY 2021 OPPS/ASC final rule with comment period, we finalized the addition of ASC payment indicator ''K5''—Items, Codes, and Services for which pricing information and claims data are not available. No payment made—to ASC Addendum DD1 (which is available via the internet on the CMS website) to indicate those services and procedures that CMS anticipates will become payable when claims data or payment information becomes available.

In the CY 2024 OPPS/ASC final rule with comment period, we finalized the addition of two ASC payment indicators, ‘‘D1’’—‘‘Ancillary dental service/item; no separate payment made’’ and ‘‘D2’’—‘‘Non office-based dental procedure added in CY 2024 or later’’, for new dental codes for CY 2024 and subsequent calendar years to indicate potentially payable dental services and procedures in the ASC setting (88 FR 81907). We added these two codes to Addendum DD1 (which is available via the internet on the CMS website).

In the CY 2025 OPPS/ASC final rule with comment period, we finalized the modification of the descriptor of ASC payment indicator ‘‘L6’’ to ‘‘Special payment; New Technology Intraocular Lens (NTIOL) or qualifying non-opioid devices’’, to account for non-opioid devices paid for under the ASC payment system pursuant to section 4135 of the CAA, 2023 (89 FR 94317). We added this code to Addendum DD1 (which is available via the internet on the CMS website).

In the CY 2026 OPPS/ASC final rule with comment period, we finalized the addition of one payment indicator, “S2”—“Skin substitute supply group; paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate” to describe skin substitute products paid separately in an ASC (90 FR 53843). We added this code to Addendum DD1 (which is available via the internet on the CMS website).

b. Final ASC Payment and Comment Indicators for CY 2027

For CY 2027, we proposed new and revised Category I and III CPT codes as well as new and revised Level II HCPCS codes. Proposed Category I and III CPT codes that are new and revised for CY 2027 and any new and existing Level II HCPCS codes with substantial revisions to the code descriptors for CY 2027, compared to the CY 2026 descriptors, are included in ASC Addenda AA and BB to this final rule with comment period and labeled with comment indicator ‘‘NP’’ to indicate that these CPT and Level II HCPCS codes were open for comment as part of the CY 2027 OPPS/ASC proposed rule.

We did not receive public comments on this provision, and therefore, we are finalizing as

proposed.

We refer readers to Addenda DD1 and DD2 of this final rule with comment period (which are available via the internet on the CMS website) for the complete list of ASC payment and comment indicators finalized for the CY 2027 update. Addenda DD1 and DD2 to this final rule with comment period (which are available via the internet on the CMS website) contain the complete list of ASC payment and comment indicators for CY 2027.

C. Payment Policies Under the ASC Payment System

1. Final ASC Payment for Covered Surgical Procedures

a. Background

Our ASC payment policies for covered surgical procedures under the revised ASC payment system are described in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66828 through 66831). Under our established policy, we use the ASC standard ratesetting methodology of multiplying the ASC relative payment weight for the procedure by the ASC conversion factor for that same year to calculate the national unadjusted payment rates for procedures with payment indicators "G2" and "A2." Payment indicator "A2" was developed to identify procedures that were included on the list of ASC covered surgical procedures in CY 2007 and, therefore, were subject to transitional payment prior to CY 2011. Although the 4-year transitional period has ended and payment indicator "A2" is no longer required to identify surgical procedures subject to transitional payment, we have retained payment indicator "A2" because it is used to identify procedures that are exempted from the application of the office-based designation.

As required under § 416.171(d), payment rates for office-based procedures (payment indicators "P2," "P3," and "R2") are the lower of the amount calculated based on PFS nonfacility Practice Expense (PE) Relative Value Units (RVUs) or the amount calculated using the ASC standard rate setting methodology for the procedure. As detailed in section XIII.C.3.b. of this final rule with comment period, we update the payment amounts for office-based

procedures (payment indicators "P2," "P3", and "R2") using the most recent available PFS and OPPS data. We compare the estimated current year rate for each of the office-based procedures, calculated according to the ASC standard rate setting methodology, to the PFS nonfacility PE RVU-based amount to determine which is lower and, therefore, would be the current year payment rate for the procedure under our final policy for the revised ASC payment system.

The rate calculation established for device-intensive procedures (payment indicator "J8") is structured so only the service (non-device) portion of the rate is subject to the ASC conversion factor. We update the payment rates for device-intensive procedures to include the most recent device offset percentages calculated under the ASC standard ratesetting methodology, as discussed in section XIII.C.4. of this final rule with comment period.

In the CY 2014 OPPS/ASC final rule with comment period (78 FR 75081), we finalized our proposal to calculate the CY 2014 payment rates for ASC covered surgical procedures according to our established methodologies, with the exception of device removal procedures. For CY 2014, we finalized a policy to conditionally package payment for device removal procedures under the OPPS. Under the OPPS, a conditionally packaged procedure (status indicators "Q1" and "Q2") describes a HCPCS code where the payment is packaged when it is provided with a significant procedure but is separately paid when the service appears on the claim without a significant procedure. Because ASC services always include a covered surgical procedure, HCPCS codes that are conditionally packaged under the OPPS are generally packaged (payment indicator "N1") under the ASC payment system. Under the OPPS, device removal procedures are conditionally packaged and, therefore, would be packaged under the ASC payment system. There is no Medicare payment made when a device removal procedure is performed in an ASC without another surgical procedure included on the claim; therefore, no Medicare payment would be made if a device was removed but not replaced. To ensure that the ASC payment system provides separate payment for surgical procedures that only involve device removal – conditionally packaged in the OPPS (status indicator "Q2") – we have continued to

provide separate payment since CY 2014 and assign the current ASC payment indicators associated with these procedures.

b. Update to ASC Covered Surgical Procedure Payment Rates for CY 2027

We proposed to update ASC payment rates for CY 2027 and subsequent years using the established rate calculation methodologies under § 416.171 and using our definition of device-intensive procedures, as discussed in section XIII.C.4. of this final rule with comment period. As the proposed OPPS relative payment weights are generally based on geometric mean costs, we proposed that the ASC payment system will generally use the geometric mean cost to determine proposed relative payment weights under the ASC standard methodology. We proposed to continue to use the amount calculated under the ASC standard ratesetting methodology for procedures assigned payment indicators "A2" and "G2".

We proposed to calculate payment rates for office-based procedures (payment indicators "P2", "P3", and "R2") and device-intensive procedures (payment indicator "J8") according to our established policies and to identify device-intensive procedures using the methodology discussed in section XIII.C.4. of this final rule with comment period. Therefore, we proposed to update the payment amount for the service portion (the non-device portion) of the device-intensive procedures using the standard ASC ratesetting methodology and the payment amount for the device portion based on the proposed CY 2027 device offset percentages that have been calculated using the standard OPPS APC ratesetting methodology. We proposed that payment for office-based procedures would be at the lesser of the proposed CY 2027 PFS nonfacility PE RVU-based amount or the proposed CY 2027 ASC payment amount calculated according to the ASC standard ratesetting methodology.

As we did for CYs 2014 through 2026, for CY 2027, we proposed to continue our policy for device removal procedures, such that device removal procedures that are conditionally packaged in the OPPS (status indicators "Q1" and "Q2") will be assigned the current ASC

payment indicators associated with those procedures and will continue to be paid separately under the ASC payment system.

We did not receive public comments on our ratesetting methodology to continue to use the amount calculated under the ASC standard ratesetting methodology for procedures assigned payment indicators "A2" and "G2". We did not receive public comments on our ratesetting methodology to update the payment amount for the service portion (the non-device portion) of the device-intensive procedures using the standard ASC ratesetting methodology and the payment amount for the device portion based on the proposed CY 2027 device offset percentages that have been calculated using the standard OPPS APC ratesetting methodology and therefore, we are finalizing as proposed.

We did not receive public comments on our ratesetting methodology that payment for office-based procedures would be at the lesser of the proposed CY 2027 PFS nonfacility PE RVU-based amount or the proposed CY 2027 ASC payment amount calculated according to the ASC standard ratesetting methodology, and therefore, we are finalizing as proposed.

We did not receive public comments on our policy for device removal procedures, such that device removal procedures that are conditionally packaged in the OPPS (status indicators "Q1" and "Q2") will be assigned the current ASC payment indicators associated with those procedures and will continue to be paid separately under the ASC payment system, and therefore, we are finalizing as proposed.

c. Final Payment for ASC Add-On Procedures Eligible for Complexity Adjustments under the OPPS

In this section, we discuss the policy to provide increased payment under the ASC payment system for combinations of certain "J1" service codes and add-on procedure codes that are eligible for a complexity adjustment under the OPPS.

(1) OPPS C-APC Complexity Adjustment Policy

Under the OPPS, complexity adjustments are utilized to provide increased payment for certain comprehensive services. As discussed in section II.A.2.b. of this final rule with comment period, we apply a complexity adjustment by promoting qualifying paired "J1" service code combinations or paired code combinations of "J1" services and add-on codes from the originating Comprehensive APC (C-APC) (the C-APC to which the designated primary service is first assigned) to the next higher paying C-APC in the same clinical family of C-APCs. A "J1" status indicator refers to a hospital outpatient service paid through a C-APC. We package payment for all add-on codes, which are codes that describe a procedure or service always performed in addition to a primary service or procedure, into the payment for the C-APC. However, certain combinations of primary service codes and add-on codes may qualify for a complexity adjustment.

We apply complexity adjustments when the paired code combination represents a complex, costly form or version of the primary service when the frequency and cost thresholds are met. The frequency threshold is met when there are 25 or more claims reporting the code combination, and the cost threshold is met when there is a violation of the 2 times rule, as specified in section 1833(t)(2) of the Act and described in section III.A.2.b. of this final rule with comment period, in the originating C-APC. These paired code combinations that meet the frequency and cost threshold criteria represent those that exhibit materially greater resource requirements than the primary service. After designating a single primary service for a claim, we evaluate that service in combination with each of the other procedure codes reported on the claim that are either assigned to status indicator "J1" or add-on codes to determine if there are paired code combinations that meet the complexity adjustment criteria. Once we have determined that a particular combination of "J1" services, or combinations of a "J1" service and add-on code, represents a complex version of the primary service because it is sufficiently costly, frequent, and a subset of the primary comprehensive service overall according to the criteria described previously, we promote the claim to the next higher cost C-APC within the clinical family unless

the primary service is already assigned to the highest cost APC within the C-APC clinical family or assigned to the only C-APC in a clinical family. We do not create new C-APCs with a comprehensive geometric mean cost that is higher than the highest geometric mean cost (or only) C-APC in a clinical family just to accommodate potential complexity adjustments. Therefore, the highest payment for any claim including a code combination for services assigned to a C-APC would be the highest paying C-APC in the clinical family.

As previously stated, we package payment for add-on codes into the C-APC payment rate. If any add-on code reported in conjunction with the "J1" primary service code does not qualify for a complexity adjustment, payment for the add-on service continues to be packaged into the payment for the primary service and the primary service code reported with the add-on code is not reassigned to the next higher cost C-APC. We list the final complexity adjustments for "J1" and add-on code combinations for CY 2027, along with all other proposed complexity adjustments, in Addendum J to this final rule with comment period (which is available via the Internet on the CMS website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices*).

(2) CY 2027 ASC Special Payment Policy for OPPS Complexity-Adjusted C-APCs

For CY 2027, we proposed to continue the special payment policy and methodology for OPPS complexity-adjusted C-APCs that was finalized in the CY 2023 OPPS/ASC final rule with comment period (87 FR 72078 through 72080). We also proposed to make a minor change to the long descriptor of ASC complexity adjustment code C7570.

For those ASC complexity adjustment codes for which we have claims data, we proposed to use the claims data to calculate the code combination utilization and estimated payments for the ASC payment system budget neutrality calculations for CY 2027. Any ASC complexity adjustment budget neutrality calculations are discussed further in section XIII.H.2.a. of this final rule with comment period. The full list of the proposed ASC complexity adjustment codes, inactive ASC complexity adjustment codes, their short descriptors, long descriptors, and

proposed ASC payment indicators for CY 2027 can be found in the CY 2027 proposed ASC CPX supplemental policy file, which also includes both the existing ASC complexity adjustment codes and proposed additions. The CY 2027 OPPS/ASC proposed rule ASC Addendum AA also includes our proposed active ASC complexity adjustment codes and their ASC payment rates. Both files are published on the CMS website at *https://www.cms.gov/medicare/medicare-fee-for-service-payment/ascpayment/asc-regulations-and-notices*. Since the complexity adjustment assignments change each year under the OPPS, the proposed list of ASC complexity adjustment codes eligible for the proposed payment policy changed slightly from the previous year. Additionally, since complexity adjustment assignments may change between the proposed rule and final rule under the OPPS, the final list of ASC complexity adjustment codes eligible for this payment policy may be slightly different than the proposed list of ASC complexity adjustment codes.

We did not receive public comments on this provision, and therefore, we are finalizing the ASC special payment policy for OPPS complexity-adjusted C-APCs as proposed. Based on our review of the final CY 2027 Addendum J OPPS complexity adjustment combinations, certain add-on codes would not be reported in conjunction with the "J1" primary service code as the add-on code is identified as a Type 1 add-on code and the "J1" primary service code would not satisfy the add-on code edit. These combinations appeared as a result of a predecessor "J1" service code mapping to both a successor "J1" service code and successor add-on code and the Type 1 add-on code's primary service code was not a "J1" service but rather a packaged procedure. Since these code combinations could not otherwise be reported together, we are not creating ASC complexity adjustment codes for such code combinations. The final ASC complexity adjustment codes, based on the most recent data available for this final rule with comment period, can be found on the CMS website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgicalcenter-asc/annual-policy-files*. Existing ASC complexity adjustment codes that do not

meet our criteria for separate payment for CY 2027 because the code combination is not eligible for a complexity adjustment under the OPPS for CY 2027 will be non-payable and assigned a status indicator of ‘‘B5’’—‘‘Alternative code may be available; no payment made’’— for CY 2027. Additionally, proposed ASC complexity adjustment codes that met our criteria based on data available for the CY 2027 OPPS/ASC proposed rule but do not meet our criteria based on claims data available for this final rule with comment period have not been finalized.

d. Final Low Volume APCs and Limit on ASC Payment Rates for Procedures Assigned to Low Volume APCs

As stated in section XIII.D.1.b. of this final rule with comment period, the ASC payment system generally uses OPPS geometric mean costs under the standard methodology to determine proposed relative payment weights under the standard ASC ratesetting methodology.

In the CY 2022 OPPS/ASC final rule with comment period (86 FR 63743 through 63747), we adopted a universal Low Volume APC policy for CY 2022. Under our policy, we expanded the low volume adjustment policy that is applied to procedures assigned to New Technology APCs to also apply to clinical and brachytherapy APCs. Specifically, a clinical APC or brachytherapy APC with fewer than 100 claims per year would be designated as a Low Volume APC. For items or services assigned to a Low Volume APC, we use up to 4 years of claims data to establish a payment rate for the APC as we currently do for low volume services assigned to New Technology APCs. The payment rate for a Low Volume APC or a low volume New Technology procedure would be based on the highest of the median cost, arithmetic mean cost, or geometric mean cost calculated using multiple years of claims data.

Based on claims data available for the CY 2027 OPPS/ASC proposed rule, we proposed to designate five brachytherapy APCs and four clinical APCs as Low Volume APCs under the ASC payment system. The four clinical APCs and five brachytherapy APCs met our criteria of having fewer than 100 single claims in the relevant claims year (CY 2025 for the CY 2027 OPPS/ASC proposed rule) and therefore, we proposed that they would be subject to our

universal Low Volume APC policy and the APC cost metric would be based on the greater of the median cost, arithmetic mean cost, or geometric mean cost using up to 4 years of claims data. Eight of the nine APCs were designated as Low Volume APCs in CY 2026. Based on data for the CY 2027 OPPS/ASC proposed rule, APC 2645 (Brachytx, non-stranded, gold-198) had 87 single claims and met our criteria to be designated as a Low Volume APC.

Comment: Commenters supported our continued use of the Low Volume APC policy.

Response: We thank commenters for their support and are finalizing our methodology for determining Low Volume APCs as proposed. Based on claims data available for this final rule with comment period, we are finalizing our proposal to designate five brachytherapy APCs and four clinical APCs as Low Volume APCs under the ASC payment system. The four clinical APCs and five brachytherapy APCs met our criteria of having fewer than 100 single claims in the relevant claims year (CY 2025 for this CY 2027 OPPS/ASC final rule with comment period) and therefore, we are finalizing our proposal that they would be subject to our universal Low Volume APC policy and the APC cost metric would be based on the greater of the median cost, arithmetic mean cost, or geometric mean cost using up to 4 years of claims data. Eight of the nine APCs were designated as Low Volume APCs in CY 2026. Based on data for this final rule with comment period, APC 2645 (Brachytx, non-stranded, gold-198) had 92 single claims and we are finalizing our proposal to designate APC 2645 as a Low Volume APC.

Table 92 includes the CY 2025 claims available for ratesetting for each of the APCs we are finalizing to be designated as a Low Volume APC for CY 2027. The cost statistics for our Low Volume APCs, such as the median, arithmetic mean, and geometric mean costs, are available for download with this final rule with comment period on the CMS website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/ascregulations-and-notices*; click on the relevant regulation to download the Low Volume APC cost statistics under the standard (ASC) ratesetting methodology in the ‘‘Downloads’’ section of the web page.

TABLE 92: LOW VOLUME APCS USING STANDARD (ASC) RATESETTING METHODOLOGY FOR CY 2027

APC	APC Description	CY 2025 Claims Available for Ratesetting
2635	Brachytx, non-str, HA, P-103	29
2642	Brachytx, stranded, C-131	43
2643	Brachytx, non-stranded,c-131	80
2645	Brachytx, non-str, gold-198	92
2647	Brachytx, NS, Non-HDRIr-192	14
5244	Level 4 Blood Product Exchanges and Related Services	2
5494	Level 4 Intraocular Procedures	5
5495	Level 5 Intraocular Procedures	72
5496	Level 6 Intraocular Procedures	10

2. Final Payment for Covered Ancillary Services

a. Background

Our payment policies under the ASC payment system for covered ancillary services generally vary according to the particular type of service and its payment policy under the OPPS. Our overall policy provides separate ASC payment for certain ancillary items and services integrally related to the provision of ASC covered surgical procedures that are paid separately under the OPPS and provides packaged ASC payment for other ancillary items and services that are packaged or conditionally packaged (status indicators "N," "Q1," and "Q2") under the OPPS.

In the CY 2013 OPPS/ASC proposed rule and final rule with comment period (77 FR 45169 and 77 FR 68457 through 68458), we further clarified our policy regarding the payment indicator assignment for procedures that are conditionally packaged in the OPPS (status indicators "Q1" and "Q2"). Under the OPPS, a conditionally packaged procedure describes a HCPCS code where the payment is packaged when it is provided with a significant procedure but is separately paid when the service appears on the claim without a significant procedure. Because ASC services always include a surgical procedure, HCPCS codes that are conditionally packaged under the OPPS are generally packaged (payment indicator "N1") under the ASC payment system (except for device removal procedures, as discussed in the CY 2022 OPPS/ASC proposed rule (86 FR 42083)). Thus, our policy generally aligns ASC payment bundles with

those under the OPPS (72 FR 42495). In all cases, for ancillary items and services also to be paid, the ancillary items and services must be provided integral to the performance of ASC covered surgical procedures for which the ASC bills Medicare.

Our ASC payment policies generally provide separate payment for drugs and biologicals that are separately paid under the OPPS at the OPPS rates and package payment for drugs and biologicals for which payment is packaged under the OPPS. However, as discussed in the CY 2022 OPPS/ASC final rule with comment period, for CY 2022, we finalized a policy to unpackage and pay separately at ASP plus 6 percent for the cost of non-opioid pain management drugs and biologicals that function as a supply when used in a surgical procedure as determined by CMS under § 416.174 (86 FR 63483).

We generally pay for separately payable radiology services at the lower of the PFS nonfacility PE RVU-based (or technical component) amount or the rate calculated according to the ASC standard ratesetting methodology (72 FR 42497). However, as finalized in the CY 2011 OPPS/ASC final rule with comment period (75 FR 72050), payment indicators for all nuclear medicine procedures (defined as CPT codes in the range of 78000 through 78999) that are designated as radiology services that are paid separately when provided integral to a surgical procedure on the ASC list are set to "Z2" so that payment is made based on the ASC standard ratesetting methodology rather than the PFS nonfacility PE RVU amount ("Z3"), regardless of which is lower (§ 416.171(d)(1)).

Similarly, we also finalized our policy to set the payment indicator to "Z2" for radiology services that use contrast agents so that payment for these procedures will be based on the OPPS relative payment weight using the ASC standard ratesetting methodology and, therefore, will include the cost for the contrast agent (§ 416.171(d)(2)).

ASC payment policy for brachytherapy sources mirrors the payment policy under the OPPS. ASCs are paid for brachytherapy sources provided integral to ASC covered surgical procedures at prospective rates adopted under the OPPS or, if OPPS rates are unavailable, at

contractor-priced rates (72 FR 42499). Since December 31, 2009, ASCs have been paid for brachytherapy sources provided integral to ASC covered surgical procedures at prospective rates adopted under the OPPS.

Our ASC policies also provide separate payment for: (1) certain items and services that CMS designates as contractor-priced, including, but not limited to, the procurement of corneal tissue; and (2) certain implantable items that have pass-through payment status under the OPPS. These categories do not have prospectively established ASC payment rates according to ASC payment system policies (72 FR 42502 and 42508 through 42509; § 416.164(b)). Under the ASC payment system, we have designated corneal tissue acquisition and hepatitis B vaccines as contractor-priced. Corneal tissue acquisition is contractor-priced based on the invoice costs for acquiring the corneal tissue for transplantation. Hepatitis B vaccines are contractor-priced based on invoiced costs for the vaccine.

Devices that are eligible for pass-through payment under the OPPS are separately paid under the ASC payment system and are contractor-priced. Under the revised ASC payment system (72 FR 42502), payment for the surgical procedure associated with the pass-through device is made according to our standard methodology for the ASC payment system, based on only the service (non-device) portion of the procedure's OPPS relative payment weight if the APC weight for the procedure includes other packaged device costs. We also refer to this methodology as applying a "device offset" to the ASC payment for the associated surgical procedure. This ensures that duplicate payment is not provided for any portion of an implanted device with OPPS pass-through payment status.

In the CY 2015 OPPS/ASC final rule with comment period (79 FR 66933 through 66934), we finalized that, beginning in CY 2015, certain diagnostic tests within the medicine range of CPT codes for which separate payment is allowed under the OPPS are covered ancillary services when they are integral to an ASC covered surgical procedure. We finalized that diagnostic tests within the medicine range of CPT codes include all Category I CPT codes in the

medicine range established by CPT, from 90000 to 99999, and Category III CPT codes and Level II HCPCS codes that describe diagnostic tests that crosswalk or are clinically similar to procedures in the medicine range established by CPT. In the CY 2015 OPPS/ASC final rule with comment period, we also finalized our policy to pay for these tests at the lower of the PFS nonfacility PE RVU-based (or technical component) amount or the rate calculated according to the ASC standard ratesetting methodology (79 FR 66933 through 66934). We finalized that the diagnostic tests for which the payment is based on the ASC standard ratesetting methodology be assigned to payment indicator "Z2" and revised the definition of payment indicator "Z2" to include a reference to diagnostic services and those for which the payment is based on the PFS nonfacility PE RVU-based amount be assigned payment indicator "Z3", and revised the definition of payment indicator "Z3" to include a reference to diagnostic services.

In the CY 2026 OPPS/ASC final rule with comment period (90 FR 53887 through 53888), we finalized our policy to unpackage and pay separately for certain skin substitute supplies when provided integral to a covered surgical procedure under the ASC payment system in conjunction with our policy to unpackage and pay separately for the same such items under the OPPS. We finalized the addition of a new ASC payment indicator "S2" – "Skin substitute supply group; paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate" to indicate a separately payable ancillary skin substitute supply when provided integral to a separately payable ASC covered surgical procedure. We finalized that payment for separately payable skin substitute supplies under the ASC payment system would be made at the same rate as is provided under the OPPS.

b. Final Payment for Covered Ancillary Items and Services for CY 2027

We proposed to update the ASC payment rates and to make changes to ASC payment indicators, as necessary, to maintain consistency between the OPPS and ASC payment system regarding the packaged or separately payable status of services and the proposed CY 2027 OPPS and ASC payment rates and subsequent years' payment rates. We proposed to continue to set the

proposed CY 2027 ASC payment rates and subsequent years' payment rates for brachytherapy sources and separately payable drugs, biologicals, and skin substitute supplies equal to the OPPS payment rates for CY 2027 and subsequent years' payment rates.

We did not receive public comments on this provision, and therefore, we are finalizing our proposal to update the ASC payment rates and to make changes to ASC payment indicators, as necessary, to maintain consistency between OPPS and ASC payment systems regarding the packaged or separately payable status of services and the final CY 2027 OPPS and ASC payment rates and subsequent years' payment rates. We are also finalizing our proposal without modification to continue to set the CY 2027 ASC payment rates for brachytherapy sources and separately payable drugs and biologicals equal to the OPPS payment rates for CY 2027 and subsequent years.

Covered ancillary services and their final payment indicators for CY 2027 are listed in Addendum BB of this final rule with comment period (which is available via the internet on the CMS website). For those covered ancillary services where the payment rate is the lower of the rate under the ASC standard rate setting methodology and the PFS proposed rates (similar to our office-based payment policy), the final payment indicators and rates set forth in this final rule with comment period are based on a comparison using the final PFS rates effective January 1, 2027. For a discussion of the PFS rates, we refer readers to the CY 2027 PFS final rule with comment period which is available on the CMS website at *https://www.cms.gov/medicare/payment/feeschedules/*.

3. Covered Surgical Procedures Designated as Office-Based Procedures

a. Background

In the August 2, 2007 ASC final rule, we finalized our policy to designate as "office-based" those procedures that are added to the ASC Covered Procedures List (CPL) in CY 2008 or later years that we determine are furnished predominantly (more than 50 percent of the time) in physicians' offices based on consideration of the most recently available volume and

utilization data for each individual procedure code and/or, if appropriate, the clinical characteristics, utilization, and volume of related codes. In that final rule, we also finalized our policy to exempt all procedures on the CY 2007 ASC list from application of the office-based classification (72 FR 42512). The procedures that were added to the ASC CPL beginning in CY 2008 that we determined were office-based were identified in Addendum AA to that final rule with payment indicator "P2" (Office-based surgical procedure added to ASC list in CY 2008 or later with PFS nonfacility PE RVUs; payment based on OPPS relative payment weight); "P3" (Office-based surgical procedures added to ASC list in CY 2008 or later with PFS nonfacility PE RVUs; payment based on PFS nonfacility PE RVUs); or "R2" (Office-based surgical procedure added to ASC list in CY 2008 or later without PFS nonfacility PE RVUs; payment based on OPPS relative payment weight), depending on whether we estimated the procedure would be paid according to the ASC standard ratesetting methodology based on its OPPS relative payment weight or at the PFS nonfacility PE RVU-based amount.

Consistent with our final policy to annually review and update the ASC CPL to include all covered surgical procedures eligible for payment in ASCs, each year we identify covered surgical procedures as either temporarily office-based (these are new procedure codes with little or no utilization data that we have determined are clinically similar to other procedures that are permanently office-based), permanently office-based, or nonoffice-based, after taking into account updated volume and utilization data.

b. CY 2027 Final Office-Based Procedures

In developing the CY 2027 OPPS/ASC proposed rule, we followed our policy to annually review and update the covered surgical procedures for which ASC payment is made and to identify new procedures that may be appropriate for ASC payment, including their potential designation as office-based. Historically, we also review the most recent claims volume and utilization data (CY 2025 claims) and the clinical characteristics for all covered surgical procedures that are currently assigned a payment indicator in CY 2026 of "G2" (Non office-

based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight) as well as for those procedures assigned one of the temporary office-based payment indicators, specifically “P2,” “P3”, or “R2” in the CY 2026 OPPS/ASC final rule with comment period (89 FR 94322 through 94326).

Our review of the CY 2025 volume and utilization data of covered surgical procedures currently assigned a payment indicator of “G2” (Non office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight) resulted in the identification of two surgical procedures – CPT code 0102T (Extracorporeal shock wave performed by a physician, requiring anesthesia other than local, and involving the lateral humeral epicondyle) and 60660 (Ablation of 1 or more thyroid nodule(s), one lobe or the isthmus, percutaneous, including imaging guidance, radiofrequency) – that we believe meet the criteria for designation as permanently office-based. The data indicate that these procedures are performed more than 50 percent of the time in physicians' offices, and the services are of a level of complexity consistent with other procedures performed routinely in physicians' offices.

We did not receive any public comments on our proposed permanent office-based designations and, therefore, are finalizing our proposal to permanently designate CPT codes 0102T and 60660 as office-based procedures beginning in CY 2027 as shown in Table 93.

We did not receive any public comments on our proposed permanent office-based designations and, therefore, are finalizing our proposal to no longer designate CPT code 53866 as a temporary office-based surgical procedure beginning in CY 2027 as shown in Table 94.

TABLE 93: ASC COVERED SURGICAL PROCEDURES TO BE NEWLY DESIGNATED AS PERMANENTLY OFFICE-BASED FOR CY 2027

CPT/HCPCS Code	Long Descriptor	Final CY 2026 ASC Payment Indicator	Final CY 2027 ASC Payment Indicator*
0102T	Extracorporeal shock wave performed by a physician, requiring anesthesia other than local, and involving the lateral humeral epicondyle	G2	P2*

60660	Ablation of 1 or more thyroid nodule(s), one lobe or the isthmus, percutaneous, including imaging guidance, radiofrequency	G2	P2*

* Payment indicators were based on a comparison of the proposed rates according to the ASC standard ratesetting methodology and the CY 2027 PFS final rates.

As discussed in the August 2, 2007 ASC final rule (72 FR 42533 through 42535), we finalized our policy to designate certain new surgical procedures as temporarily office-based until adequate claims data are available to assess their predominant sites of service, whereupon if we confirm their office-based nature, the procedures are permanently assigned to the list of office-based procedures. In the absence of claims data, we use other available information, including our clinical advisors' judgment, predecessor CPT and Level II HCPCS codes, information submitted by representatives of specialty societies and professional associations, and information submitted by commenters during the public comment period.

In Table 130 of the CY 2026 OPPS/ASC final rule with comment period, we finalized assigning temporary office-based designations to four surgical procedures for CY 2026 (90 FR 53850). We reviewed CY 2025 volume and utilization data for the four surgical procedures designated as temporarily office-based in the CY 2026 OPPS/ASC final rule with comment period. As shown in Table 94, for one of the four surgical procedures – CPT code 53866 (Catheterization with removal of temporary device for ischemic remodeling (ie, pressure necrosis) of bladder neck and prostate) – there are greater than 50 claims available and the volume and utilization indicated this procedure was not performed predominantly in the office setting based on CY 2025 claims data. Therefore, we proposed to no longer designate this procedure as temporarily office-based and to designate this procedure a payment indicator of "G2" - "'Non office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight." for CY 2027.

TABLE 94: ASC COVERED SURGICAL PROCEDURES TO BE NO LONGER DESIGNATED AS TEMPORARILY OFFICE-BASED FOR CY 2027

CPT/HCPCS Code	Long Descriptor	Final CY 2026 ASC Payment Indicator	Final CY 2027 ASC Payment Indicator
53866	Catheterization with removal of temporary device for ischemic remodeling (ie, pressure necrosis) of bladder neck and prostate	R2	G2

For the remaining three procedures that were designated as temporarily office-based in the CY 2026 OPPS/ASC final rule with comment period and temporarily assigned one of the office-based payment indicators, specifically "P2", "P3", or "R2," there were fewer than 50 claims; therefore, there was an insufficient number of claims to determine if the office setting was the predominant setting of care for these procedures. Therefore, as shown in Table 70 of the CY 2027 OPPS/ASC proposed rule, we proposed to continue to designate such procedures as temporarily office-based for CY 2027 and assign one of the office-based payment indicators. Additionally, for CY 2027, we did not propose to designate any new CY 2027 CPT codes for ASC covered surgical procedures as temporarily office-based.

We did not receive public comments on this provision, and therefore, we are finalizing our proposed temporary office-based designation to the procedures shown in Table 95. The procedures for which the final office-based designation for CY 2027 is temporary are also indicated by an asterisk in Addendum AA to this final rule with comment period (which is available via the internet on the CMS website at *https://www.cms.gov/Medicare/Medicare-Feefor-Service-Payment/ASCPayment/ASCRegulations-and-Notices)*.

TABLE 95: CY 2027 PAYMENT INDICATORS FOR NEW AND EXISTING ASC COVERED SURGICAL PROCEDURES TO BE DESIGNATED AS TEMPORARILY OFFICE-BASED

CPT/HCPCS Code	Long Descriptor	Final CY 2026 ASC Payment Indicator	Final CY 2027 ASC Payment Indicator*
0588T	Revision or removal of integrated single device neurostimulation system including electrode array and receiver or pulse generator, including analysis, programming, and imaging guidance when performed, posterior tibial nerve	R2	R2*
64598	Revision or removal of neurostimulator electrode array, peripheral nerve, with integrated neurostimulator	R2	R2*
67229	Treatment of extensive or progressive retinopathy, 1 or more sessions, preterm infant (less than 37 weeks gestation at birth), performed from birth up to 1 year of age (e.g., retinopathy of prematurity), photocoagulation or cryotherapy	R2	R2*

* Payment indicators were based on a comparison of the proposed rates according to the ASC standard ratesetting methodology and the CY 2027 PFS final rates.

4. Device-Intensive ASC Covered Surgical Procedures

a. Background

We refer readers to the CY 2019 OPPS/ASC final rule with comment period (83 FR 59040 through 59041), for a summary of our existing policies regarding ASC covered surgical procedures that are designated as device-intensive.

In the CY 2019 OPPS/ASC final rule with comment period (83 FR 59040 through 59043), we modified our criteria for device-intensive procedures to better capture costs for procedures with significant device costs. We adopted a policy to allow procedures that involve surgically inserted or implanted, high-cost, single-use devices to qualify as device-intensive procedures. In addition, we modified our criteria to lower the device offset percentage threshold from 40 percent to 30 percent. The device offset percentage is the percentage of device costs within a procedure's total costs. Specifically, for CY 2019 and subsequent years, we adopted a policy that device-intensive procedures would be subject to the following criteria:

- All procedures must involve implantable or insertable devices assigned a CPT or HCPCS code;
- The required devices (including single-use devices) must be surgically inserted or implanted; and
- The device offset amount must be significant, which is defined as exceeding 30 percent of the procedure's mean cost. Corresponding to this change in the cost criterion, we adopted a policy that the default device offset for new codes that describe procedures that involve the implantation of medical devices will be 31 percent beginning in CY 2019. For new codes describing procedures that are payable when furnished in an ASC and involve the implantation of a medical device, we adopted a policy that the default device offset would be applied in the same manner as the policy we adopted in section IV.B.2. of the CY 2019 OPPS/ASC final rule with comment period (83 FR 58944 through 58948). We amended § 416.171(b)(2) of the regulations to reflect these new device criteria.

In addition, as also adopted in section IV.B.2. of the CY 2019 OPPS/ASC final rule with comment period, to further align the device-intensive policy with the criteria used for device pass-through status, we specified, for CY 2019 and subsequent years, that for purposes of satisfying the device-intensive criteria, a device-intensive procedure must involve a device that:

- Has received FDA marketing authorization, has received an FDA IDE and has been classified as a Category B device by FDA in accordance with 42 CFR 405.203 through 405.207 and 405.211 through 405.215, or meets another appropriate FDA exemption from premarket review;
- Is an integral part of the service furnished;
- Is used for one patient only;
- Comes in contact with human tissue;
- Is surgically implanted or inserted (either permanently or temporarily); and
- Is not any of the following:

++ Equipment, an instrument, apparatus, implement, or item of this type for which depreciation and financing expenses are recovered as depreciable assets as defined in Chapter 1 of the Medicare Provider Reimbursement Manual (CMS Pub. 15-1); or

++ A material or supply furnished incident to a service (for example, a suture, customized surgical kit, scalpel, or clip, other than a radiological site marker).

In the CY 2022 OPPS/ASC final rule with comment period (86 FR 63773 through 63775), we modified our approach to assigning device-intensive status to surgical procedures under the ASC payment system. First, we adopted a policy of assigning device-intensive status to procedures that involve surgically inserted or implanted, high-cost, single-use devices if their device offset percentage exceeds 30 percent under the ASC standard ratesetting methodology, even if the procedure is not designated as device-intensive under the OPPS. Second, we adopted a policy that if a procedure is assigned device-intensive status under the OPPS, but has a device offset percentage below the device-intensive threshold under the standard ASC ratesetting methodology, the procedure will be assigned device-intensive status under the ASC payment system with a default device offset percentage of 31 percent. The policies were adopted to provide consistency between the OPPS and ASC payment system and provide a more appropriate payment rate for surgical procedures with significant device costs under the ASC payment system.

In the CY 2023 OPPS/ASC final rule with comment period (87 FR 72078 through 72080), we finalized our policy to create certain C-codes, or ASC complexity adjustment codes that describe certain combinations of a primary covered surgical procedure as well as a packaged (payment indicator = "N1") procedure that are otherwise eligible for a complexity adjustment under the OPPS (as listed in Addendum J). Each ASC complexity adjustment code's APC assignment is based on its corresponding OPPS complexity adjustment code's APC assignment. In the CY 2023 OPPS/ASC final rule with comment period, we stated our belief that it would be appropriate for these ASC complexity adjustment codes to qualify for device-intensive status

under the ASC payment system if the primary procedure of the code was also designated as device-intensive. Under our current policy, the ASC complexity adjustment code retains the device portion of the primary procedure (also called the "device offset amount") and not the device offset percentage. Therefore, for device-intensive ASC complexity adjustment codes, we set the device portion of the combined procedure equal to the device portion of the primary procedure and calculate the device offset percentage by dividing the device portion by the ASC complexity adjustment code's APC payment rate. Further, we apply our standard ASC payment system ratesetting methodology to the non-device portion of the ASC complexity adjustment code's APC payment rate; that is, we multiply the OPPS relative weight by the ASC budget neutrality adjustment and the ASC conversion factor and sum that amount with the device portion to calculate the ASC payment rate.

In the CY 2025 OPPS/ASC final rule with comment period, we finalized a modification to our policy regarding default device offset percentages for new codes that meet our criteria for device-intensive status. Under both the OPPS and ASC payment system, for new device-intensive procedures that lack claims data, or lack claims data from a predecessor code or a clinically-similar code that uses the same device, we apply the greater of the APC-wide device offset percentage or 31 percent (the previous default device offset percentage). We believe that an APC-wide average device offset percentage is, in most cases, a better reflection of device costs when the typical device costs of procedures assigned to such APC are significantly greater than 31 percent. This policy does not apply to new device-intensive procedures assigned to New Technology APCs.

In the CY 2026 OPPS/ASC final rule with comment period, we discussed the implementation of the Final Remedy for the 340B-Acquired Drug Payment Policy for Calendar Years 2018-2022 rule and the impact of the OPPS conversion factor on the ASC payment system. Since most ASC payment rates for surgical procedures are constructed from OPPS relative weights or the PFS unadjusted nonfacility PE RVU-based amount, the remedy's

proposed prospective offset to the OPPS conversion has a very limited impact on the ASC payment system. The only impact of the proposed reduction to the OPPS conversion factor is the payment rate for device-intensive procedures under the ASC payment system. Since the ASC payment system holds device portions constant between the two settings, the device portion is the device offset percentage multiplied by the OPPS payment rate. As we stated in that rule, we believed it would be inaccurate and inappropriate to use OPPS payment rates that have been reduced by the remedy's prospective offset since this could accumulate to have a potentially noticeable impact on ASC payment rates for certain device-intensive procedures over time. Therefore, we finalized our policy that the OPPS payment rates used for ratesetting under the ASC payment system for CY 2026 and subsequent years would not include the prospective offset to the OPPS conversion factor as a result of the 340B remedy offset that we proposed to implement in the CY 2026 OPPS/ASC proposed rule.

As discussed in section XIII.G.2.a. of this final rule with comment period, historically, the device portions of device-intensive procedures have not been scaled so that payment for device portions would remain constant between the OPPS and ASC payment system. However, due to increased utilization of orthopedic procedures in the ASC setting, ASC expenditures on device portions of device-intensive procedures represent a substantially larger share of total ASC expenditures than in prior years. For this final rule with comment period, we estimate a proposed large increase in the device portions for device-intensive procedures as a result of the proposed 340B drug payment policy which results in a large decrease in the ASC weight scaler. We solicited comment on whether our device-intensive calculation methodology should continue to exclude device portions from the ASC weight scaler, or alternatively, whether these device portions should be included in the expenditures subject to scaling through the ASC weight scaler. If we were to include device portions as subject to scaling, ASC payment rates for device-intensive procedures would decrease and ASC payment rates for non-device intensive procedures would increase. We estimated that treating device expenditures for device-intensive

procedures as scalable prospective expenditures would increase the proposed ASC weight scaler from 0.809 to 0.865 in CY 2027 but would decrease the ASC payment for the device portion of device intensive procedures by approximately 14 percent.

We did not propose any changes to our device-intensive procedure policies under the ASC payment system for CY 2027, but we solicited comment on whether our device-intensive calculation methodology should continue to exclude device portions from the ASC weight scaler or whether device portions should represent scalable prospective expenditures. For the proposed CY 2027 device offset percentages, which included device offset percentages based on CY 2025 claims processed through March 31, 2026, we refer readers to Addendum FF of the CY 2027 OPPS/ASC proposed rule. Final CY 2027 device offset percentages may differ from the proposed percentages as we rely on the most recently available claims data for the CY 2027 OPPS/ASC final rule with comment period (CY 2025 claims data processed through June 30, 2026).

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: Several commenters supported continuing to exclude the device portion of device-intensive procedures from the ASC weight scalar. The commenters stated that implantable and insertable device acquisition costs generally do not vary by site of service and that applying the scaler to device costs would reduce the device portion by approximately 14 percent, potentially making complex procedures financially infeasible in ASCs. They stated that this could impede the migration of appropriate care from hospital outpatient departments to lower-cost ASCs. The commenters requested that CMS preserve OPPS–ASC payment parity for the device component and evaluate procedure-level access effects before adopting any alternative methodology.

Response: We appreciate the commenters' feedback regarding their support for continuing to exclude the device portion of device-intensive procedures from the ASC weight

scalar. As discussed in further detail in section XIII.G. of this final rule with comment period, we are finalizing our proposal to continue excluding the device portion of device-intensive procedures from the ASC weight scalar.

Comment: Several commenters requested that CMS designate CPT code 52282 (Cystourethroscopy, with insertion of permanent urethral stent) as device-intensive and establish its CY 2027 device offset using manufacturer invoice data. The commenters stated that the historical claims are not representative because no permanent prostatic urethral stent with FDA marketing authorization was commercially available in the United States for approximately a decade, making the claims that support the proposed zero percent device offset unreliable.

Response: As discussed in section III. of this final rule with comment period, we agree with the commenters that no permanent prostatic urethral stent with FDA marketing authorization had been available on the U.S. market for approximately 9 years before FDA approved such a device through the premarket approval application process in late 2025. Therefore, we believe that the CY 2025 claims data for CPT code 52282 do not accurately reflect the device and service costs associated with inserting a permanent prostatic urethral stent and are not an appropriate data source for calculating the device offset percentage for CPT code 52282. In the absence of representative CY 2025 claims data, we are accepting the commenters' recommendation to assign device-intensive status to CPT code 52282 for CY 2027. Although our policy permits temporarily assigning a higher device offset percentage in certain rare circumstances based on additional information, including manufacturer pricing data, we do not find that the information submitted warrants departing from our default device offset methodology for this procedure. We believe that applying the default methodology appropriately recognizes device costs while maintaining incentives for efficient purchasing. Therefore, we will apply our default device offset methodology to CPT code 52282 for CY 2027.

Comment: Several commenters opposed removing device-intensive status for CPT code

55882 (Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation; with insertion of transurethral ultrasound transducer for delivery of thermal ultrasound, including suprapubic tube placement and placement of an endorectal cooling device, when performed) for CY 2027 under the ASC payment system. The commenters stated that this procedure requires proprietary, single-use transurethral ultrasound and endorectal cooling devices that are integral to the service, contact human tissue, and are temporarily inserted into the patient. They stated that the proposed offset is distorted by incomplete device reporting, noting that the average invoice cost of $8,089 represents approximately 49 percent of the proposed $16,366 geometric mean cost. The commenters also reported that claims identifying C1889 produced offsets above the 30-percent threshold, whereas many hospitals reported little or no device cost. They requested a 49-percent device offset based on documented acquisition costs.

Response: CPT code 55882 became effective January 1, 2025. In reviewing these comments, we discovered that we had correctly assigned device-intensive status to this procedure under the ASC payment system but had inadvertently not assigned device-intensive status to this procedure under the OPPS. In general, a new CPT code that meets our criteria for device-intensive status and is separately payable in both the OPPS and ASC payment system should be designated as device-intensive under both the OPPS and the ASC payment system. (Once claims data is available, differences in the claims data available under the two systems' ratesetting methodologies may result in a procedure receiving device-intensive status under the ASC payment system but not under the OPPS.)

The incomplete reporting of devices associated with CPT code 55882 under the OPPS underscores the importance of our device edits policy for device-intensive procedures. In the absence of an applicable device edit that would have otherwise applied since we assigned CPT code 55882 as device-intensive for CY 2025, we do not believe it would be appropriate to selectively determine which claims to use to calculate the device offset percentage; instead, we

believe it is appropriate to rely on a full year of claims data during which CPT code 55882 is subject to the device edits policy. Therefore, because usable CY 2025 claims data are unavailable for CPT code 55882, we are accepting the commenter's recommendation to maintain device-intensive status for the code for CY 2027 and will apply our device edits and device credits policies to the procedure beginning in CY 2027 by assigning the procedure device-intensive status for both the ASC and OPPS settings. Although our policy permits temporarily assigning a higher device offset percentage in certain rare circumstances based on additional information, including manufacturer pricing data, we do not find that the information submitted warrants departing from our default device offset methodology for this procedure. We believe that applying the default methodology appropriately recognizes device costs while maintaining incentives for efficient purchasing. Therefore, we will apply our default device offset methodology to CPT code 55882 for CY 2027.

Comment: Several commenters requested that we designate CPT code 0786T (Insertion or replacement of percutaneous electrode array, sacral, with integrated neurostimulator, including imaging guidance, when performed) as device intensive for CY 2027. The commenters stated that the procedure requires implantation of a single-use integrated sacral neuromodulation system and that the manufacturer-reported device cost of $18,500 represents approximately 83.5 percent of the proposed APC payment. The commenters stated that the two claims apparently used were invalid or unrepresentative because the code had status indicator "E1" until the device received FDA approval in June 2025 and commercial use did not begin until after November 2025. They requested that we disregard those claims and apply the default offset for the APC, manufacturer invoice pricing, or another appropriate new technology methodology.

Response: We agree with the commenters that we should disregard CY 2025 claims for CPT code 0786T. As we stated previously, in the CY 2025 OPPS/ASC final rule with comment period (89 FR 94214 through 94219), for purposes of determining device offset percentages, we

will not use claims data from procedures that had a status indicator of ‘‘E1’’. Since CPT code 0786T was assigned a status indicator of “E1” for all of CY 2025, under our current policy, we will continue to assign CPT code 0786T device-intensive status for CY 2027 and will apply a device offset percentage based on our default device offset methodology.

Comment: Several commenters requested that we designate CPT code 0730T (Trabeculotomy by laser, including optical coherence tomography (OCT) guidance) as device intensive and apply a 65-percent device offset. The commenters explained that the procedure requires two proprietary, single-use optical interfaces that contact the cornea and are integral to OCT-guided imaging and laser treatment under a CMS-approved Category B IDE study. The commenters stated that the combined $3,750 acquisition cost represents approximately 65 percent of the proposed geometric mean cost for APC 5493 and therefore exceeds the 30-percent device-cost threshold.

Response: CPT code 0730T describes a minimally invasive glaucoma surgical procedure that reduces intraocular pressure by improving aqueous outflow. Specifically, CPT code 0730T describes a laser trabeculotomy procedure that noninvasively creates a channel through the trabecular meshwork, unlike other laser trabeculoplasty procedures that apply laser energy to stimulate biological changes that improve aqueous outflow. We are not accepting the commenter’s recommendation to treat the patient interface system as a device for purposes of determining device-intensive status. Our criteria for device-intensive status require that a device be surgically inserted or implanted into the patient. In the CY 2006 OPPS/ASC final rule with comment period (70 FR 68629 through 68630), we explained that the surgical insertion or implantation criterion encompasses devices inserted or implanted through a natural or surgically created orifice, as well as devices inserted or implanted through a surgically created incision. We do not consider placement beneath the eyelid and against the ocular surface to constitute insertion through a natural or surgically created orifice or incision. Therefore, we do not consider the patient interface system associated with CPT code 0730T to be an insertable

medical device for purposes of device-intensive status.

Comment: Several commenters requested that we expand device-intensive policy to permit CPT codes 0686T (Histotripsy (ie, non-thermal ablation via acoustic energy delivery) of malignant hepatocellular tissue, including image guidance) and 0888T (Histotripsy (ie, non-thermal ablation via acoustic energy delivery) of malignant renal tissue, including imaging guidance), which describe histotripsy of liver and kidney tumors, respectively, to qualify based on the cost of a nonimplantable, single-use device applied to the patient's skin. The commenters stated that the device will cost $7,500 in CY 2027 and stated that both procedures satisfy the 30-percent device-cost threshold, notwithstanding that the device is neither surgically inserted nor implanted. The commenters stated that revising the policy and increasing payment would facilitate beneficiary access to noninvasive histotripsy in the lower-cost ASC setting.

Response: While we understand the commenters' concerns regarding payment adequacy for capital-intensive procedures furnished in the ASC setting and may consider these concerns in future rulemaking, we did not propose revising the eligibility criteria for device-intensive procedures. We believe that expanding the definition of device-intensive procedures to include high-cost items that contact a patient's skin, but are not surgically implanted/inserted, could have significant unintended consequences for both the OPPS and the ASC payment system. Therefore, we are not accepting the commenters' recommendations.

Comment: A commenter opposed the proposed device offset percentage for CPT code 0885T (Colonoscopy, flexible, with initial transendoscopic mechanical dilation (eg, nondrug-coated balloon) followed by therapeutic drug delivery by drug-coated balloon catheter for colonic stricture, including fluoroscopic guidance, when performed) and requested that we continue to assign device-intensive status. The commenter stated that the three claims used to calculate the proposed offsets were erroneous because the ProTractX3 drug-coated balloon was available only through company-funded IDE trials and the facilities submitting the claims were not trial participants. The commenter requested that in the absence of

sufficient claims data, the procedure should be assigned the APC-level device offset percentage under the OPPS.

Response: We rely on hospitals to accurately report device costs associated with procedures. However, based on this comment and other public comments raising concern with determining device intensive status for services with very few claims, we believe that in instances where a procedure has very few claims upon which to determine device intensive status it would be appropriate to apply a low volume methodology for device intensive status which we are finalizing for this CY 2027 OPPS/ASC final rule with comment period and which is discussed further later in this section of the preamble.

Under this low volume policy for device-intensive procedures, for procedures assigned device-intensive status in the current year with fewer than 10 claims in the ratesetting year, we will use the greater of: (1) the device offset percentage calculated from the available claims; or (2) the device offset percentage calculated under our default methodology, which is the greater of 31 percent or the device offset percentage of the APC to which the procedure is assigned.

Given the limited number of claims – three claims for this final rule with comment period – the device offset percentage of CPT code 0885T would fall under this low volume policy for device-intensive procedures and would be assigned a default device offset of 45.02 percent based on the APC-wide device offset of APC 5331 (Complex GI Procedures).

Comment: Commenters supported our proposal to designate CPT code 27486 (Revision of total knee arthroplasty, with or without allograft; 1 component) as device intensive and to continue the device-intensive designation for CPT code 31295 (Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); maxillary sinus ostium, transnasal or via canine fossa), noting that the associated device costs exceed the 30-percent threshold. The commenters requested that we also designate CPT codes 31296 (Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); frontal sinus ostium), 31297 (Nasal/sinus endoscopy, surgical, with dilation

(eg, balloon dilation); sphenoid sinus ostium), and 31298 (Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); frontal and sphenoid sinus ostia) as device intensive because these clinically related sinus procedures use similar balloon dilation devices; they noted that the calculated offset for CPT code 31296 exceeds 30 percent and recommended a stabilization policy for procedures such as CPT codes 31297 and 31298 that fluctuate near the threshold.

Response: We appreciate the commenters' recommendation to establish a stabilization policy for procedures with device offset percentages that fluctuate around the 30-percent device-intensive threshold and we are accepting this recommendation. We have previously heard concerns regarding payment rate volatility from device-intensive procedures that fluctuate above and below our device-intensive threshold on a year-to-year basis (87 FR 72065, 88 FR 81920, 90 FR 53853). In response to concerns regarding the reliability of limited outpatient claims data from procedures assigned to the inpatient-only list for device-intensive status, we are finalizing a low-volume device-intensive procedure policy under the OPPS. In response to such concerns and the concerns from commenters regarding the payment volatility from low-volume device-intensive procedures that fluctuate above and below our device-intensive threshold of 30 percent, we are also adopting this policy for the ASC payment system beginning in CY 2027. Therefore, under our CY 2027 low volume device-intensive procedures policy, for procedures assigned device-intensive status in the current year with fewer than 10 claims available in the ratesetting year, we will use the greater of: (1) the device offset percentage calculated from the available claims; or (2) the device offset percentage calculated under our default methodology, which is the greater of 31 percent or the device offset percentage of the APC to which the procedure is assigned.

Based on our review of the claims data available under the standard ratesetting methodology for this CY 2027 OPPS/ASC final rule with comment period, CPT codes 31295, 31296, and 31297 would be considered low-volume device-intensive procedures under our new

policy. CPT code 31298 did not meet our device-intensive threshold based on our review of the claims data, nor would it be considered a low-volume device-intensive procedure under our new policy and, therefore, we are not accepting the commenter's recommendation to assign CPT code 31298 device-intensive status for CY 2027.

Comment: A commenter supported our proposal to assign device-intensive status to CPT code 52284 (Cystourethroscopy, with mechanical urethral dilation and urethral therapeutic drug delivery by drug-coated balloon catheter for urethral stricture or stenosis, male, including fluoroscopy, when performed) and recommended finalizing the associated device offsets. The commenter explained that the procedure requires the Optilume Stricture drug-coated balloon catheter and the proposed OPPS device offset appropriately reflects the device-intensive nature of the procedure.

Response: We appreciate the commenter's support and are assigning a device offset percentage to CPT code 52284 based on the CY 2025 claims data available for this final rule with comment period.

Comment: A commenter supported our proposal to assign device-intensive status to CPT code 64728 (Decompression; median nerve at the carpal tunnel, percutaneous, with intracarpal tunnel balloon dilation, including ultrasound guidance) but requested an increase from the proposed default device offset of 31 percent. The commenter recommended a device offset of 61.69 percent under the ASC payment system.

Response: We appreciate the commenter's support of our assignment of device-intensive status to CPT code 64728. Although our policy permits temporarily assigning a higher device offset percentage in certain rare circumstances based on additional information, including manufacturer pricing data, we do not find that the information submitted warrants departing from our default device offset methodology for this procedure. We believe that applying the default methodology appropriately recognizes device costs while maintaining incentives for efficient purchasing. Therefore, we will apply our default device offset methodology to CPT code 64728

for CY 2027.

Comment: A commenter requested that we designate CPT code 52649 (Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)) as device intensive, stating that the procedure requires single-use, insertable devices, including a morcellator reported with HCPCS code C1782 and a laser fiber reported with C1889. The commenter stated that the proposed device offset under the ASC payment system understate the costs of these required devices.

Response: For this final rule with comment period, the CY 2025 claims data included more than 7,000 single claims for CPT code 52649 based on the standard ratesetting methodology. We rely on hospitals to accurately report device costs associated with procedures and the device offset percentage calculated from this volume of claims indicates that the device costs associated with the procedure are below the 30-percent device-intensive threshold. Therefore, we are not accepting the commenter's recommendation and are calculating the device offset percentage for CPT code 52649 using the CY 2025 claims data available for this final rule with comment period.

Comment: Several commenters requested that CMS designate CPT code 53854 (Transurethral destruction of prostate tissue; by radiofrequency generated water vapor thermotherapy) as device intensive and calculate its device offset using only claims that identify the required single-use delivery device through HCPCS code C1889 or revenue center code 0278. The commenters stated that the device is integral to the procedure, used for one patient, contacts human tissue, and is surgically inserted, thereby satisfying CMS' device criteria. They reported that only 30.84 percent of claims identified the required device, producing an all-claims offset of 17.39 percent, whereas claims identifying the device produced an offset of 45.07 percent, above the 30-percent threshold.

Response: For this final rule with comment period, the CY 2025 claims data included more than 1,000 single claims for CPT code 53854 based on the standard ratesetting methodology. We rely on hospitals to accurately report device costs associated with procedures and the device offset percentage calculated from this volume of claims indicates that the device costs associated with the procedure are below the 30-percent device-intensive threshold. Therefore, we are not accepting the commenter's recommendation and are calculating the device offset percentage for CPT code 53854 using the CY 2025 claims data available for this final rule with comment period.

Comment: Commenters requested that CMS designate CPT codes 43263 (Endoscopic retrograde cholangiopancreatography (ercp); with pressure measurement of sphincter of oddi), 45402 (Laparoscopy, surgical; proctopexy (for prolapse), with sigmoid resection), and 47371 (Laparoscopy, surgical, ablation of 1 or more liver tumor(s); cryosurgical) as device-intensive procedures under the ASC payment system for CY 2027. The commenters noted that the device offset percentages published in Addendum FF—39.06 percent, 34.65 percent, and 41.35 percent, respectively—each exceed the 30-percent threshold, although CMS proposed payment indicator "A2" for CPT code 43263 and G2 for CPT codes 45402 and 47371. The commenters stated that these procedures use surgically inserted, single-use devices and that failure to apply the device-intensive methodology could understate ASC resource costs, discourage migration to lower-cost settings, and limit beneficiary access. If CMS determines that any code fails another eligibility criterion, the commenters requested a code-specific explanation reconciling that determination with the published device offsets.

Response: Based on our medical officers' review of the procedure and the associated claims data for CPT code 43263, we agree with the commenters that CPT code 43263 meets our criteria for device-intensive status for CY 2027.

We are finalizing our proposal to remove CPT code 45402 from the inpatient-only list and add this procedure to the ASC list of covered surgical procedures. Based on our medical

officers' review of the procedure, we are not accepting the commenter's recommendation to assign device-intensive status to CPT code 45402 for CY 2027 as this procedure does not meet our device-intensive criteria. Specifically, we do not believe this procedure requires an insertable or implantable device.

Based on our review of the claims data associated with CPT code 47371, the device offset percentage for CPT code 47371 is below our device-intensive threshold and is therefore ineligible for device-intensive status for CY 2027.

Comment: A commenter requested that CMS grant temporary device-intensive status to CPT code 66174 (Transluminal dilation of aqueous outflow canal (eg, canaloplasty); without retention of device or stent), which requires an advanced microcatheter that is surgically inserted into the eye. The commenter stated that the procedure previously qualified as device intensive in the CY 2025 proposed rule but lost that status following changes in reported costs and cost-to-charge ratios, despite subsequent efforts to improve hospital device-cost reporting. The commenter requested that CMS calculate the device offset using only claims reporting HCPCS code C1889 or include revenue code 0272 in offset calculations.

Response: For this final rule with comment period, the CY 2025 claims data included more than 300 single claims for CPT code 66174 based on the standard ratesetting methodology. We rely on hospitals to accurately report device costs associated with procedures and the device offset percentage calculated from this volume of claims indicates that the device costs associated with the procedure are below the 30-percent device-intensive threshold. Additionally, revenue code 0272 is designated for sterile supplies associated with the operating room and would not be an applicable source of device costs under our device-intensive criteria. Therefore, we are not accepting the commenter's recommendation and are calculating the device offset percentage for CPT code 66174 using the CY 2025 claims data available for this final rule with comment period.

Comment: A commenter identified potentially inconsistent device-intensive designations

within craniofacial and mandibular procedure families, noting that CPT codes 21142 (Reconstruction midface, lefort i; 2 pieces, segment movement in any direction, without bone graft) and 21195 (Reconstruction of mandibular rami, horizontal, vertical, c, or l osteotomy; with bone graft (includes obtaining graft)) are designated as device intensive, while clinically similar CPT codes 21141 (Reconstruction midface, lefort i; single piece, segment movement in any direction (eg, for long face syndrome), without bone graft), 21143 (Reconstruction midface, lefort i; 3 or more pieces, segment movement in any direction, without bone graft), and 21196 (Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation) are not. The commenter requested that CMS clarify how the device-intensive criteria are applied across clinical families and reconsider classifications that may not accurately reflect the resources required to furnish the procedures.

Response: We apply the device-intensive criteria uniformly across procedures, including procedures within the same clinical family. However, device-intensive determinations also rely on device cost information reported on hospital outpatient claims. We rely on hospitals to report accurately the device costs associated with each procedure, and we acknowledge that limited claims volume may result in fluctuations in device offset percentages among clinically similar procedures, including the low-volume craniofacial and mandibular procedures identified by the commenter.

In this CY 2027 OPPS/ASC final rule with comment period, we are finalizing a low-volume device-intensive procedure policy. Under this policy, for a procedure assigned device-intensive status for the current year for which fewer than 10 claims are available for ratesetting, we will apply the greater of: (1) the device offset percentage calculated using the available claims; or (2) the device offset percentage calculated under our default methodology, which is the greater of 31 percent or the device offset percentage of the APC to which the procedure is assigned. We believe this policy will promote greater stability and consistency in device-intensive determinations for low-volume procedures.

Comment: A commenter requested we designate CPT code 1084T (placeholder CPT code X588T) (Implantation of scaffolding allograft to reinforce the suprachoroidal space) as device intensive under the ASC payment system. The commenter stated that the procedure requires a device that comprises two to three permanently implanted scleral allografts and a single-use delivery system with a reported acquisition cost of approximately $4,485. The commenter stated that the device, including the implanted allografts, qualifies as a device under the OPPS. Specifically, the commenter stated that the implanted allografts satisfy the criteria based on their section 361 HCT/P status. The commenter also stated that even if CMS treated the single-use delivery system, characterized as a single-use access cannula, as an excluded instrument, the reported acquisition cost of the implanted allografts would separately satisfy the cost threshold for determining device-intensive status. The commenter requested an HCPCS-specific device offset reflecting the $4,485 cost or, alternatively, application of the APC-level device offset. The commenter stated that without device-intensive status, the ASC payment would be less than the device acquisition cost, effectively limiting the procedure to the higher-cost hospital outpatient setting.

Response: To qualify as a device-intensive procedure, a procedure must involve a device that, among other criteria, has received FDA marketing authorization; has received an FDA investigational device exemption and has been classified as a Category B device by FDA under 42 CFR 405.203 through 405.207 and 405.211 through 405.215; or qualifies for another appropriate exemption from FDA premarket review. The commenter stated that the implanted scleral allografts that are implanted with CPT code 1084T are regulated solely under section 361 of the Public Health Service Act and therefore are not subject to FDA premarket review. Although we confirmed that the product is listed in FDA's Human Cell and Tissue Establishment Registration system, FDA registration and listing do not, by themselves, establish that a product satisfies all of the criteria in 21 CFR 1271.10(a) for regulation solely under section 361 of the PHS Act. As we stated previously (90 FR 33642), FDA acceptances of an establishment

registration and 361 HCT/P listing form does not constitute a determination that an establishment is compliant with applicable FDA rules and regulations, that the FDA has agreed with the manufacturer's self-determination as a 361 HCT/P, or that the HCT/P is licensed or approved by FDA (21 CFR 1271.27(b)). As the FDA may ultimately determine that the manufacturer's self-determination was not appropriate, we believe it would be improper for CMS to conclude that the allografts are appropriately exempt from FDA premarket review based on the self-determination of the manufacturer. The commenter did not provide additional evidence sufficient to establish that the allografts satisfy this device-intensive criterion. Therefore, in the absence of such information, we are not accepting the commenter's recommendation to assign device-intensive status to 1084T for CY 2027.

Comment: A commenter requested that CMS remove the device-intensive designation for CPT code 0621T (Trabeculostomy ab interno by laser;). The commenter questioned whether the procedure satisfies the 30-percent device-cost threshold, noting that CMS previously reported a 4.6-percent device offset and that the available claims were submitted by investigational trial sites because the ELIOS System lacks FDA marketing authorization. The commenter stated that the single-use fiber-optic laser probe used in the procedure is a disposable instrument connected to capital equipment and should be treated as a packaged surgical supply, consistent with comparable ophthalmic laser probes. The commenter stated that the designation would increase the ASC payment thereby substantially increasing beneficiary coinsurance and potentially influencing treatment selection.

Response: We appreciate the concerns raised by the commenter; however, based on our medical officer's review of the procedure and the associated device, CPT code 0621T meets our criteria for device-intensive status for CY 2027. The procedure is associated with a Category B IDE study and requires a single-use device that is surgically inserted through a surgical incision into the anterior chamber of the eye. Therefore, we are not accepting the commenter's recommendation to remove device-intensive status to CPT code 0621T.

Comment: A commenter supported CMS' proposal to continue designating CPT code 0671T (Insertion of anterior segment aqueous drainage device into the trabecular meshwork, without external reservoir, and without concomitant cataract removal, one or more) as a device-intensive procedure and calculating its ASC payment rate accordingly. The commenter explained that the procedure involves insertion of an anterior segment aqueous drainage device into the trabecular meshwork and is performed extensively in the ASC setting. The commenter stated that maintaining both the proposed assignment to APC 5493 and the device-intensive designation is necessary to provide appropriate ASC payment and preserve beneficiary access to trabecular bypass procedures.

Response: We appreciate the commenter's support of our proposal. Our final determination of device-intensive status and the final device offset percentage for CPT code 0671T is based on the CY 2025 claims data available for this final rule with comment period.

Comment: A commenter requested that CMS revise the ASC device-intensive eligibility criteria at 42 CFR 416.171(b)(2) to include qualifying medical devices applied in or on wounds or other skin lesions, consistent with the transitional pass-through criteria at 42 CFR 419.66(b)(3). The commenter stated that the current requirement that a device be surgically inserted or implanted categorically excludes procedures involving wound-applied devices, such as the RECELL System, even when device costs exceed the applicable threshold. The commenter stated that this difference could make furnishing such procedures in ASCs financially impracticable and limit beneficiaries' access to lower-cost settings. The commenter requested that CMS adopt the revision or, alternatively, acknowledge the difference between the two policies and solicit public comment in future rulemaking.

Response: We did not propose revising the eligibility criteria for device-intensive procedures. We believe that expanding the definition of device-intensive procedures to include items applied to a patient's skin could have significant unintended consequences for both the

OPPS and the ASC payment system. Therefore, we are not accepting the commenters' recommendations.

After consideration of public comments, we are revising our device-intensive procedures policy to include a low volume device-intensive procedures policy for CY 2027. Under this new policy, for a procedure assigned device-intensive status for the current year for which fewer than 10 claims are available for ratesetting, we will apply the greater of: (1) the device offset percentage calculated using the available claims; or (2) the device offset percentage calculated under our default methodology, which is the greater of 31 percent or the device offset percentage of the APC to which the procedure is assigned. For final CY 2027 device offset percentages based on the claims data for this final rule with comment period, CY 2025 claims processed through June 30, 3036, we refer readers to Addendum FF of this final rule with comment period.

c. Adjustment to ASC Payments for No Cost/Full Credit and Partial Credit Devices

Our ASC payment policy for costly devices implanted or inserted in ASCs at no cost/full credit or partial credit is set forth in § 416.179 of our regulations and is consistent with the OPPS policy that was in effect until CY 2014. We refer readers to the CY 2008 OPPS/ASC final rule with comment period (72 FR 66845 through 66848) for a full discussion of the ASC payment adjustment policy for no cost/full credit and partial credit devices. ASC payment is reduced by 100 percent of the device offset amount when a hospital furnishes a specified device without cost or with a full credit and by 50 percent of the device offset amount when the hospital receives partial credit in the amount of 50 percent or more of the cost for the specified device.

Effective CY 2014, under the OPPS, we finalized our proposal to reduce OPPS payment for applicable APCs by the full or partial credit a provider receives for a device, capped at the device offset amount. Although we finalized our proposal to modify the policy of reducing payments when a hospital furnishes a specified device without cost or with full or partial credit under the OPPS, in the CY 2014 OPPS/ASC final rule with comment period (78 FR 75076 through 75080), we finalized our proposal to maintain our ASC policy for reducing payments to

ASCs for specified device-intensive procedures when the ASC furnishes a device without cost or with full or partial credit. Unlike the OPPS, there is currently no mechanism within the ASC claims processing system for ASCs to submit to CMS the amount of the actual credit received when furnishing a specified device at full or partial credit. Therefore, under the ASC payment system, we finalized our proposal for CY 2014 to continue to reduce ASC payments by 100 percent or 50 percent of the device offset amount when an ASC furnishes a device without cost or with full or partial credit, respectively.

Under current ASC policy, all ASC device-intensive covered surgical procedures are subject to the no cost/full credit and partial credit device adjustment policy. Specifically, when a device-intensive procedure is performed to implant or insert a device that is furnished at no cost or with full credit from the manufacturer, the ASC appends the HCPCS "FB" modifier on the line in the claim with the procedure to implant or insert the device. The contractor reduces payment to the ASC by the device offset amount that we estimate represents the cost of the device when the necessary device is furnished without cost or with full credit to the ASC. We continue to believe that the reduction of ASC payment in these circumstances is necessary to pay appropriately for the covered surgical procedure furnished by the ASC.

In the CY 2019 OPPS/ASC final rule with comment period (83 FR 59043 through 59044) we adopted a policy to reduce the payment for a device-intensive procedure for which the ASC receives partial credit by one-half of the device offset amount that would be applied if a device was provided at no cost or with full credit if the credit to the ASC is 50 percent or more (but less than 100 percent) of the cost of the new device. The ASC will append the HCPCS "FC" modifier to the HCPCS code for the device-intensive surgical procedure when the facility receives a partial credit of 50 percent or more (but less than 100 percent) of the cost of a device. To report that the ASC received a partial credit of 50 percent or more (but less than 100 percent) of the cost of a new device, ASCs have the option of either: (1) submitting the claim for the device-intensive procedure to their Medicare contractor after the procedure's performance, but

prior to manufacturer acknowledgment of credit for the device, and subsequently contacting the contractor regarding a claim adjustment, once the credit determination is made; or (2) holding the claim for the device implantation or insertion procedure until a determination is made by the manufacturer on the partial credit and submitting the claim with the "FC" modifier appended to the implantation procedure HCPCS code if the partial credit is 50 percent or more (but less than 100 percent) of the cost of the device. Beneficiary coinsurance would be based on the reduced payment amount. As finalized in the CY 2015 OPPS/ASC final rule with comment period (79 FR 66926), to ensure our policy covers any situation involving a device-intensive procedure where an ASC may receive a device at no cost or receive full credit or partial credit for the device, we apply our "FB"/"FC" modifier policy to all device-intensive procedures.

In the CY 2019 OPPS/ASC final rule with comment period (83 FR 59043 through 59044) we stated we would reduce the payment for a device-intensive procedure for which the ASC receives partial credit by one-half of the device offset amount that would be applied if a device was provided at no cost or with full credit, if the credit to the ASC is 50 percent or more (but less than 100 percent) of the cost of the device. In the CY 2020 OPPS/ASC final rule with comment period, we finalized continuing our existing policies for CY 2020. We noted that we inadvertently omitted language that this policy would apply not just in CY 2019 but also in subsequent calendar years. We intended to apply this policy in CY 2019 and subsequent calendar years. Therefore, we finalized our proposal to apply our policy for partial credits specified in the CY 2019 OPPS/ASC final rule with comment period (83 FR 59043 through 59044) in the CY 2022 OPPS/ASC final rule with comment period for CY 2022 and subsequent calendar years (86 FR 63775 through 63776). Specifically, for CY 2022 and subsequent calendar years, we would reduce the payment for a device-intensive procedure for which the ASC receives partial credit by one-half of the device offset amount that would be applied if a device was provided at no cost or with full credit, if the credit to the ASC is 50 percent or more (but less than 100 percent) of the cost of the device. To report that the ASC received a partial

credit of 50 percent or more (but less than 100 percent) of the cost of a device, ASCs have the option of either: (1) submitting the claim for the device intensive procedure to their Medicare contractor after the procedure's performance, but prior to manufacturer acknowledgment of credit for the device, and subsequently contacting the contractor regarding a claim adjustment, once the credit determination is made; or (2) holding the claim for the device implantation or insertion procedure until a determination is made by the manufacturer on the partial credit and submitting the claim with the "FC" modifier appended to the implantation procedure HCPCS code if the partial credit is 50 percent or more (but less than 100 percent) of the cost of the device. Beneficiary coinsurance would be based on the reduced payment amount.

We did not propose any changes to our policies related to no cost/full credit or partial credit devices for CY 2027.

We did not receive any comments on our policies related to no cost/full credit or partial credit devices, and we are finalizing the continuation of our existing policies for CY 2027 without modification.

D. Final Additions to ASC Covered Surgical Procedures and Covered Ancillary Services Lists

1. Final Additions to the List of ASC Covered Surgical Procedures

Section 1833(i)(1) of the Act requires us, in part, to specify, in consultation with appropriate medical organizations, surgical procedures that are appropriately performed on an inpatient basis in a hospital but that can also be safely performed in an ASC, a CAH, or an HOPD, and to review and update the list of ASC covered surgical procedures at least every 2 years. We evaluate the ASC covered procedures list (ASC CPL) each year to determine whether procedures should be added to or removed from the list, and changes to the list are often made in response to specific concerns raised by interested parties.

In the CY 2019 OPPS/ASC final rule with comment period (83 FR 59029 through 59030), we defined a surgical procedure under the ASC payment system as any procedure described within the range of Category I CPT codes that the CPT Editorial Panel of the AMA

defines as ‘‘surgery’’ (CPT codes 10000 through 69999) (72 FR 42476), as well as procedures that are described by Level II HCPCS codes or by Category I CPT codes or by Category III CPT codes that directly crosswalk or are clinically similar to procedures in the CPT surgical range that we determined met the criteria established in previous years for addition to the ASC CPL.

Under our current regulations at §§ 416.2 and 416.166, covered surgical procedures furnished on or after January 1, 2026, are surgical procedures that meet the criteria specified in § 416.166(b)(2). In the CY 2026 OPPS/ASC final rule with comment period, we finalized a policy to expand the ASC CPL by revising our criteria for adding surgical procedures to the ASC CPL (90 FR 53855 through 53886). Under the revised criteria, procedures added to the ASC CPL must be separately paid under the OPPS and are not (1) currently designated as requiring inpatient care under § 419.22(n), (2) only able to be reported using a CPT unlisted surgical procedure code, or (3) otherwise excluded under § 411.15. Additionally, we moved certain general standards and exclusions at § 416.166(b)(1) and (c), used to evaluate services for addition to the ASC CPL prior to January 1, 2026, to a new section at § 416.166(d) of the following non-binding physician considerations: (1) Is not expected to pose a significant safety risk when performed in an ASC; (2) Is one of which standard medical practice dictates the beneficiary would not typically be expected to require active medical monitoring and care at midnight following the procedure; (3) Generally results in extensive blood loss; (4) Requires major or prolonged invasion of body cavities; (5) Directly involves major blood vessels; (6) Is generally emergent or life- threatening in nature; and (7) commonly requires systemic thrombolytic therapy. We believe that these revised criteria are sufficient to ensure, along with appropriate patient selection and complex medical judgement of the physician, that the procedure can be performed safely on an ambulatory basis, including procedures that involve the five previous exclusion criteria. We believe that this expansion of the ASC CPL could advance the goals of increasing physician and patient choice and expanding site neutral options in conjunction with patient safety considerations. For further discussion on our policy to revise the

ASC CPL criteria and expand the procedures added to the list, please refer to section XIII.D. of the CY 2026 OPPS/ASC final rule with comment period (90 FR 53855 through 53886).

For a detailed discussion of the history of our policies for adding surgical procedures to the ASC CPL, we refer readers to the CY 2021 through CY 2026 OPPS/ASC final rules with comment period (85 FR 86143 through 86145; 86 FR 63777 through 63805; 87 FR 72068 through 72076; 88 FR 81923 through 81945; 89 FR 94331 through 94334; and (90 FR 53855 through 53886).

2. Changes to the List of ASC Covered Surgical Procedures for CY 2027

Historically, we have reviewed the clinical characteristics of procedures and consulted with appropriate medical organizations, other interested parties, and our clinical advisors to determine if those procedures would meet our existing regulatory criteria under 42 CFR 416.2 and 42 CFR 416.166.

As part of our evaluation process to add procedures to the CPL, we assess potential procedures against the revised ASC CPL criteria at § 416.166(b)(2). For CY 2027, we reviewed interested parties' nominations received in the pre-proposed rule nominations process. Additionally, we reviewed procedures that are proposed to be removed from the IPO list for CY 2027, as part of the continuation of the elimination of the IPO list, as described in section IX. discussed earlier in this final rule with comment period. Based upon this review, we proposed to update the ASC CPL by adding 618 procedures that we proposed to remove from the IPO list for CY 2027. This includes four procedures that were recommended by interested parties for addition to the ASC CPL: CPT code 49596 (Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); greater than 10 cm, incarcerated or strangulated), 49616 (Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when

performed, total length of defect(s); 3 cm to 10 cm, incarcerated or strangulated), 40617 (Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); greater than 10 cm, reducible), and 40618 (Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); greater than 10 cm, incarcerated or strangulated). As stated in the proposed rule, we believe these procedures would meet the revised ASC CPL criteria under 42 CFR 416.166, if we finalize our proposal to remove these services from the IPO list for CY 2027. These procedures were listed in the public use file titled "Proposed Additions to the List of ASC Covered Procedures for CY 2027," which is available on the CMS website.

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: Several commenters supported our proposal to add 618 procedures proposed for removal from the IPO list to the ASC CPL for CY 2027. Commenters supported the continued expansion of the ASC CPL, and specifically supported the increased flexibility and physician autonomy to use their clinical judgment in determining the appropriate site-of-service. Some physician specialty societies stated that certain codes proposed for addition to the ASC CPL are already being performed in the ASC setting. Commenters also supported allowing procedures to be performed in lower cost settings when appropriate.

Response: We thank the commenters for their support.

Comment: Several commenters opposed our proposal to continue to expand the ASC CPL by adding 618 procedures, with patient safety being a primary concern. Commenters were especially concerned that these procedures are on the IPO list and many are associated with risks that would have previously excluded them from the ASC CPL under our previous exclusion

criteria. Commenters were concerned that these procedures could be performed in the ASC setting, which may not have the same specialized capabilities or emergency care as a hospital setting. Some commenters recommended that CMS reinstate the previous exclusion criteria, with some commenters stating that the expansion of the ASC CPL removed important safety guardrails. Multiple commenters also requested that CMS review the codes individually to determine if they were appropriate to perform in the ASC setting, taking into account risk factors including the average length of stay, risk of complications, and patient profile.

Several commenters also expressed concern that we proposed to remove procedures from the IPO list and add them to the ASC CPL in the same year. Multiple commenters requested that CMS delay the addition of these codes, with recommendations ranging from a two to several year gap. Some commenters also suggested waiting to add these codes until they were performed more often in the outpatient setting or until we are able to assess the impact of the codes added to the ASC CPL for CY 2026.

Response: We thank the commenters for their input. As we stated in the CY 2026 OPPS/ASC final rule with comment period, we believe there are sufficient safety guardrails for ASCs, including State and local regulations, Conditions for Coverage (CfCs), accreditation requirements, and medical malpractice laws, to ensure that physicians are able to prioritize patient safety when determining the site-of-service (90 FR 53857). Additionally, while the prior exclusion criteria are important considerations in determining whether a surgical procedure may be safely performed in an ASC, we believe ASCs are currently and increasingly able to safely provide services that would be covered under the current criteria when considered appropriate for a patient by their physician. Since we maintained the prior general standard and exclusionary criteria in a different section of §416.166 as non-binding physician considerations for patient safety, we believe these criteria will still act as a roadmap for physician decision-making.

We recognize commenters' concerns regarding our proposal to add procedures to the ASC CPL that were proposed for removal from the IPO list for CY 2027 as part of the second

phase of the elimination of the IPO list. As we have previously stated, we believe that concurrently adding these procedures to the ASC CPL as the IPO list is phased-out allows for greater consistency and less confusion between the two lists. We also believe that current guardrails in place mentioned previously are sufficient to ensure patient safety (90 FR 53857). Additionally, as commenters have stated, we believe some of the proposed procedures are currently being performed in the ASC setting.

Comment: Several commenters provided requests for data monitoring and guidance as CMS continues to expand the ASC CPL. Commenters requested that CMS monitor the patient safety and quality outcomes of procedures performed in the ASC setting, including hospital transfers, procedure complications. Commenters also suggested that CMS monitor the payment effects of adding these procedures to the ASC CPL. Some commenters also requested that CMS provide guidance on site-of-service selection and implementing procedures added to the ASC CPL. Additionally, multiple commenters requested that CMS make changes to strengthen the ASC CfCs in alignment with the addition of former IPO procedures being added to the ASC CPL.

Response: We thank the commenters for their recommendations. We agree with the value of monitoring quality, safety, and payment data as procedures are added the ASC CPL. As we have previously stated, we would welcome any patient outcomes data, analyses, or recommendations that interested parties would like to share (90 FR 53858). We will take these recommendations into consideration for future rulemaking.

As we stated in the CY 2026 OPPS/ASC final rule with comment period, in regards to providing further guidance, we note the balance between several factors on this important issue, namely, the need to provide clear information about CMS billing and payment rules that ensure hospitals, physicians, and other interested parties can understand and operate within them, and our belief that the specific decision about the most appropriate care setting for a given surgical procedure that preserves patient safety is a complex medical judgment made by the physician

based on the beneficiary's individual clinical needs and preferences and on the general coverage rules requiring that any procedure be reasonable and necessary.

Comment: Some commenters expressed concerns regarding beneficiary cost-sharing for procedures performed in the ASC setting. A commenter noted that cost-sharing in the hospital outpatient setting is capped at the Part A inpatient deductible, while ASC beneficiary cost-sharing in the ASC setting is not capped. The commenter recommended that CMS to take steps to ensure beneficiaries are informed of the cost-sharing consequences of site-of-service choice.

Response: We thank the commenters for their input. As we stated in the CY 2026 OPPS/ASC final rule with comment period, we are aware that in some limited instances beneficiaries may incur greater cost-sharing for procedures in an ASC setting that we proposed to add to the ASC CPL, but note that this is not an occurrence that is unique to these procedures. As we stated in the CY 2018 OPPS/ASC final rule with comment period (82 FR 59389), section 4011 of the 21st Century Cures Act (Pub. L. 114– 255) amended section 1834 of the Act by adding a new subsection (t), which requires the Secretary to make available to the public via a searchable website, with respect to an appropriate number of items and services, the estimated payment amount for the item or service under the OPPS and ASC payment systems and the estimated beneficiary liability applicable to the item or service. We implemented this provision by providing our Outpatient Procedure Price Lookup tool available via the internet at https://www.medicare.gov/procedure-price-lookup. This web page allows beneficiaries to compare their potential cost-sharing liability for procedures performed in the hospital outpatient setting versus the ASC setting. We believe this tool helps inform beneficiaries of potential cost-sharing amounts for receiving a service in the ASC setting compared to the outpatient setting, and note that this tool would include a comparison of cost-sharing liability for procedures in the outpatient hospital and ASC settings in the future. Additionally, we will take these recommendations regarding beneficiary education into future consideration.

Comment: Many commenters requested that CMS clarify that if a procedure is added to

the ASC CPL, it does not mean that the procedure must be performed in the ASC setting or that it is the most appropriate site-of-service for that procedure.

Response: We thank the commenters for their request. As we emphasized in the CY 2026 OPPS/ASC final rule with comment period, the fact that a procedure is added to the ASC CPL should not be interpreted to mean the procedure is only appropriately performed in ASC setting or that the ASC setting is the most appropriate setting for a beneficiary and instead defer to the clinical judgment of the physician (90 FR 53858).

Comment: Multiple commenters requested that CMS remove the criterion at § 416.166(b)(2)(ii)(B), which excludes the addition of unlisted CPT codes to the ASC CPL, stating that there is no clear safety rationale for this exclusion.

Response: We thank the commenters for their input. Under § 416.166(c)(7), covered surgical procedures do not include procedures that can only be reported using a CPT unlisted surgical procedure code. As discussed in the August 2, 2007 ASC final rule (72 FR 42485), it is not possible to know what specific procedure would be represented by an unlisted code, and therefore, it is not possible to evaluate procedures reported by unlisted CPT codes according to applicable regulatory criteria at §416.166. Therefore, we are not accepting this recommendation.

Comment: Multiple commenters requested that CMS remove CPT code 0967T (Transanal insertion of endoluminal temporary colorectal anastomosis protection device, including vacuum anchoring component and flexible sheath connected to external vacuum source and monitoring system) from the ASC CPL, as the technology associated with this procedure has not received FDA approval.

Response: We thank the commenters for bringing this to our attention. As the technology associated with this code has not received FDA approval, we are finalizing to reassign this procedure to status indicator “E1” (Not covered by any Medicare outpatient benefit category; Statutorily excluded by Medicare; Not reasonable and necessary; Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) in the OPPS. As this code will no

longer be separately paid under the OPPS, a requirement for placement on the ASC-CPL, we are finalizing to remove CPT code 0967T from the ASC CPL and assigning it a nonpayable payment indicator.

Comment: Multiple commenters requested that CMS add CPT codes 97607 (Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters) and 97608 (Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters) for CY 2028, allowing CMS additional time to consider rate-setting approaches for these procedures.

Response: We thank the commenters for their recommendations. We will consider it for future rulemaking.

Comment: We received several comments requesting that we align payment for non-sheet form skin substitutes with payment for sheet-form skin substitute products.

Response: We thank the commenters for their input. After review of the comments, we are finalizing our proposal to add G0681 and G0683 to the ASC CPL in conjunction with our finalized proposal for G0681 and G0683 discussed in section V.B. of this final rule with comment period, under our established policy, we are also finalizing separate payment in CY 2027 in the ASC setting.

Comment: Multiple commenters recommended specific codes to be added to the ASC CPL including, echocardiography, electrophysiological studies, and percutaneous coronary interventions. We received 26 procedure recommendations for the CPL.

Response: We thank commenters for their recommendations. We individually assessed

each of the recommended procedures to determine whether these procedures meet each of the applicable revised regulatory criteria at § 416.166. Based on our review of the clinical characteristics of the procedures and their similarity to other procedures that are currently on the ASC CPL, we believe that 1 procedure out of the 26 procedure recommendations we received meet the general requirements for covered surgical procedures for the ASC CPL as set forth in the revised § 416.166(b)(2):

- CPT code 64629 (Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; each additional vertebral body, lumbar or sacral (list separately in addition to code for primary procedure)).

In the upcoming section, we explain our rationale for not including the 25 recommended procedures, organized by category. We note that while we did not add these codes to the ASC CPL, we did determine some of these codes are appropriate to add to list of covered ancillary procedures, as discussed in section XIII.D.3. of this final rule with comment period.

- Two wound care procedures. As these procedures are non-surgical, they would not qualify as separately payable surgical procedures on the ASC CPL.

- 23 cardiovascular procedures, including transesophageal ecochardiography, aortography, angiography, and venography procedures. As these procedures are non-surgical, they would not qualify as separately payable surgical procedures on the ASC CPL. Sixteen of these procedures are already on the list of covered ancillary procedures. We are also adding 5 of the procedures to the list of covered ancillary procedures. The remaining two codes requested were previously deleted by the AMA.

After consideration of public comments, we are finalizing our proposal to update the ASC CPL by adding 618 procedures that we proposed to remove from the IPO list for CY 2027. Additionally, we are finalizing adding an additional code, CPT code 64629, recommended by commenters to the ASC CPL for CY 2027. These procedures, along with their long descriptor and payment indicators, are listed in the public use file titled ‘‘Final Additions to the List of ASC

Covered Procedures for CY 2027,'' which is available on the CMS website.

3. Covered Ancillary Services

Covered ancillary services are specified in § 416.164(b) and, as stated previously, are eligible for separate ASC payment. As provided at § 416.164(b), we make separate ASC payments for ancillary items and services when they are provided integral to ASC covered surgical procedures that include the following: (1) brachytherapy sources; (2) certain implantable items that have pass-through status under the OPPS; (3) certain items and services that we designate as contractor-priced, including, but not limited to, procurement of corneal tissue; (4) certain drugs and biologicals for which separate payment is allowed under the OPPS; (5) certain radiology services for which separate payment is allowed under the OPPS; and (6) non-opioid pain management drugs, biologicals, and medical devices as determined by CMS under § 416.174; and (7) groups of skin substitute supply products. Payment for ancillary items and services that are not paid separately under the ASC payment system is packaged into the ASC payment for the covered surgical procedure.

In the CY 2019 OPPS/ASC final rule with comment period (83 FR 59062 through 59063), consistent with the established ASC payment system policy (72 FR 42497), we finalized the policy to update the ASC list of covered ancillary services to reflect the payment status for the services under the OPPS and to continue this reconciliation of packaged status for subsequent calendar years. As discussed in prior rulemaking, maintaining consistency with the OPPS may result in changes to ASC payment indicators for some covered ancillary services. For example, if a covered ancillary service was separately paid under the ASC payment system in CY 2026, but will be packaged under the CY 2027 OPPS, we would also package the ancillary service under the ASC payment system for CY 2027 to maintain consistency with the OPPS. Comment indicator "CH" is used in Addendum BB (which is available via the Internet on the CMS website) to indicate covered ancillary services for which we proposed a change in the ASC

payment indicator to reflect a proposed change in the OPPS treatment of the service for CY 2025.

In the CY 2022 OPPS/ASC final rule with comment period, we finalized our proposal to revise § 416.164(b)(6) to include, as ancillary items that are integral to a covered surgical procedure and for which separate payment is allowed, non-opioid pain management drugs and biologicals that function as a supply when used in a surgical procedure as determined by CMS (86 FR 63490). In the CY 2025 OPPS/ASC final rule with comment period, we revised § 416.164(b)(6) to read ‘‘Non-opioid pain management drugs, biologicals, and medical devices as determined by CMS under § 416.174,’’ as we finalized a policy to place qualifying medical devices on the ASC covered ancillary services list (89 FR 94361).

In the CY 2026 OPPS/ASC final rule with comment period, we finalized our proposal to pay separately for the provision of certain groups of skin substitute products when used during a covered surgical procedure, by revising § 416.164(b) to include groups of skin substitute products as covered ancillary items and services that are integral to a covered surgical procedure.

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: A commenter requested that CMS ensure that our policy for adding procedures to the list of covered ancillary services does not lead to fragmented care because a needed ancillary service is not on the list. The commenter requested that CMS maintain a transparent process for aligning ancillary service assignments with additions to the ASC CPL.

Response: We appreciate the commenter’s input. CMS reviews the list of covered ancillary procedures on a yearly basis in conjunction with its review of the ASC CPL. We also encourage interested parties to provide recommendations for covered ancillary procedures through the pre-rulemaking nomination process and comment period and notify CMS if they believe a necessary ancillary service needs to be added to the list. We believe that our current review process takes into account the need to add procedures to the list of covered ancillary

procedures to prevent fragmented care. We also note that we added several procedures to the list of covered ancillary procedures in CY 2026 in conjunction with the expansion of the ASC CPL, and plan to finalize further additions for CY 2027.

Comment: Multiple commenters recommended the following codes to be added to the list of covered ancillary services for CY 2027: CPT codes 0897T (Noninvasive augmentative arrhythmia analysis derived from quantitative computational cardiac arrhythmia simulations, based on selected intervals of interest from 12-lead electrocardiogram and uploaded clinical parameters, including uploading clinical parameters with interpretation and report), 1086T (Intraprocedural estimate of coronary fractional flow derived by augmentative algorithmic analysis of data from real-time coronary angiography, with creation of functional map of coronary circulation, when performed, with review and interpretation (List separately in addition to code for primary procedure)), 97610 (Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day), and 97611, previously described by placeholder code 976XX, (Real-time fluorescence wound imaging with clinical darkness to identify presence, location, load of bacteria, and measure wound size, per day).

Response: We thank the commenters for their recommendations. We agreed with the commenters that CPT code 1086T could be added to the list of covered ancillary procedures for CY 2027 as we determined the procedure described to be integral to ASC CPL procedures. However, we did not find the other recommended codes to be to be appropriate to add to the list of covered ancillary services because we did not find them to be integral to any procedures on the ASC CPL, which is a requirement for placement on the list of covered ancillary services. Therefore, we are adding one additional procedure, CPT code 1086T, recommended by commenters to the list of ASC covered ancillary services for CY 2027.

In summary, we are finalizing adding the following 6 procedures recommended by interested parties to the list of ASC covered ancillary services for CY 2027, including 5

procedures that commenters recommended for addition to the ASC CPL: CPT codes 1086T (intraprocedural estimate of coronary fractional flow derived by augmentative algorithmic analysis of data from real-time coronary angiography, with creation of functional map of coronary circulation, when performed, with review and interpretation (List separately in addition to code for primary procedure), 93313 (Echocardiography, transesophageal, real-time with image documentation (2d) (with or without m-mode recording); placement of transesophageal probe only), 93314 (Echocardiography, transesophageal, real-time with image documentation (2d) (with or without m-mode recording); image acquisition, interpretation and report only), 93315 (Transesophageal echocardiography for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report), 93316 (Transesophageal echocardiography for congenital cardiac anomalies; placement of transesophageal probe only), and 93317 (Transesophageal echocardiography for congenital cardiac anomalies; image acquisition, interpretation and report only). New CPT and HCPCS codes for covered ancillary services for CY 2027 can be found in section XIII.B. of this final rule.

E. CY 2027 Non-Opioid Policy for Pain Relief Under the OPPS and ASC Payment System

1. Background

The Consolidated Appropriations Act (CAA), 2023 (Pub. L. 117-328), was signed into law on December 29, 2022. Section 4135(a) and (b) of the CAA, 2023, titled Access to Non-Opioid Treatments for Pain Relief, amended section 1833(t)(16) and section 1833(i) of the Act, respectively, to provide for temporary additional payments for non-opioid treatments for pain relief (as that term is defined in section 1833(t)(16)(G)(i) of the Act). In particular, section 1833(t)(16)(G) of the Act provides that with respect to a non-opioid treatment for pain relief furnished on or after January 1, 2025, and before January 1, 2028, the Secretary shall not package payment for the non-opioid treatment for pain relief into payment for a covered OPD service (or group of services) and shall make an additional payment for the non-opioid treatment for pain relief as specified in clause (ii) of that section. Clauses (ii) and (iii) of

section 1833(t)(16)(G) of the Act provide for the amount of additional payment and set a limitation on that amount.

Paragraph (10) of section 1833(i) of the Act cross-references the OPPS provisions about the additional payment amount and payment limitation for non-opioid treatments for pain relief and applies them to payment under the ASC payment system. In particular, paragraph (A) of paragraph (10) of section 1833(i) of the Act, as added by section 4135(b) of the CAA, 2023, provides that in the case of surgical services furnished on or after January 1, 2025, and before January 1, 2028, additional payments shall be made under the ASC payment system for non-opioid treatments for pain relief in the same amount provided in clause (ii) and subject to the limitation in clause (iii) of section 1833(t)(16)(G) of the Act for the OPPS. Paragraph (B) of section 1833(i)(10) of the Act provides that a drug or biological that meets the requirements of 42 CFR 416.174 and is a non-opioid treatment for pain relief shall also receive additional payment in the amount provided in clause (ii) and subject to the limitation in clause (iii) of section 1833(t)(16)(G) of the Act.

Additional payments under this policy began on January 1, 2025. As stated in the CY 2025 OPPS/ASC final rule with comment period (89 FR 94343 through 94344), the statute directs CMS to provide "additional payment", and for purposes of this policy, we interpret this language to be equivalent to "separate payment," since CMS provides an additional payment by unpackaging the product and then making a separate payment. "Separate payment" is the more commonly used terminology in the OPPS rule and likely more familiar to readers. To avoid confusion, we will continue to use "separate payment" throughout the rest of this section, which we believe to be synonymous with "additional payment." Under section 1833(t)(2)(E) of the Act, the temporary separate payments must be made in a budget neutral manner.

For background information on the ASC Payment Policy for Non-Opioid Post-Surgery Pain Management Drugs and Biologicals prior to CY 2025, please see the summary provided in the CY 2025 OPPS/ASC final rule with comment period (89 FR 94342 through 94343).

2. Finalized CY 2025 Non-Opioid Policy Implementation of Section 4135 of the CAA, 2023

In CY 2025, CMS finalized our implementation methodology for section 4135 of CAA, 2023 (hereafter referred to as "section 4135") (89 FR 94343 through 94361) to provide for temporary separate payments for certain non-opioid treatment for pain relief in the hospital outpatient department and ambulatory surgical center settings on a temporary basis from January 1, 2025 through December 31, 2027. CMS also finalized regulation text at 42 CFR 416.174 and 42 CFR 419.43(k), which outline the payment for non-opioid pain management drugs, biologicals, and medical devices under both the ASC payment system and OPPS, respectively.

a. Drugs and Biologicals Subject to the ASC Non-Opioid Policy (42 CFR 416.174)

Section 1833(i)(10)(B), titled "Transition", provides that a drug or biological that meets the requirements of the regulation at 42 CFR 416.174, the current ASC non-opioid policy, and also meets the definition of a non-opioid treatment for pain relief at section 1833(t)(16)(G)(iv) of the Act shall receive separate payments under section 4135, subject to the payment limitation. In light of this requirement, we finalized in the CY 2025 OPPS/ASC final rule with comment period that drugs and biologicals that meet the definition of a non-opioid treatment for pain relief for purposes of section 4135 that were subject to the ASC policy for non-opioid treatments authorized by section 6082 of the SUPPORT Act in CY 2024, would instead receive separate payments, subject to the limitation, for the duration of the payment period for section 4135 (89 FR 94344).

b. Definition of Non-Opioid Treatment for Pain Relief

Section 1833(t)(16)(G)(iv) of the Act defines a non-opioid treatment for pain relief for a drug, biological product, or medical device and requires, in part, that such treatment does not receive transitional pass-through payment and has payment that is packaged into a payment for a covered OPD service (or group of services). In addition, in order for a drug or biological product to qualify as a non-opioid treatment for pain relief, pursuant to section 1833(t)(16)(G)(iv)(I), the

product must have "a label indication approved by the Food and Drug Administration to reduce postoperative pain, or produce postsurgical or regional analgesia, without acting upon the body's opioid receptors". In order for a medical device to qualify as a non-opioid treatment for pain relief, pursuant to section 1833(t)(16)(G)(iv)(II) of the Act, it must, in part, be "used to deliver a therapy to reduce postoperative pain, or produce post-surgical or regional analgesia". A medical device must also, pursuant to section 1833(t)(16)(G)(iv)(II)(aa) and (bb) of the Act have both "an application under section 515 of the Federal Food, Drug, and Cosmetic Act that has been approved with respect to the device, been cleared for market under section 510(k) of such Act, or is exempt from the requirements of section 510(k) of such Act pursuant to subsection (l) or (m) or section 510 of such Act or section 520(g) of such Act" and "demonstrated the ability to replace, reduce, or avoid intraoperative or postoperative opioid use or the quantity of opioids prescribed in a clinical trial or through data published in a peer-reviewed journal".

c. Evidence Requirement for Medical Devices

To determine whether a medical device fulfills the statutory requirement that it has demonstrated the ability to replace, reduce, or avoid intraoperative or postoperative opioid use or the quantity of opioids prescribed in a clinical trial or through data published in a peer-reviewed journal, we finalized in the CY 2025 OPPS/ASC final rule with comment period (89 FR 94345) a policy to review all data submitted during the public comment period to determine if the device demonstrates the ability to replace, reduce, or avoid intraoperative or postoperative opioid use or the quantity of opioids. In CY 2025, we encouraged interested parties submitting non-opioid device recommendations to submit any relevant literature that demonstrates that the named medical device replaces, reduces, or avoids opioid use per this statutory provision with their public comments. We review any literature submitted and determine whether it meets this evidence criterion. There is no requirement that commenters submit any data or literature with their device recommendations. If there is no data or literature submitted for a medical device, or if the materials submitted do not demonstrate any ability of the medical device to replace,

reduce, or avoid opioids, the medical device would not meet this evidence criterion and would not qualify for separate payment under section 4135.

d. Non-Opioid Product Indications

(1) FDA-Approved Indications for Drugs and Biologicals

Section 1833(t)(16)(G)(iv)(I) of the Act specifies that to meet the definition of a non-opioid treatment for pain relief and to be eligible for separate payment, a drug or biological product must have a label indication approved by the Food and Drug Administration to reduce postoperative pain, or produce postsurgical or regional analgesia, without acting upon the body's opioid receptors.

Given these statutory requirements, we finalized a policy in the CY 2025 OPPS/ASC final rule with comment period (89 FR 94345 through 94346) only to approve separate payment for drug or biological products with an FDA-approved indication that closely aligns with the statutorily required indication language to reduce post-operative pain or produce post-surgical or regional analgesia. We noted that products without an indication that meets this statutory requirement would not qualify. We specifically stated that products with only a general pain indication will not qualify.

As discussed in the CY 2025 OPPS/ASC final rule with comment period (89 FR 94345 through 94346), we note that the Congress specifically included language at section 1833(t)(16)(G)(iv)(I) of the Act requiring that drugs or biologicals have "a label indication approved by the Food and Drug Administration to reduce postoperative pain, or produce postsurgical or regional analgesia, without acting upon the body's opioid receptors." Therefore, products without an indication that meets the statutory requirement will not qualify.

(2) Intended Use for Medical Devices

Regarding medical devices, section 1833(t)(16)(G)(iv)(II) of the Act specifies that such a device must be used to deliver a therapy to reduce postoperative pain or produce postsurgical or regional analgesia to qualify for separate payment under section 4135. It also must have an

application approved under section 515 of the Federal Food, Drug, and Cosmetic Act (the FD&C Act), have been cleared for market under section 510(k) of the FD&C Act, or be exempt from the requirements of section 510(k) of the FD&C Act pursuant to section 510(l) or (m) or 520(g) of the FD&C Act. For CY 2025, for medical devices, we finalized without modification our proposal that a device must be used to deliver a therapy to reduce postoperative pain or produce postsurgical or regional analgesia to qualify for separate payment under section 4135 (89 FR 94346 through 94347). We also finalized that the medical device must have an application approved under section 515 of the FD&C Act, been cleared for market under section 510(k) of the FD&C Act, or be exempt from the requirements of section 510(k) of the FD&C Act pursuant to sections 510(l) or (m) or 520(g) of the FD&C Act (89 FR 94346 through 94347). This is consistent with the regulation text at 42 CFR 419.43(k)(2)(i) through (iv).

e. Amount of Payment

Section 1833(t)(16)(G)(ii)(I) of the Act provides that, for a non-opioid treatment for pain relief that is a drug or biological product, the amount of separate payment is the amount of payment for such product determined under section 1847A of the Act that exceeds the portion of the otherwise applicable Medicare OPD fee schedule that the Secretary determines is associated with the drug or biological, subject to a limitation, as described in the next section. Section 1833(t)(16)(G)(ii)(II) of the Act provides that, for a non-opioid treatment for pain relief that is a medical device, the amount of separate payment is the amount of the hospital's charges for the device, adjusted to cost, that exceeds the portion of the otherwise applicable Medicare OPD fee schedule that the Secretary determines is associated with the device, subject to a limitation, as described in the next section.

In the CY 2025 OPPS/ASC final rule with comment period, we finalized a policy to assign a payment offset of zero dollars for the qualifying drugs, biologicals, and devices for CY 2025 (89 FR 94347 through 94348). A zero dollar offset means that we would not offset or remove the amount that the non-opioid product represents from the procedure payment rate when

setting payment rates. We finalized a zero dollar offset for the initial year of the policy as some of these products are new products or newly separately paid in the OPPS setting and their costs may not be fully reflected yet in the cost of procedures in which they may be used. Therefore, we stated that the separate payment for a drug or biological would be determined by subtracting from the amount calculated using the methodology outlined in section 1847A of the Act the portion of the otherwise applicable Medicare OPD fee schedule associated with the drug or biological, which as previously discussed, we finalized to be zero dollars for CY 2025. For the amount of payment for a medical device, since we are unable to reduce charges to costs for ASCs, we stated that the separate payment amount would be contractor-priced by the ASC's Medicare Administrative Contractor reduced by the portion of the otherwise applicable Medicare OPD fee schedule amount associated with the medical device, which as previously discussed, we finalized to be zero dollars for CY 2025. These separate payment amounts are all subject to the payment limitation, described in the subsequent section.

Section 1833(i)(10) of the Act establishes the same separate payment for the ASC setting as for hospital outpatient departments, as described in section 1833(t)(16)(G)(ii) of the Act. Both separate payments are subject to the limitation in section 1833(t)(16)(G)(iii) of the Act, which specifies that the separate payment amount shall not exceed the estimated average of 18 percent of the OPD fee schedule amount for the OPD service (or group of services) with which the non-opioid treatment for pain relief is furnished. Given this statutory requirement, we finalized paying the same separate payment amount for qualifying non-opioid products in both the HOPD and ASC settings starting on January 1, 2025 through December 31, 2027.

As the statute requires separate payment for these non-opioid treatments for pain relief, these products cannot be packaged into the procedure payment. Under our current threshold packaging policy, if the estimated per day cost for a drug or biological is less than or equal to the applicable OPPS drug packaging threshold, we package payment for the drug or biological into the payment for the associated procedure. Similarly, under our comprehensive APC (C-APC)

policy, we package all payments for services integral, ancillary, supportive, dependent, and adjunctive to the primary service into a single payment for the primary comprehensive service. For CY 2025, we finalized that non-opioid treatments for pain relief would not be subject to the threshold packaging policy and would also be separately paid when used during a comprehensive APC (C-APC) procedure in the HOPD setting (89 FR 94347 through 94348). See section V.B.1.a. of this final rule with comment period for more information regarding the drug packaging threshold. Section II.A.2.b. of this final rule with comment period contains further information on C-APC packaging.

f. Payment Limitation

Section 1833(t)(16)(G)(iii) of the Act states that the separate payment amount specified in clause (ii), (which is described in the previous section) shall not exceed the estimated average of 18 percent of the OPD fee schedule amount for the OPD service (or group of services) with which the non-opioid treatment for pain relief is furnished, as determined by the Secretary.

In the CY 2025 OPPS/ASC final rule with comment period, we finalized a policy to base the 18 percent payment limitation on the volume weighted average of the payment rates of the top five primary procedures by volume into which a non-opioid treatment for pain relief would have their payment packaged, absent this policy. We also finalized applying the 18 percent payment limitation per date of service billed (89 FR 94349).

g. Payment Limitation with No Claims Data

For drugs, biologicals, and devices with no claims data, such as for newly FDA - approved and marketed products or products that did not previously have their own product-specific HCPCS code by which to track payment and utilization data, we finalized in the CY 2025 OPPS/ASC final rule with comment period (89 FR 94350) a policy where CMS will utilize the services with which a product would be expected to be furnished and would typically be packaged absent this policy, to calculate the payment limitation based on expected clinical use patterns. The finalized policy stated that CMS will determine the service, or group of services,

to use to calculate the payment limitation through engagement with interested parties and a review by CMS Medical Officers and clinical staff during annual rulemaking. In the absence of engagement from interested parties, we will determine clinically appropriate procedures with which we would expect the drug or device to be frequently used in order to determine the payment limitation, including review of FDA approval or other marketing authorization materials, procedures identified in literature available to CMS, and other relevant materials. We noted that we may update the payment limitation amount in future rulemaking as we gather additional claims data on the utilization of and payment for this product.

3. Final CY 2026 Non-Opioid Policy Implementation of Section 4135 of the CAA, 2023

In CY 2026, we finalized to continue the policies implemented in the CY 2025 OPPS ASC final rule (90 FR 53888 through 53909), with minor modifications to permit timely consideration of qualifying products. In that final rule we finalized to maintain a zero-dollar offset for all qualifying products regulated under the non-opioid policy, consistent with our belief that costs for some of these products may not be fully reflected yet in the cost of procedures in which they may be used. Additionally, the data used for CY 2026 ratesetting was derived from CY 2024 claims, which was prior to the effective date of this policy in CY 2025. We also finalized conforming regulatory text changes at 42 CFR 416.174(c)(1) to remove language specific to CY 2025, allowing us to consider or revise the offset amount through annual rulemaking.

We finalized a list of qualifying drugs, biologicals, and devices that meet the statutory criteria for separate payment under section 4135. Similarly, we finalized payment limitation calculations for the qualifying non-opioid products, and finalized our approach to determining those payment limitations based on the proposed procedure payment rates and utilization data available in the CY 2026 OPPS/ASC proposed rule, which we stated was the best data available at the time of writing the CY 2026 OPPS/ASC proposed rule.

In response to public comments, we finalized a modification to allow for more timely consideration of qualifying products by establishing a process to evaluate and approve additional non-opioid treatments for pain relief on a quarterly basis, rather than limiting consideration to annual rulemaking. We also made conforming regulatory text revisions at 42 CFR 419.43(k) and 416.174 to remove references tying qualification only to annual rulemaking.

4. CY 2027 Non-Opioid Policy Implementation of Section 4135 of the CAA, 2023

For CY 2027, we proposed to continue the policies finalized in the CY 2026 OPPS/ASC final rule without modification (90 FR 53448), aside from a technical modification to the payment limitation calculations as described further in this section.

We continued to believe a zero-dollar offset is appropriate for all qualifying products regulated under the non-opioid policy as some of these products are new products or newly separately paid in the OPPS setting and their costs may not be fully reflected in the cost of procedures in which they may be used. Additionally, given the clinical nature of non-opioid treatments for pain relief, they can be used in a variety of procedures, making an APC offset impractical. A continued zero-dollar offset aligns with comment support for a zero-dollar offset as discussed in the CY 2026 OPPS/ASC final rule with comment period (90 FR 53892).

We noted that the payment limitation calculations will now be displayed in a public use file for the proposed rule. The non-opioid payment limitation public use file is available on the CMS website under downloads for the CY 2027 OPPS proposed rule. By including the payment limitations in the public use file, we are able to use the most recently available data to calculate the payment limitations. Accordingly, the final payment limitation calculation in the CY 2027 OPPS/ASC final rule with comment period will be based on the final rule procedure payment rates and utilization data available for the final rule. Therefore, there could be slight changes between the proposed rule payment calculations and the final rule payment calculations as the payment rates and utilization data is updated between the proposed and final rules.

Given our updated policy to evaluate and approve additional non-opioid treatments for pain relief on a quarterly basis, as finalized in the CY 2026 OPPS/ASC final rule with comment period, we anticipated that we would include additional qualifying non-opioid products in the table of qualifying products in the final rule with comment period. For parties interested in submitting additional products for consideration under this policy, we referred readers to the guidance posted on the CMS website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient-pps/non-opioid-treatments-pain-relief*. We stated we would review eligible products as provided in the guidance.

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: Several commenters supported our proposal to continue the policies finalized in the CY 2026 OPPS/ASC final rule with comment period. Commenters supported CMS's continued implementation of separate payments for qualifying non-opioid products under section 4135. Commenters supported the proposed continued exclusion of qualifying products from C-APCs and the proposed changes to 340B drug payment policy for CY 2027. Commenters also supported the proposal to continue to apply a zero-dollar offset, as commenters believed maintaining the current payment methodology during the final year of the statute would help minimize confounding factors to allow CMS to better identify the effects of the policy.

Response: We thank the commenters for their support.

Comment: Some commenters took issue with the statutory 18 percent payment limitation, noting that the cap often results in payment below a facility's documented device cost, leaving hospitals and ASCs to absorb the difference. A commenter encouraged CMS to monitor and report the effect of the statutory 18 percent payment limitation. Another commenter requested that we reevaluate the methodology used to establish the payment limitation for qualifying non-opioid products under section 1833(t)(16)(G)(iii) of the Act. The commenter suggested that rather than relying on a volume-weighted average derived from the top five

primary procedures by volume into which a given product would otherwise be packaged (which may be clinically unrelated), CMS should include device-specific cost information tied to the product's own associated CPT codes, or establish a minimum payment threshold based on documented acquisition costs already recognized through existing hospital cost reporting mechanisms.

Response: We thank the commenters for sharing their concerns. While the 18 percent limitation is a statutory requirement and, so we do not have flexibility under the current statute to remove the 18 percent cap, we agree that the methodology for calculating the payment limitation is a matter within our discretion. At this time, we continue to believe that our existing methodology to calculate the 18 percent limitation for qualifying products is appropriate for several reasons, including that it is consistent with other methodologies, including the transitional pass-through payment methodology under section 1833(t)(6) of the Act, which similarly relies on procedure-based averaging to establish payment amounts. We also believe that by calculating the volume-weighted average across five procedures, rather than a single procedure, provides stability and predictability in payment.

As discussed in prior rulemaking (89 FR 94348), our prior analysis found that approximately 90 percent of the utilization, on average, for these non-opioid products is focused in the top five most frequently performed services for each product. Given this, we believe that using the top five services would provide a representative estimate for purposes of the payment limitation.

Additionally, we remind readers that the statute specifies the additional payment amount specified shall not exceed the estimated average of 18 percent of the OPD fee schedule amount for the OPD service (or group of services) with which the non-opioid treatment for pain relief is furnished, as determined by the Secretary. Therefore, some of the suggestions mentioned by commenters, such as establishing minimum payment thresholds, are not allowable under statute.

We appreciate the suggestions and will consider the commenter's suggested alternatives as part of our ongoing evaluation of the section 4135 payment methodology.

Comment: We received comments requesting that we reconsider our interpretations of the statutory criteria for qualifying products. On the criteria for devices, a commenter suggested that we consider substantial and technical equivalence when evaluating whether devices meet the clinical literature requirement. Specifically, the commenter recommended that CMS clarify that peer-reviewed evidence from technically equivalent or substantially equivalent devices may be considered when evaluating qualification under section 4135, particularly where a device shares the same mechanism of action, intended use, regulatory classification, and HCPCS category as an already recognized technology. Regarding the criteria for drug products, a commenter requested that we broaden our interpretation of the label indication to include drugs that may not have "postoperative" or "postsurgical" in the indication, explicitly.

Response: We thank the commenters for their input. Regarding devices, section 4135 requires that each medical device meets the applicable statutory and regulatory criteria to meet the definition of a non-opioid treatment for pain relief, including the clinical literature requirement. As we have explained in our assessment of products in prior rules, we believe that the device demonstrating the ability to reduce, replace, or avoid opioid use in a clinical trial or peer-reviewed journal must be the same device as the one being studied in order to qualify for separate payment under section 4135 of the CAA, 2023 (90 FR 53898). Approving a device for separate payment under section 4135 based on its similarity to another device that has independently met the criteria would effectively allow a product to qualify without its own supporting clinical evidence. Therefore, we do not believe this approach is consistent with the statute's requirement that qualification be assessed on a product-specific basis.

With regard to drugs, as we stated in prior final rules (89 FR 94246 and 90 FR 53892) we "only approve separate payment for drug or biological products with an FDA-approved indication to reduce post-operative pain or produce post-surgical or regional analgesia. Products

such as those with only a general pain indication will not qualify." As we explained, if there is no mention of postoperative or post-surgical use in the FDA-approved indications for the products being evaluated, they do not meet the statutory requirement. For CY 2027, we continue to believe this approach conforms with the statute. While some commenters have stated that a broad pain indication could include a more specific one we defer to the FDA to approve indications for drugs and biological products, based on the relevant statutory and regulatory authorities, and it is not within our purview to infer indications that have not been specifically finalized in the FDA's review. Therefore, while we understand the commenters' concerns, we decline to change our approach to evaluating qualification for payment under section 4135.

Comment: We received a comment requesting that we look more broadly at how other CMS policies may interact with our implementation of section 4135 in a way that could threaten patient access to non-opioid choices. The commenter specifically noted that two CMMI models, the Transforming Episode Accountability Model (TEAM) and Comprehensive Care for Joint Replacement (CJR-X), could have unintended consequences and limit the effectiveness of the policy changes in the NOPAIN Act.

Response: We thank the commenter for raising these concerns. However, we note that the comments are outside of the scope of this rulemaking.

Comment: One comment recommended that CMS consider additional evidence when evaluating whether non-opioid pain treatments qualify for separate payment, including real-world evidence on clinical outcomes, opioid utilization and overall value. Per the commenter, this approach would help ensure that reimbursable services demonstrate a meaningful impact on reducing opioid use.

Response: We thank the commenter for their suggestion. Under the statutory requirements for qualifying devices, we review submitted clinical trial data or evidence published in peer-reviewed journals to determine whether a device has demonstrated the ability to replace, reduce, or avoid intraoperative or postoperative opioid use, or the quantity of opioids

prescribed, a measure similar to the one the commenter recommends we consider in our review. Under the statutory requirements for qualifying drugs and biological products, we will only approve separate payment, under section 4135, for drug or biological products with an FDA-approved indication that closely aligns with the statutorily required indication language to reduce post-operative pain or produce post-surgical ore regional anesthesia. However, we will consider the ideas submitted by commenters as we consider payment approaches for non-opioid alternatives, as appropriate, in future rulemaking.

Comment: A commenter requested that we consider occupational therapy for separate payment under section 4135.

Response: This policy includes payment for drugs, biologicals, and medical devices; therefore, an occupational therapy service is out of scope for purposes of this final rule with comment period.

Comment: We received a comment regarding the Report to Congress that is required for HHS to complete under the NOPAIN Act by January 1, 2028. The commenter requested that we publish the report, provide a timeline for release, and include data on the effect of the 18 percent payment limitation and a recommendation regarding an extension of the policy.

Response: We thank the commenter for their suggestions. We note this section of the statute is out of scope for purposes of this rulemaking.

Comment: We received several comments asking us to extend separate payments for qualifying products beyond the December 31, 2027, expiration of the NOPAIN Act. Commenters urged CMS to work with Congress to permanently extend or otherwise authorize a long term continuation of the policy beyond CY 2027. Commenters anticipated that adoption of qualifying products will slow with the approaching expiration. Accordingly, commenters believed that extending the separate payment window for qualifying products will allow for increased data collection over a longer period, while allowing hospitals to more clearly observe the benefits to patients and multimodal clinical strategies to manage pain without opioids.

Additionally, some commenters made recommendations for the structure of a new separate payment policy after the current one expires, were we to create a new one. For example, a commenter suggested that we allow for separate payment in both the ASC and OPPS settings.

Response: We understand the commenters' concerns and the significant interest in preparing for the upcoming expiration of the NOPAIN Act. We note that the authority to extend, make permanent, or otherwise modify the duration of the NOPAIN Act rests with Congress. We will continue to implement the policy, as enacted, for the duration of the statutory period.

Comment: We received comments supporting our proposal to continue to provide separate payment for certain qualifying products under section 4135 of the CAA, 2023, including for the Iovera System (C9809), ON-Q Pump (C9804), IceMan (C9810), and Zynrelef (J0668).

Response: We thank the commenters for their support.

Comment: We received a comment requesting that we revise the top 5 primary procedures used to calculate the payment limitation for the SPRINT PNS System (HCPCS code C9807). The commenter suggested that we remove CPT code 64555 as a primary procedure, since it is used to report the implantation of the SPRINT PNS System itself, and so, per the commenter, it should not serve as the basis for calculating the separate payment intended to reimburse the cost of the qualifying non-opioid device.

Response: Section 1833(t)(16)(G)(iii) of the Act directs CMS to calculate the payment limitation based on the OPD service (or group of services) with which the non-opioid treatment is furnished. Since CPT code 64555 describes the implantation procedure through which the SPRINT PNS System is furnished to the patient, we believe continuing to include CPT code 64555 as one of the five procedures upon which to base the payment limitation for the device for CY 2027 is appropriate. Therefore, for CY 2027, we are finalizing to apply our existing methodology to qualifying non-opioid products, including finalizing the top 5 primary procedures we proposed to use to calculate the 18 percent payment limitation. However, we acknowledge that the commenter has raised an interesting point and appreciate the comment.

Comment: A commenter explained that during the first year and a half of implementation of the NOPAIN Act, facilities have struggled to get payment for the applicable products, particularly devices. The commenter mentioned that MACs require facilities to submit certain paperwork, yet still deny claims once all the paperwork has been submitted. The commenter explained that Congress intended for these products to be readily available to Medicare beneficiaries and requested that CMS clearly communicate with the MACs as to how they should facilitate implementation of the NOPAIN Act.

Response: We thank the commenter for noting their concerns. As we have stated in past OPPS/ASC final rules with comment period (see, for example, 87 FR 71879 and 88 FR 81660 through 81661), the fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under the OPPS does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. Coverage of a claim where the qualifying non-opioid product is used would require an independent showing, made at the time the claim is adjudicated, that the service was reasonable and necessary for the individual beneficiary under section 1862(a)(1)(A) of the Act. CMS includes a list of qualifying products, HCPCS codes, and provides annual updates to payment limitation amounts for each qualifying product in quarterly change requests, which MACs review to aid in their review of claims. We would refer the commenter to the appropriate MAC for further questions on particular claims.

After consideration of public comments, we are finalizing our proposal to continue the policies finalized in the CY 2025 OPPS/ASC final rule with comment period with the CY 2026 OPPS/ASC final rule with comment period minor modification to permit more timely consideration of payment requests. Table 96 includes the final list of qualifying products for separate payment under section 4135.

We note that we did not receive any comments to the proposed rule requesting separate payment for a new non-opioid product. However, since the time that the proposed rule was

released, we approved the Stimuplex needles as a qualifying product under our revised process to review non-opioid products for separate payment more frequently than annual rulemaking. As such, the approval is reflected in the table under revised descriptor for HCPCS code C9812.

We remind readers that the payment limitation calculations will now be displayed in a public use file for the final rule. The non-opioid payment limitation public use file is available on the CMS website under downloads for the CY 2027 OPPS final rule. By including the payment limitations in the public use file, we are able to use the most recently available data for this final rule to calculate the payment limitations. Accordingly, the final payment limitation calculation in this final rule with comment period is based on the final rule procedure payment rates and utilization data available for the final rule. Therefore, there could be slight changes between the proposed rule payment calculations and the final rule payment calculations as the payment rates and utilization data is updated between the proposed and final rules.

TABLE 96: FINAL LIST OF QUALIFYING PRODUCTS FOR SEPARATE PAYMENT IN CY 2027 UNDER SECTION 4135 OF THE CAA, 2023

Brand Name	HCPCS Code	Long Descriptor
Exparel	J0666*	Injection, bupivacaine liposome, 1 mg
Omidria	J1097	Phenylephrine 10.16 mg/ml and ketorolac 2.88 mg/ml ophthalmic irrigation solution, 1 ml
Dextenza	J1096	Dexamethasone, lacrimal ophthalmic insert, 0.1 mg
Zynrelef	J0668 (previously C9088**)	Instillation, bupivacaine and meloxicam, 1 mg/0.03 mg
Ketorolac tromethamine Injection	J1885	Injection, ketorolac tromethamine, per 15 mg
Journavx	C9818	Suzetrigine, oral, 1 mg
Caldolor	J1741	Injection, ibuprofen, 100 mg
ON-Q Pump	C9804	Elastomeric infusion pump (e.g., ON-Q* Pump with Bolus), including catheter and all disposable system components, non-opioid medical device (must be a qualifying Medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of the CAA, 2023)
SPRINT Peripheral Nerve Stimulator System	C9807	Nerve stimulator, percutaneous, peripheral (e.g., SPRINT Peripheral Nerve Stimulation System), including electrode and all disposable system components, non-opioid medical device (must be a qualifying Medicare non-

Brand Name	HCPCS Code	Long Descriptor
		opioid medical device for post-surgical pain relief in accordance with section 4135 of the CAA, 2023)
Cryo Nerve Block Therapy	C9808	Nerve cryoablation probe (e.g., cryoICE, cryoSPHERE, cryoSPHERE MAX, cryoICE cryoSPHERE, cryoICE Cryo2), including probe and all disposable system components, non-opioid medical device (must be a qualifying Medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of the CAA, 2023)
ambIT Electronic Infusion Pump	C9806	Rotary peristaltic infusion pump (e.g., ambIT Pump), including catheter and all disposable system components, non-opioid medical device (must be a qualifying Medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of the CAA, 2023)
Iovera System	C9809	Cryoneurolysis needle (e.g., iovera System), including needle/tip and all disposable system components, non-opioid medical device (must be a qualifying Medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of the CAA, 2023)
IceMan	C9810	Water circulating motorized cold therapy device (e.g., IceMan) including all system components (e.g. pads, console, disposable parts), non-opioid medical device (must be a qualifying medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of the cCAA 2023)
Sapphire Infusion Pump	C9811	Electronic ambulatory infusion pump (e.g. Sapphire pump), including all pump components, including disposable components , non-opioid medical device (must be a qualifying Medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of the CAA, 2023)
Ultrasound-visible nerve block needles (SonoPlex, SonoBlock, SonoTap, Stimuplex)	C9812	Echogenic nerve block needles (e.g. SonoPlex, SonoBlock, SonoTap, Stimuplex), non-opioid medical device (must be a qualifying Medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of the CAA, 2023)
Perforated continuous infusion catheter set (InfiltraLong)	C9813	Perforated continuous infusion catheter set (e.g. InfiltraLong), including all components, non-opioid medical device (must be a qualifying Medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of the CAA, 2023)
Continuous anesthesia conduction catheter sets (SonoLong, E-Cath)	C9814	Continuous anesthesia echogenic conduction catheter set (e.g. SonoLong, E-Cath), non-opioid medical device (must be a qualifying Medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of the CAA, 2023)
CADD-Solis infusion pump	C9815	Linear peristaltic pain management infusion pump (e.g. CADD-Solis ambulatory infusion pump), and all disposable system components, non-opioid medical device (must be a qualifying Medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of the CAA, 2023)
ambIT Electronic Infusion Pump (Reusable)	C9816	Rotary peristaltic infusion pump (e.g., reusable ambIT Pump) including all disposable system components, reusable non-opioid medical device (must be a qualifying Medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of the CAA, 2023)
Game Ready System	C9817	Electronic cryo-pneumatic compression, pain management system (e.g. Game Ready® GRPro 2.1 System), including control unit, anatomically correct wrap(s), and other system component(s), non-opioid medical device (must be a qualifying Medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of the CAA, 2023)

*Previously described by HCPCS code C9290.
**HCPCS Code C9088 was replaced by HCPCS code J0668 (Instillation, bupivacaine and meloxicam, 1 mg/0.03 mg) effective October 1, 2025.

F. New Technology Intraocular Lenses (NTIOLs)

New Technology Intraocular Lenses (NTIOLs) are intraocular lenses that replace a patient's natural lens that has been removed in cataract surgery and that also meet the requirements listed in § 416.195.

1. NTIOL Application Cycle

Our process for reviewing applications to establish new classes of NTIOLs is as follows:

- Applicants submit their NTIOL requests for review to CMS by the annual deadline which is announced in the annual OPPS/ASC final rule with comment period. For a request to be considered complete, we require submission of the information requested in the guidance document titled "Application Process and Information Requirements for Requests for a New Class of NTIOLs or Inclusion of an IOL in an Existing NTIOL Class" posted on the CMS website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/new-technology-intraocular-lenses-ntiols*.

- We announce annually, in the CY OPPS/ASC proposed rule updating the ASC and OPPS payment rates for the following calendar year, a list of all requests to establish new NTIOL classes accepted for review during the calendar year in which the proposal is published. In accordance with section 141(b)(3) of Pub. L. 103-432 and our regulations at § 416.185(b), the deadline for receipt of public comments is 30 days following publication of the list of requests to establish a new NTIOL class as published in the proposed rule.

- In the final rule with comment period updating the ASC and OPPS payment rates for the following calendar year, we—

++ Provide a list of determinations made as a result of our review of all new NTIOL class requests and public comments.

++ When a new NTIOL class is created, identify the predominant characteristic of NTIOLs in that class that sets them apart from other IOLs (including those previously approved

as members of other expired or active NTIOL classes) and that is associated with an improved clinical outcome.

++ Set the date of implementation of a payment adjustment in the case of approval of an IOL as a member of a new NTIOL class prospectively as of 30 days after publication of the ASC payment update final rule, consistent with the statutory requirement.

++ Announce the deadline for submitting requests for review of an application for a new NTIOL class for the following calendar year.

2. Requests to Establish New NTIOL Classes for CY 2027

We did not receive any requests for review to establish a new NTIOL class for CY 2027 by March 1, 2026, the due date published in the CY 2026 OPPS/ASC final rule with comment period (90 FR 53909).

3. Payment Adjustment

The current payment adjustment for a 5-year period from the implementation date of a new NTIOL class is $50 per lens. Since implementation of the process for adjustment of payment amounts for NTIOLs in 1999, we have not revised the payment adjustment amount, and we do not propose to revise the payment adjustment amount for CY 2027.

We received public comments on our existing policy. The following is a summary of the comments we received and our response.

Comment: Several commenters supported increasing the New Technology Intraocular Lens additional payment from $50 to $100 per lens for CY 2027. The commenters stated that the payment has remained unchanged since the NTIOL policy was established in 1999 and no longer reflects inflation, research and development costs, or advances in lens technology. The commenters stated that a higher payment would encourage innovation and improve beneficiary access to lenses addressing unmet needs following cataract surgery. Some commenters also requested annual updates to the NTIOL payment and annual publication of active NTIOL classes to provide greater transparency, permit submission of new applications, and encourage renewed

participation in the program.

Response: We responded to this comment in the CY 2024 OPPS/ASC final rule with comment period (88 FR 81955 through 81956). We refer readers to that final rule with comment period for our response on an increase to the NTIOL $50 per lens payment adjustment. All historical NTIOL classes are publicly available in the NTIOL Application Determination Reference Document on the CMS website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/new-technology-intraocular-lenses-ntiols*. There are currently no active NTIOL classes.

4. Announcement of CY 2028 Deadline for Submitting Requests for CMS Review of Applications for a New Class of NTIOLs

The current payment adjustment for a 5-year period from the implementation date of a new NTIOL class is $50 per lens. Since implementation of the process for adjustment of payment amounts for NTIOLs in 1999, we have not revised the payment adjustment amount, and we do not propose to revise the payment adjustment amount for CY 2027.

In accordance with § 416.185(a) of our regulations, CMS announces that to be considered for payment effective beginning in CY 2027, request for review of applications for a new class of new technology IOLs must be received by 5 p.m. Eastern Standard Time, on March 1, 2027. Send requests via email to outpatientpps@cms.hhs.gov or by mail to ASC/NTIOL, Division of Outpatient Care, Mailstop C4–05–07, Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244–1850. To be considered, requests for NTIOL reviews must include information requested on the CMS website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/newtechnology-intraocular-lenses-ntiols*.

G. Proposed Calculation of the ASC Payment Rates and the ASC Conversion Factor

1. Background

In the August 2, 2007 ASC final rule (72 FR 42493), we established our policy to base ASC relative payment weights and payment rates under the revised ASC payment system on APC groups and the OPPS relative payment weights. Consistent with that policy, and the requirement at section 1833(i)(2)(D)(ii) of the Act that the revised payment system be implemented so that it would be budget neutral, the initial ASC conversion factor (CY 2008) was calculated so that estimated total Medicare payments under the revised ASC payment system in the first year would be budget neutral to estimated total Medicare payments under the prior (CY 2007) ASC payment system (the ASC conversion factor is multiplied by the relative payment weights calculated for many ASC services in order to establish payment rates). That is, application of the ASC conversion factor was designed to result in aggregate Medicare expenditures under the revised ASC payment system in CY 2008 being equal to aggregate Medicare expenditures that would have occurred in CY 2008 in the absence of the revised system, taking into consideration the cap on ASC payments in CY 2007, as required under section 1833(i)(2)(E) of the Act (72 FR 42522). We adopted a policy to make the system budget neutral in subsequent calendar years (72 FR 42532 through 42533; § 416.171(e)).

In the CY 2008 OPPS/ASC final rule with comment period (72 FR 66857 through 66858), we set out a step-by-step illustration of the final budget neutrality adjustment calculation based on the methodology finalized in the August 2, 2007 ASC final rule (72 FR 42521 through 42531) and as applied to updated data available for the CY 2008 OPPS/ASC final rule with comment period. The application of that methodology to the data available for the CY 2008 OPPS/ASC final rule with comment period resulted in a budget neutrality adjustment of 0.65.

For CY 2008, we adopted the OPPS relative payment weights as the ASC relative payment weights for most services and, consistent with the final policy, we calculated the CY 2008 ASC payment rates by multiplying the ASC relative payment weights by the final CY 2008 ASC conversion factor of $41.401. For covered office-based surgical procedures,

covered ancillary radiology services (excluding covered ancillary radiology services involving certain nuclear medicine procedures or involving the use of contrast agents, as discussed in section XIII.D.2. of the CY 2023 OPPS/ASC proposed rule (87 FR 44715 through 44716)), and certain diagnostic tests within the medicine range that are covered ancillary services, the established policy is to set the payment rate at the lower of the PFS unadjusted nonfacility PE RVU-based amount or the amount calculated using the ASC standard ratesetting methodology. Further, as discussed in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66841 through 66843), we also adopted alternative ratesetting methodologies for specific types of services (for example, device-intensive- procedures).

As discussed in the August 2, 2007 ASC final rule (72 FR 42517 through 42518) and as codified at § 416.172(c) of the regulations, the revised ASC payment system accounts for geographic wage variation when calculating individual ASC payments by applying the pre-floor and pre-reclassified IPPS hospital wage indexes to the labor-related share, which is 50 percent of the ASC payment amount based on a GAO report of ASC costs using 2004 survey data. Beginning in CY 2008, CMS accounted for geographic wage variation in labor costs when calculating individual ASC payments by applying the pre-floor and pre-reclassified hospital wage index values that CMS calculates for payment under the IPPS, using updated Core Based Statistical Areas (CBSAs) issued by OMB in June 2003.

The reclassification provision in section 1886(d)(10) of the Act is specific to acute care hospitals. We believe that using the most recently available pre-floor and pre-reclassified IPPS hospital wage indexes result in the most appropriate adjustment to the labor portion of ASC costs. We continue to believe that the pre-floor, pre-reclassified hospital wage indexes, which are updated yearly and are used by several other Medicare payment systems, appropriately account for geographic variation in labor costs for ASCs (89 FR 23424). -Therefore, the wage index for an ASC is the pre-floor and pre-reclassified hospital wage index for the fiscal year under the IPPS of the CBSA that maps to the CBSA where the ASC is located.

On July 21, 2023, OMB issued OMB Bulletin No. 23-01, which provided the delineations of all Metropolitan Statistical Areas, Metropolitan Divisions, Micropolitan Statistical Areas, Combined Statistical Areas, and New England City and Town Areas in the U.S. and Puerto Rico based on the standards published on July 16, 2021, in the **Federal Register** (86 FR 37770) and 2020 Census Bureau data. (A copy of this bulletin may be obtained at *https://www.whitehouse.gov/wp-content/uploads/2023/07/OMB-Bulletin-23-01.pdf*.) As discussed in the FY 2025 IPPS/LTCH PPS final rule with comment period (89 FR 69253 through 69266), we finalized our proposal to use the new CBSAs delineations issued by OMB in OMB Bulletin No. 23-01 for the IPPS hospital wage index beginning in CY 2025. Therefore, because the ASC wage indexes for the calendar year are the pre-floor and pre-reclassified IPPS hospital wage indexes for the fiscal year, in the CY 2025 OPPS/ASC final rule with comment period (89 FR 94362 through 94363) we finalized our proposal to include the new OMB delineations into CY 2025 ASC wage indexes. We believe that using the revised delineations based on OMB Bulletin No. 23-01 will increase the integrity of the ASC wage index system by creating a more accurate representation of current geographic variations in wage levels. In addition to adopting the revised delineations based on OMB Bulletin No. 23-01, we also finalized our proposal to limit year-to-year ASC wage index value changes to no more than a 5-percent decrease, similar to the policy of other Medicare payment systems under Parts A and B. This 5-percent cap, implemented in a budget neutral manner through the wage index scalar, mitigates any large negative impacts of adopting the new delineations and prevents large year-to-year declines in wage index values as a means to reduce volatility in Medicare payments.

The proposed CY 2027 ASC wage indexes reflect the OMB labor market area delineations (including the revisions to the OMB labor market delineations discussed previously, as set forth in OMB Bulletin No. 23-01). We note that, in certain instances, there might be urban or rural areas for which there is no IPPS hospital that has wage index data that could be used to set the wage index for that area. When all of the areas contiguous to the CBSA of interest are

rural and there is no IPPS hospital that has wage index data that could be used to set the wage index for that area, our policy has been to determine the ASC wage index by calculating the average of all wage indexes for urban areas in the State (75 FR 72058 through 72059). For CY 2026, we applied this methodology to ASCs located in CBSA 35 (Rural North Dakota) (90 FR 53911). For CY 2027, we proposed to continue to apply a proxy wage index based on this methodology to ASCs located in CBSA 35 (Rural North Dakota). In other situations, where there are no IPPS hospitals located in a relevant labor market area, we apply our current policy of calculating an urban or rural area's wage index by calculating the average of the wage indexes for CBSAs (or metropolitan divisions where applicable) that are contiguous to the area with no wage index. For CY 2027, we proposed that we continue to apply a proxy wage index based on this methodology to ASCs located in CBSA 25980 (Hinesville, GA). Further, the proposed CY 2027 ASC wage index includes our policy finalized in the CY 2025 OPPS/ASC final rule with comment period that limits wage index changes to decrease by no more than 5 percent from the final CY 2026 ASC wage index value. As we discussed in the April 2025 Update to the Ambulatory Surgical Center Payment System (Change Request 14017), to limit wage index changes by no more than 5 percent from the final CY 2026 ASC wage index, some counties may require a transition CBSA before being fully reflected in the OMB labor market delineations as set forth in OMB Bulletin No. 23-01.

We received one public comment on our proposal. The following is a summary of the comment we received and our response.

Comment: A commenter supported policies to mitigate the effects of inadequate wage indices on rural ASCs and requested greater alignment between the ASC and OPPS wage-index methodologies. The commenter stated that, unlike hospitals, ASCs cannot obtain geographic reclassification to another labor market area and do not receive the frontier-state wage-index floor of 1.0. As an example, the commenter noted that the projected CY 2027 rural wage index applicable to ASCs in South Dakota is 0.7979, while hospitals in the State receive a wage index

of at least 1.0 under the frontier-state floor. The commenter requested that CMS extend hospital geographic-reclassification and frontier-state wage-index-floor policies to ASCs.

Response: We appreciate the concerns the commenter has raised. The reclassification provision in section 1883(d)(10) of the Act is specific to acute care hospitals. The reclassification provision does not apply to an area but reflects the circumstances of the reclassified hospital and its own reported wages. Therefore, complete alignment between ASC and OPPS wage index methodologies is not currently possible. While we believe that using the most recently available pre-floor and pre-reclassified IPPS hospital wage indexes results in the most appropriate adjustment to the labor portion of ASC costs, we will continue to monitor wage index differences between the OPPS and ASC payment systems and may take the commenter's recommendation into consideration in future rulemaking.

After consideration of public comments we received, we are finalizing our proposal to use the most recently available pre-floor and pre-reclassified IPPS hospital wage indexes to the labor-related share to create the final CY 2027 ASC wage indexes and to limit wage index decreases by no more than 5 percent from the final CY 2026 ASC wage index for a particular CBSA. The final CY 2027 ASC wage indexes reflect the OMB labor market area delineations (including the revisions to the OMB labor market delineations discussed previously, as set forth in OMB Bulletin No. 23–01) unless the county is otherwise in a transition CBSA. Additionally, based on the absence of IPPS hospitals, we are also finalizing our proposal to apply a proxy wage index based to ASCs located in CBSA 25980 (Hinesville, GA) and in CBSA 35 (Rural North Dakota).

2. Calculation of the ASC Payment Rates

a. Updating the ASC Relative Payment Weights for CY 2027 and Future Years

We update the ASC relative payment weights each year using the national OPPS relative payment weights (and PFS nonfacility PE RVU-based amounts, as applicable) for that same calendar year and uniformly scale the ASC relative payment weights for each update year to

make them budget neutral (72 FR 42533). The OPPS relative payment weights are scaled to maintain budget neutrality for the OPPS. We then scale the OPPS relative payment weights again to establish the ASC relative payment weights. To accomplish this, we hold estimated total ASC payment levels constant between calendar years for purposes of maintaining budget neutrality in the ASC payment system. That is, we apply the weight scalar to ensure that projected expenditures from the updated ASC payment weights in the ASC payment system are equal to what would be the current expenditures based on the scaled ASC payment weights. In this way, we ensure budget neutrality and that the only changes to total payments to ASCs result from increases or decreases in the ASC payment update factor.

As discussed in section II.A.1.a. of this final rule with comment period, we are using the CY 2025 claims data to be consistent with the OPPS claims data for this final rule with comment period. Consistent with our established policy, we proposed to scale the CY 2027 relative payment weights for ASCs according to the following method. Holding ASC utilization, the ASC conversion factor, and the mix of services constant from CY 2025, we proposed to compare the estimated total payment using the CY 2026 ASC relative payment weights with the estimated total payment using the CY 2027 ASC relative payment weights to take into account the changes in the OPPS relative payment weights between CY 2026 and CY 2027.

In consideration of our policy to provide a higher ASC payment rate with ASC complexity adjustment codes for certain primary procedures when performed with add-on packaged services, we included estimated total spending and estimated utilization for these codes in our budget neutrality calculation for CYs 2023 and 2024. For this final rule with comment period, our proposed ASC complexity adjustment codes for CY 2027 did not impact the ASC weight scalar.

Additionally, as discussed in section XIII.E. of the CY 2025 OPPS/ASC final rule with comment period (89 FR 94342 through 94361), section 4135(a) and (b) of the CAA, 2023, titled "Access to Non-Opioid Treatments for Pain Relief", amended sections 1833(t)(16) and 1833(i)

of the Act, respectively, to provide for temporary separate payments for non-opioid treatments for pain relief. As discussed in further detail in section XIII.E. of the CY 2025 OPPS/ASC final rule with comment period, for qualifying non-opioid products, we finalized applying an 18 percent payment limitation on the volume-weighted payment average of the top 5 services associated with the use of the qualifying non-opioid product. In CY 2024, four of these qualifying nonopioid products were separately payable without the 18 percent payment limitation – HCPCS Codes C9089 (Bupivacaine implant, 1 mg), J0666 (Inj, bupivacaine liposome), J1096 (Dexametha opth insert 0.1 mg), and J1097 (Phenylep ketorolac opth soln). Therefore, to maintain budget neutrality, we estimated the total anticipated reduction in ASC spending for these qualifying non-opioid products for CY 2025 as a result of the 18 percent payment limitation required by section 4135 of the CAA, 2023. Based on the updated 18 percent payment limitations and CY 2025 utilization, we estimate that the proposed CY 2027 payment limitations will not impact the ASC weight scalar.

We proposed to use the ratio of estimated CY 2026 to estimated CY 2027 total payments (the weight scalar) to scale the proposed ASC relative payment weights for CY 2027. The proposed CY 2027 ASC weight scalar was 0.809. Consistent with historical practice, we proposed to scale, using this method (with an ASC weight scalar rounded to the nearest thousandth), the ASC relative payment weights of covered surgical procedures, covered ancillary radiology services, and certain diagnostic tests within the medicine range of CPT codes, which are covered ancillary services for which the ASC payment rates are based on OPPS relative payment weights.

We proposed that we would not scale ASC payment for separately payable covered ancillary services that have a predetermined national payment amount (that is, their national ASC payment amounts are not based on OPPS relative payment weights), such as drugs and biologicals that are separately paid or services that are contractor-priced or paid at reasonable cost in ASCs. Any service with a predetermined national payment amount, would be included in

the ASC budget neutrality comparison, but scaling of the ASC relative payment weights would not apply to those services or the portion of those services. The ASC payment weights for those services without predetermined national payment amounts would be scaled to eliminate any difference in the total payment between the current year and the update year.

Historically, the device portions of device-intensive procedures were not scaled so that payment for device portions would remain constant between the OPPS and ASC payment systems. However, due to increased utilization of orthopedic procedures in the ASC setting, ASC expenditures on device portions of device-intensive procedures represent a substantially larger share of total ASC expenditures than in prior years. We estimate that spending attributable to device portions increased from approximately 5.4 percent of total ASC expenditures in CY 2016 to roughly 32.4 percent of total ASC expenditures in 2026. As device expenditures account for an increasingly significant share of total ASC spending, large year-to-year increases in the estimated device portions of surgical procedures require correspondingly larger reductions to the non-device portions of surgical procedures and certain ancillary services to maintain budget neutrality.

The change in the proposed ASC weight scalar for CY 2027 illustrates this effect. Specifically, the ASC weight scalar would decrease from 0.872 in CY 2026 to a proposed 0.809 in CY 2027. This reduction is largely attributable to the substantial increase in expenditures for device portions of device-intensive procedures under the ASC payment system. In turn, this increase in device portions results from the proposed budget-neutral increase in OPPS payment rates for surgical procedures that would offset the drug payment reductions associated with our proposed payment policy for 340B acquired drugs as a result of the OPPS Drug Acquisition Cost Survey.

As the ASC payment system uses the OPPS conversion factor to determine payment for the device portions of device-intensive procedures, this alters the payment relativity between services under the OPPS because the entire portion of ASC payment rates for non-device-

intensive procedures is based on the lower ASC conversion factor. Because of the proposed large increase in the device portions for device-intensive procedures in CY 2027 as a result of the proposed 340B drug payment policy, we solicited comment on whether the device portions of device-intensive procedures calculated using the OPPS conversion factor should continue to be excluded from the ASC weight scaler, or alternatively, whether these device portions should be subject to scaling through the ASC weight scaler. We estimated that treating device expenditures for device-intensive procedures as scalable prospective expenditures would increase the proposed ASC weight scaler from 0.809 to 0.865 in CY 2027 and would reduce the device portions of device intensive procedures by approximately 14 percent.

For any given year's ratesetting, we typically use the most recent full calendar year of claims data to model budget neutrality adjustments. We proposed to use the CY 2025 claims data to model our budget neutrality adjustment for CY 2027.

We received public comments on our proposal. The following is a summary of the comments we received and our responses.

Comment: Commenters opposed the proposed CY 2027 ASC weight scalar of 0.809, stating that the secondary scaling adjustment unnecessarily reduces ASC payments, widens the disparity with HOPD payments, and discourages migration to lower-cost ASCs. Many commenters urged CMS to eliminate the ASC weight scalar because continued annual application is not statutorily required, or alternatively to establish a single budget-neutrality calculation using combined OPPS and ASC utilization and service mix. Some commenters supported CMS's alternative of including device portions of device-intensive procedures in scalable expenditures, which would increase the scalar to approximately 0.865 and mitigate reductions for non-device-intensive services, although some recommended phasing in or partially applying this approach. Other commenters opposed scaling device portions because device acquisition costs are fixed and warned that the resulting approximately 14-percent reduction could impair access to device-intensive procedures. These commenters recommended

maintaining the device-payment exclusion and instead removing the 340B-related OPPS conversion-factor increase from the ASC ratesetting and scalar calculations so that a hospital drug-payment policy does not distort ASC payment rates.

Response: We appreciate the public comments we received on our proposed ASC weight scalar for CY 2027 and our comment solicitation on whether the device portions of device-intensive procedures calculated using the OPPS conversion factor should continue to be excluded from the ASC weight scalar, or alternatively, whether these device portions should be included in the expenditures subject to scaling through the ASC weight scalar. We agree with commenters that our budget neutrality adjustment places the budget neutrality burden on non-device portions of surgical procedures subject to the ASC weight scalar; however, we remain concerned with both the potential payment reduction and payment asymmetry between the OPPS and ASC payment systems from applying the ASC weight scalar to the device portions of device-intensive procedures. We believe that applying the ASC weight scalar to device portions of device-intensive procedures would significantly reduce the ASC payment rate for such procedures and could potentially reduce future access to device-intensive procedures in the ASC setting which are predominantly performed in the hospital outpatient setting. For these reasons, we are not revising our methodology to include device portions as subject to scaling through the ASC weight scalar. We also considered the commenters' recommendation to use an OPPS conversion factor that excludes the 340B-related OPPS budget neutrality adjustment. Unfortunately, this approach would introduce the same payment asymmetry between the OPPS and ASC payment systems for device portions of device-intensive procedures as applying the ASC weight scalar to device portions as well as continuing the budget neutrality burden placed on non-device portions. For these reasons, we did not believe adopting an alternative OPPS conversion factor was appropriate. Therefore, for CY 2027, we are finalizing our proposal to continue our longstanding policy of using the ratio of total payments based on the CY 2026 relative payment weights to total payments based on the CY 2027 relative payment weights to scale the ASC

relative payment weights, while continuing to exclude the device portions of device-intensive procedures from expenditures subject to scaling. We will continue to explore alternative methodologies that maintain budget neutrality under the ASC payment system – which preserves the Part B trust fund and reduces beneficiary cost-sharing – while advancing payment policies that expand access to site-neutral options for beneficiaries.

Comment: Commenters opposed proposed CY 2027 ASC payment reductions for ophthalmic, interventional pain, and dialysis vascular-access procedures. Commenters stated that the reductions would occur despite the overall ASC payment update and, in some cases, while corresponding HOPD payments would increase. They stated that the reduced payments do not adequately reflect the costs of the staff, supplies, devices, imaging, equipment, and other resources required to furnish these services, particularly in independent and rural ASCs. Commenters expressed concern that continued reductions could limit access, encourage consolidation, delay time-sensitive care, or shift services to more costly HOPDs or other less desirable treatment alternatives.

With respect to ophthalmic services, commenters opposed reductions for cataract, glaucoma, retinal, and other procedures, including vitreoretinal procedures described by CPT codes 67036, 67041 through 67043, 67108, 67110, 67113, 67210, 67227, and 67228. Commenters requested that CMS verify that the claims data capture all associated device, supply, and equipment costs; consider HOP Panel review and site-of-service substitution; publish relevant claims-volume and trimming information; and provide procedure-specific explanations for any reductions that are finalized. Commenters also requested that CMS reverse or reassess reductions for interventional pain procedures described by CPT codes 62321, 62323, 64479, 64483, 64490, 64493, 64633, and 64635 and evaluate the cumulative effects of successive payment reductions on beneficiary access. Finally, commenters opposed the effect of the reduced ASC weight scalar on dialysis vascular-access services, particularly non-device-intensive procedures such as CPT code 36902 and supported including device expenditures in

the weight-scalar calculation. Commenters generally requested that CMS adopt payment methodologies that more accurately recognize ASC resource costs, stabilize or increase payment for these services, and preserve access to care in lower-cost non-hospital settings.

Response: We appreciate the comments regarding our proposed CY 2027 ASC payment rates for the procedures identified by the commenters and understand the concerns raised regarding the potential effects of payment reductions on beneficiary access. ASCs currently do not submit cost reports, so the absence of these data limits our ability to independently assess whether our proposed rates adequately reflect the costs of the staff, supplies, devices, imaging, equipment, and other resources. Additionally, the HOP Panel advises on OPPS matters and the ASC budget neutrality calculation is outside the scope of its charter. We did not revise claims trimming or the underlying ratesetting methodology involved – the payment rate reductions for these procedures are driven by the ASC budget neutrality adjustment providing a corresponding decrease in total nondevice portion expenditures in response to the increase in OPPS device portion expenditures adopted under the ASC payment system.

For the reasons previously described with respect to our budget neutrality methodology, we are finalizing our longstanding budget neutrality calculation because of concerns about underpayment of the significant device costs associated with device-intensive procedures and the importance of preserving beneficiary access to device-intensive procedures in the ASC setting. We intend to continue monitoring beneficiary access to non-device-intensive procedures in the ASC setting and may consider future payment policies to address this issue.

After consideration of the public comments we received, we are finalizing our proposal to use scaled OPPS relative weights to establish ASC relative payment weights and to use the ratio of CY 2026 to CY 2027 total payments (the weight scalar) to ASC relative payment weights for CY 2027. We are also finalizing our proposal to continue using the OPPS conversion factor, which we are finalizing as $99.970 for CY 2027 in this final rule with comment period, to continue maintaining device portions between the OPPS and ASC payment systems for device-

intensive surgical procedures. While we understand the concerns raised by interested parties regarding the payment reductions for non device-intensive procedures for CY 2027, we currently are not adopting an alternative methodology and are maintaining our longstanding calculation of budget neutrality under the ASC payment system and holding device portions constant between the OPPS and ASC payment systems for device-intensive procedures. We will continue to explore alternative methodologies to address concerns with the payment rates for non-device intensive procedures under the ASC payment system while providing budget neutrality under the ASC payment system for future rulemaking. The final CY 2027 ASC weight scalar is 0.814. Consistent with historical practice, we are finalizing our proposal to scale the ASC relative payment weights of covered surgical procedures, covered ancillary radiology services, and certain diagnostic tests within the medicine range of CPT codes, which are covered ancillary services for which the ASC payment rates are based on OPPS relative payment weights.

b. Updating the ASC Conversion Factor

Under the OPPS, we typically apply a budget neutrality adjustment for provider-level changes, most notably a change in the wage index values for the upcoming year, to the conversion factor. Consistent with our final ASC payment policy, for the CY 2017 ASC payment system and subsequent years, in the CY 2017 OPPS/ASC final rule with comment period (81 FR 79751 through 79753), we finalized our policy to calculate and apply a budget neutrality adjustment to the ASC conversion factor for supplier-level changes in wage index values for the upcoming year, just as the OPPS wage index budget neutrality adjustment is calculated and applied to the OPPS conversion factor.

For CY 2027, we calculated the proposed adjustment for the ASC payment system by using the most recent CY 2025 claims data available and estimating the difference in total payment that would be created by introducing the proposed CY 2027 ASC wage indexes. Specifically, holding CY 2025 ASC utilization, service-mix, and the proposed CY 2027 national payment rates after application of the weight scalar constant, we calculated the total adjusted

payment using the CY 2026 ASC wage indexes and the total adjusted payment using the proposed CY 2027 ASC wage indexes which included the 5-percent cap on wage index decreases for an ASC. We used the 50 percent labor-related share for both total adjusted payment calculations. We then compared the total adjusted payment calculated with the CY 2026 ASC wage indexes to the total adjusted payment calculated with the proposed CY 2027 ASC wage indexes and applied the resulting ratio of 1.0016 (the proposed CY 2027 ASC wage index budget neutrality adjustment) to the CY 2026 ASC conversion factor to calculate the proposed CY 2027 ASC conversion factor.

Section 1833(i)(2)(D)(v) of the Act requires that the ASC conversion factor be reduced by a productivity adjustment in each calendar year. Section 1886(b)(3)(B)(xi)(II) of the Act defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multifactor productivity (MFP). We finalized the methodology for calculating the productivity adjustment in the CY 2011 PFS final rule with comment period (75 FR 73394 through 73396) and revised it in the CY 2012 PFS final rule with comment period (76 FR 73300 through 73301) and the CY 2016 OPPS/ASC final rule with comment period (80 FR 70500 through 70501). The proposed productivity adjustment for CY 2027 was projected to be 0.8 percentage point, as published in the FY 2027 IPPS/LTCH PPS proposed rule (91 FR 19496) based on IGI's 2025 fourth quarter forecast.

Section 1833(i)(2)(C)(i) of the Act requires that, if the Secretary has not updated amounts established under the revised ASC payment system in a calendar year, the payment amounts shall be increased by the percentage increase in the Consumer Price Index for all urban consumers (CPI-U), U.S. city average, as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved. The statute does not mandate the adoption of any particular update mechanism, but it requires the payment amounts to be increased by the CPI-U in the absence of any update. Because the Secretary updates the ASC payment amounts

annually, we adopted a policy, which we codified at § 416.171(a)(2)(ii)), to update the ASC conversion factor using the CPI-U for CY 2010 and subsequent calendar years.

In the CY 2019 OPPS/ASC final rule with comment period (83 FR 59075 through 59080), we finalized a policy to apply the hospital market basket update (which is the inpatient hospital market basket percentage increase reduced by the productivity adjustment) to ASC payment system rates for an interim period of 5 years (CY 2019 through CY 2023), during which we would assess whether there was a migration of the performance of procedures from the hospital setting to the ASC setting as a result of the use of a hospital market basket update, as well as whether there were any unintended consequences, such as less than expected migration of the performance of procedures from the hospital setting to the ASC setting. At that time, the most recently available full year of claims data to assess the expected migration applying the productivity-adjusted hospital market basket update during the interim period was within the period from CY 2019 through CY 2022. However, the impact of the COVID-19 PHE on health care utilization, CY 2020 in particular, was tremendously profound, particularly for elective surgeries, because many beneficiaries avoided healthcare settings, when possible, to avoid possible infection from the SARS-CoV-2 virus. As a result, it was nearly impossible to disentangle the effects from the COVID-19 PHE in our analysis of whether the higher update factor for the ASC payment system caused increased migration to the ASC setting. To analyze whether procedures migrated from the hospital setting to the ASC setting, we needed to use claims data from a period during which the COVID-19 PHE had less of an impact on health care utilization. Therefore, for CY 2024, we finalized our proposal to extend the 5-year interim period an additional 2 years through CY 2024 and CY 2025 which we subsequently extended through CY 2026 in the CY 2026 OPPS/ASC final rule with comment period (90 FR 53914 through 53915). We believed hospital outpatient and ASC utilization data from CYs 2023 through 2025 would enable us to more accurately analyze whether the application of the hospital market basket update to the ASC payment system had an effect on the migration of services from

the hospital setting to the ASC setting. We revised our regulations at § 416.171(a)(2)(iii), (iv), (vi), (vii), and (viii) which establish the annual update to the ASC conversion factor, to reflect these extensions.

For the CY 2027 OPPS/ASC proposed rule, we proposed to extend our utilization of the hospital market basket update factor in the ASC payment system for one additional year, through CY 2027, as we continue to review and evaluate hospital outpatient and ASC utilization data, as well as the migration of surgical procedures between settings. In conjunction with our proposal, we proposed revising our regulations at § 416.171(a)(2)(iii), (iv), (vi), (vii), and (viii), which establish the annual update to the ASC conversion factor, the 2.0 percentage point reduction for ASCs that fail to meet the standards for reporting ASC quality measures, and the productivity adjustment, to reflect this one-year extension.

We received public comments on this proposal. The following is a summary of the comments we received and our responses.

Comment: Most commenters supported CMS's proposal to extend use of the productivity-adjusted hospital market basket, rather than the CPI-U, as the ASC payment update factor through CY 2027. Commenters stated that the hospital market basket better reflects ASC cost growth because ASCs purchase similar supplies, equipment, devices, and implants as HOPDs and compete for the same clinical workforce. They also stated that aligning the ASC and OPPS update factors supports migration to lower-cost ASCs, reduces payment disparities, and generates Medicare and beneficiary savings, and many commenters urged CMS to make the hospital market basket update policy permanent rather than extending it for one year. Other commenters opposed the extension, stating that hospitals and ASCs have different cost structures and patient populations and that the hospital market basket does not accurately measure ASC input costs. These commenters recommended that CMS collect minimally burdensome ASC cost data and develop an ASC-specific market basket, while some supporters stated that any new index should apply consistently to both ASCs and HOPDs to preserve alignment between the

payment systems.

Response: We appreciate the feedback from commenters. We did not propose to collect ASC-specific cost data in our CY 2027 OPPS/ASC proposed rule. ASCs currently do not submit cost reports, so we are unable to discern if there is a meaningful difference in the cost structures between the hospital and ASC setting and if such differences would necessitate a different update factor. We agree with commenters that providing the same annual update mechanism under the OPPS and ASC payment systems can support the migration of services to the lower-cost ASC setting. We are finalizing our proposal to apply the productivity-adjusted hospital market basket update to the ASC payment system for CY 2027.

2. CY 2027 Final ASC Conversion Factor

For CY 2027, we finalized our proposal to utilize the final inpatient hospital market basket percentage increase of 3.2 percent reduced by the productivity adjustment of 0.9 percentage point, resulting in a final hospital market basket update of 2.3 percent for ASCs meeting the quality reporting requirements. Therefore, we are finalizing our proposal to apply a 2.3 percent hospital market basket update factor to the CY 2026 ASC conversion factor for ASCs meeting the quality reporting requirements to determine the CY 2027 ASC payment amounts. The ASCQR Program affected payment rates beginning in CY 2014 and, under this program, there is a 2.0 percentage point reduction to the hospital market basket update factor for ASCs that fail to meet the ASCQR Program requirements. We refer readers to section XIV.E. of the CY 2019 OPPS/ASC final rule with comment period (83 FR 59138 through 59139) and section XIV.E. of this final rule with comment period for a detailed discussion of our policies regarding payment reduction for ASCs that fail to meet ASCQR Program requirements.

For CY 2027, we are adjusting the CY 2026 ASC conversion factor ($56.322) by a wage index budget neutrality factor of 1.0018 in addition to the productivity-adjusted hospital market basket update of 2.3 percent, discussed previously, which results in a final CY 2027 ASC conversion factor of $57.721 for ASCs meeting quality reporting requirements. For ASCs not

meeting quality reporting requirements, we are adjusting the CY 2026 ASC conversion factor ($56.322) by the wage index budget neutrality factor of 1.0018 in addition to the reduced productivity-adjusted hospital market basket update of 0.3 percent, discussed previously, which results in a final CY 2027 ASC conversion factor of $56.592 for ASCs not meeting the quality reporting requirements.

3. Display of the Final CY 2027 ASC Payment Rates

Addenda AA and BB to this final rule with comment period (which are available on the CMS website) display the final ASC payment rates for CY 2027 for covered surgical procedures and covered ancillary services, respectively. The final payment rates included in Addenda AA and BB to this final rule with comment period reflect the full ASC payment update and not the reduced payment update used to calculate payment rates for ASCs not meeting the quality reporting requirements under the ASCQR Program.

These Addenda contain several types of information related to the final CY 2027 payment rates. Specifically, in Addendum AA, a "Y" in the column titled "To be Subject to Multiple Procedure Discounting" indicates that the surgical procedure would be subject to the multiple procedure payment reduction policy. As discussed in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66829 through 66830), most covered surgical procedures are subject to a 50 percent reduction in the ASC payment for the lower-paying procedure when more than one procedure is performed in a single operative session.

Comment: Numerous commenters opposed CMS' proposed change from "No" to "Yes" for multiple-procedure discounting of device-intensive procedures, including CPT codes 54401, 54405, 54410, 54416, 63650, 63655, 63663, 63664, 63685, 64553, 64555, 64561, 64575, and 64590, and requested continuation of the current exemption.

Response: The change to these procedures' multiple procedure discount status in the proposed rule Addendum AA was inadvertent and not an intentional proposed policy change.

Therefore, for CY 2027, we are not finalizing the proposed change in the multiple-

procedure discounting designation for CPT codes 54401, 54405, 54410, 54416, 63650, 63655, 63663, 63664, 63685, 64553, 64555, 64561, 64575, and 64590. These procedures will continue to be identified with an "N" in the "Subject to Multiple Procedure Discounting" column of ASC Addendum AA. The values displayed in the column titled "Final CY 2027 Payment Weight" are the final relative payment weights for each of the listed services for CY 2027. The final relative payment weights for all covered surgical procedures and covered ancillary services where the ASC payment rates are based on OPPS relative payment weights were scaled for budget neutrality. Therefore, scaling was not applied to the device portion of the device-intensive- procedures; services that are paid at the PFS nonfacility PE RVU-based amount; separately payable covered ancillary services that have a predetermined national payment amount, such as drugs and biologicals and brachytherapy sources that are separately paid under the OPPS; or services that are contractor-priced or paid at reasonable cost in ASCs. This includes separate payment for non-opioid pain management drugs.

To derive the final CY 2027 payment rate displayed in the "Final CY 2027 Payment Rate" column, each ASC payment weight in the "Final CY 2027 Payment Weight" column was multiplied by the final CY 2027 conversion factor. The conversion factor includes a budget neutrality adjustment for changes in the wage index values and the annual update as reduced by the productivity adjustment. The final CY 2027 ASC conversion factor uses the final CY 2027 productivity adjusted hospital market basket update factor of 2.3 percent (which is equal to the inpatient hospital market basket percentage increase of 3.2 percent reduced by the productivity adjustment of 0.9 percentage point).

In Addendum BB, there are no relative payment weights displayed in the "Final CY 2027 Payment Weight" column for items and services with predetermined national payment amounts, such as separately payable drugs and biologicals. The "Proposed CY 2027 Payment" column displays the final CY 2027 national unadjusted ASC payment rates for all items and services. The final CY 2027 ASC payment rates listed in Addendum BB for separately payable drugs and

biologicals are generally based on the most recently available data used for payment in physicians' offices. For CY 2021, we finalized adding a new column to ASC Addendum BB titled "Drug Pass-Through Expiration during Calendar Year" where we flag through the use of an asterisk each drug for which pass-through payment is expiring during the calendar year (that is, on a date other than December 31st).

Addendum EE to this final rule with comment period provides the HCPCS codes and short descriptors for surgical procedures that are to be excluded from payment in ASCs for CY 2027 as they are designated as unsafe surgical procedures, unlisted surgical procedures, or on the inpatient-only list.

Addendum FF to this final rule with comment period displays the OPPS payment rate (based on the standard ratesetting methodology), the APC device offset percentage, the device offset percentage for determining device-intensive status (based on the standard ratesetting methodology), and the device portion of the ASC payment rate for CY 2027 for covered surgical procedures.

XIV. Measure Removal for the Hospital Outpatient Quality Reporting and Ambulatory Surgical Center Quality Reporting Programs

A. Background

We refer readers to sections XV. and XVII. of this final rule with comment period for program-specific background information, including statutory authority and program measure sets, regarding the Hospital Outpatient Quality Reporting and Ambulatory Surgical Center (ASC) Quality Reporting Programs, respectively.

B. Removal of the Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients Measure in the Hospital Outpatient Quality Reporting and the ASC Quality Reporting Programs

We refer readers to the CY 2014 OPPS/ASC final rule with comment period where we adopted the Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients (the Colonoscopy Follow-Up Interval) measure into the Hospital Outpatient Quality Reporting and the ASC Quality Reporting Programs (78 FR 75101 through 75102 and 78 FR 75127 through 75128), and the CY 2024 OPPS/ASC final rule with comment period where we modified the measure to align with updated clinical guidelines (88 FR 81972 through 81973 and 88 FR 82020 through 82021). The Colonoscopy Follow-Up Interval measure assesses the percentage of patients aged 45 to 75 years receiving a screening colonoscopy without biopsy or polypectomy who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in the colonoscopy report.[179]

When we adopted the Colonoscopy Follow-up Interval measure, we sought to address what was, at the time, the critical issue of colonoscopies potentially performed too frequently and

[179] Partnership for Quality Measurement. Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients. Available at *https://p4qm.org/measures/0658*.

potentially increasing patients' exposure to procedural harm.[180] [181] The measure was designed to promote adherence to recommended screening intervals through documentation of follow-up recommendations in the colonoscopy report, thereby increasing provider and patient awareness of appropriate screening intervals. Importantly, this measure assesses whether the recommended 10-year interval for a follow-up colonoscopy is documented in the colonoscopy report, rather than whether appropriate clinical care is delivered. In other words, the measure does not assess whether the follow-up colonoscopy was performed according to this recommended interval.

We continue to believe that it is important to encourage high-quality colonoscopy care in hospital outpatient departments and ASCs. We note that the Hospital Outpatient Quality Reporting Program and ASC Quality Reporting Program measure sets both currently include another measure that is tied more closely to outcomes of continued interest and importance—the Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy measure (79 FR 66948 through 66955 and 79 FR 66970 through 66979, respectively), which assesses the incidence of hospital returns within 7 days of a colonoscopy, including emergency department visits, observation stays, and unplanned readmissions. The Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy measure is therefore a more patient-outcome focused measure of procedure-related adverse events across both programs in contrast to the Colonoscopy Follow-Up Interval measure, which assesses documentation of recommended follow-up intervals rather than patient outcomes.[182] For these reasons, in the CY 2027 OPPS/ASC proposed rule (91 FR 41957), we proposed to remove the Colonoscopy Follow-Up Interval measure from the Hospital Outpatient Quality Reporting and the ASC Quality Reporting Programs, beginning with the CY 2027 reporting period/CY 2029 payment determination. For

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[180] Lieberman, D. A., Faigel, D. O., Logan, J. R., Mattek, N., Holub, J., Eisen, G., Morris, C., Smith, R., & Nadel, M. (2009). Assessment of the quality of colonoscopy reports: results from a multicenter consortium. *Gastrointestinal endoscopy*, *69*(3 Pt 2), 645–653. *https://doi.org/10.1016/j.gie.2008.08.034*.

[181] Goodwin, J. S., Singh, A., Reddy, N., Riall, T. S., & Kuo, Y. F. (2011). Overuse of screening colonoscopy in the Medicare population. *Archives of internal medicine*, *171*(15), 1335–1343. *https://doi.org/10.1001/archinternmed.2011.212*.

[182] Partnership for Quality Measurement. Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy. Available at *https://p4qm.org/measures/2539*.

both programs, removal is appropriate under removal factor 6 (42 CFR 419.46(i)(3)(i)(F) and 416.320(c)(2)(vi)), the availability of a measure that is more strongly associated with a desired patient outcome for the particular topic. The Hospital Outpatient Quality Reporting Program and ASC Quality Reporting Program measure sets would continue to retain the Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy measure.

Additionally, we continue to prioritize appropriate colonoscopy care in our other quality reporting or value-based programs. For example, we have a Colorectal Cancer Screening measure within the gastroenterology Merit-based Incentive Payment System (MIPS) Value Pathway [183] and the Medicare Shared Savings Program,[184] which assesses the percentage of adults 45 to 75 years of age who had appropriate screening for colorectal cancer.

We invited and received public comments on this proposal. The following is a summary of the comments we received and our responses.

Comment: Many commenters supported removing the Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients measure stating that this measure primarily assesses whether a recommended follow-up interval was documented rather than whether appropriate clinical care occurred or meaningful patient outcomes were achieved. Many commenters supported streamlining quality reporting by removing measures and reporting requirements that are duplicative, redundant, or no longer needed and focusing on more clinically meaningful, patient-centered measures that better reflect care quality, patient safety, and outcomes.

Many commenters supported removing the measure stating that chart abstraction, data collection, and reporting requirements create administrative burden, and that removal would allow facilities to focus on higher-priority quality improvement activities that more directly

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[183] CMS MIPS Gastroenterology Care Value Pathway. Available at *https://qpp.cms.gov/reporting-requirements/measures-activities/explore-mvps/2026/M1422*.

[184] CMS Measures Inventory Tool. Colorectal Cancer Screening, Medicare Shared Savings Program. Available at *https://cmit.cms.gov/cmit/#/MeasureView?variantId=11552&sectionNumber=1*.

benefit patients. A few commenters supported removing the measure due to consistently high performance with limited meaningful differentiation thereby reducing its value as a quality measure. A few commenters noted that the measure may be topped out and supported focusing resources on measures with greater potential to drive meaningful improvements in patient outcomes and care quality.

Response: We thank commenters for their support. We agree that removing the Colonoscopy Follow-Up Interval measure will reduce reporting burden and allow hospitals and ASCs to focus resources on measurable clinical outcomes and direct patient care. We agree with commenters that the measure has consistently high performance in the Hospital Outpatient Quality Reporting and ASC Quality Reporting Programs.

Comment: A few commenters supported removing the measure from facility-based programs, stating that it was developed to assess clinician performance and is not appropriate for evaluating hospital or ASC performance.

Response: We appreciate commenters' support; however, we disagree that the measure is not appropriate for evaluating hospital outpatient department or ASC performance. As we stated when we adopted the Colonoscopy Follow-Up Interval Measure into the Hospital Outpatient Quality Reporting and ASC Quality Reporting Programs, while this measure was originally developed at the clinician-level, the measure steward later respecified the measure at the facility level and performed field testing for this measure in the Hospital Outpatient Department and ASC settings and CMS determined, based on that testing, that the measure was appropriate and feasible for those settings (78 FR 75099 through 75100 and 78 FR 75125).

We are removing the measure now because another measure is available that more directly assesses procedure-related adverse events, not because we believe this measure is not appropriate for the hospital outpatient department and ASC settings. The retained measure, Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy, assesses

hospital returns within 7 days of a colonoscopy, including emergency department visits, observation stays, and unplanned readmissions.

Comment: A few commenters expressed concern that removing the Colonoscopy Follow-Up Interval measure could weaken efforts to prevent unnecessary or low-value colonoscopies which could increase procedural risks.

Response: We appreciate commenters' concerns regarding unnecessary or low-value colonoscopies, health care costs, patient safety, continuity of care, and colorectal cancer prevention and follow-up. When we adopted the Colonoscopy Follow-Up Interval measure, we sought to address issues related to colonoscopies potentially being performed too frequently which would increase patients' exposure to procedural harm.[185] [186] The measure was designed to promote adherence to recommended screening intervals through documentation of follow-up recommendations. However, the measure assesses whether the recommended 10-year follow-up interval is documented in the colonoscopy report, rather than whether appropriate clinical care is delivered or whether the follow-up colonoscopy is performed according to the recommended interval. The Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy measure allows us to better assess procedure-related adverse events than the Colonoscopy Follow-Up Interval measure.

Comment: A few commenters expressed concern that removing this measure could undermine efforts to reduce health care costs.

Response: We appreciate commenters' concerns regarding health care costs. We agree that avoiding unnecessary colonoscopies can reduce health care costs. As we previously stated, however, the Colonoscopy Follow-Up Interval measure does not assess whether a follow-up colonoscopy is performed according to the recommended 10-year follow-up interval. Retaining

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[185] Lieberman, D. A., Faigel, D. O., Logan, J. R., Mattek, N., Holub, J., Eisen, G., Morris, C., Smith, R., & Nadel, M. (2009). Assessment of the quality of colonoscopy reports: results from a multicenter consortium. *Gastrointestinal endoscopy*, *69*(3 Pt 2), 645–653. *https://doi.org/10.1016/j.gie.2008.08.034*.

[186] Goodwin, J. S., Singh, A., Reddy, N., Riall, T. S., & Kuo, Y. F. (2011). Overuse of screening colonoscopy in the Medicare population. *Archives of internal medicine*, *171*(15), 1335–1343. *https://doi.org/10.1001/archinternmed.2011.212*.

the Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy measure prioritizes a measure more strongly associated with a desired patient outcome and assesses procedure-related adverse events, including hospital returns within 7 days of a colonoscopy,[187] that can increase health care costs.

Comment: A few commenters stated that this measure supports colorectal cancer prevention. A few commenters expressed concern about removing a measure that aligns with United States Preventive Services Task Force's recommendations and is included in the Core Quality Measures Collaborative (CQMC) Gastroenterology core measure set.

Response: The CQMC's Gastroenterology core measure set is focused on ambulatory care measures at the clinician reporting level. We agree that the measure's inclusion in this measure set indicates that it has clinical value but note that the Hospital Outpatient Quality Reporting and ASC Quality Reporting Programs assess facility-level performance. In the CY 2027 Physician Fee Schedule proposed rule, the Colonoscopy Follow-up Interval measure was proposed for removal from MIPS because it is topped-out, meaning the median performance rate is 95 percent or higher (91 FR 44160 through 44162 and 91 FR 44416). We appreciate commenters' concerns regarding alignment with United States Preventive Services Task Force recommendations, which recommends screening for colorectal cancer in adults aged 45 to 75 years.[188] We continue to prioritize appropriate colorectal cancer screening in other quality reporting or value-based programs, such as the Colorectal Cancer Screening measure in the gastroenterology MIPS Value Pathway[189] and the Medicare Shared Savings Program.[190]

Comment: A few commenters stated that removing the measure would eliminate a distinct and complementary aspect of quality measurement. These commenters stated that the

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[187] Partnership for Quality Measurement. Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy. Available at *https://p4qm.org/measures/2539*.
[188] United States Preventive Services Task Force. A & B Recommendations. Available at *https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations.*
[189] CMS MIPS Gastroenterology Care Value Pathway. Available at *https://qpp.cms.gov/reporting-requirements/measures-activities/explore-mvps/2026/M1422*.
[190] CMS Measures Inventory Tool. Colorectal Cancer Screening, Medicare Shared Savings Program. Available at *https://cmit.cms.gov/cmit/#/MeasureView?variantId=11552&sectionNumber=1*.

Colonoscopy Follow-Up Interval and the Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy measure assess different aspects of care, so maintaining both provides a more comprehensive assessment of quality.

Response: We understand commenters' concerns that the Colonoscopy Follow-Up Interval measure and the Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy measures do not assess the same clinical areas. The Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy measure provides an outcome-focused assessment of procedure-related adverse events, including hospital returns within 7 days of a colonoscopy.[191] We seek to implement measures that are focused on patient outcomes to evaluate the results of clinical care. The Colorectal Cancer Screening measure, which assesses the percentage of adults 45 to 75 years of age who had appropriate screening for colorectal cancer,[192] is more complementary to the Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy measure than the Colonoscopy Follow-Up Interval measure, which assesses documentation of a recommended follow-up interval.[11]

As discussed above, the Colonoscopy Follow-Up Interval measure sought to address patients' exposure to procedural harm from unnecessarily frequent colonoscopies, while the Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy measure assesses procedure-related adverse events. Moreover, the Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy measure is more strongly associated with patient outcomes than the Colonoscopy Follow-Up Interval measure. Thus, removal of the Colonoscopy Follow-Up Interval measure is appropriate under removal factor 6 (42 CFR 419.46(i)(3)(i)(F) and 416.320(c)(2)(vi)), the availability of a measure that is more strongly associated with a patient outcome for the particular topic.

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[191] Partnership for Quality Measurement. Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy. Available at *https://p4qm.org/measures/2539*.

[192] CMS Measures Inventory Tool. Colorectal Cancer Screening, Medicare Shared Savings Program. Available at *https://cmit.cms.gov/cmit/#/MeasureView?variantId=11552&sectionNumber=1*.

Comment: A few commenters recommended evaluating or monitoring whether removal of the measure results in unintended effects on clinical practice or adherence to screening recommendations. A commenter recommended improving the reliability of the Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy measure to ensure it provides useful information to facilities. A commenter recommended considering less burdensome approaches, including provider education, clinical decision support tools, or broader quality improvement initiatives, to support guideline-concordant screening practices without maintaining a standalone reporting measure.

Response: We thank commenters for their recommendations and will consider them as we evaluate the effects of removing the Colonoscopy Follow-Up Interval measure. As part of our measure maintenance process, we will conduct ongoing monitoring and evaluation analyses to evaluate measure performance of the Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy measure, and to identify any potential unintended consequences. Regarding burden, the Facility 7-Day Risk Standardized Hospital Visit Rate after Outpatient Colonoscopy measure is calculated from Medicare claims and administrative data making associated burden related to data collection minimal for hospitals and ASCs in contrast to the Colonoscopy Follow-up Interval measure which requires chart-abstraction. Regarding reliability of the measure, sufficient case numbers for reliability purposes were assessed during the measure development process and would be reassessed through the measure maintenance review process.

After consideration of the public comments we received, we are finalizing the removal of the Colonoscopy Follow-Up Interval measure from the Hospital Outpatient Quality Reporting and the ASC Quality Reporting Programs as proposed beginning with the CY 2027 reporting period/CY 2029 payment determination.

XV. Hospital Outpatient Quality Reporting Program

A. Background

The Hospital Outpatient Quality Reporting Program promotes transparency and quality of care furnished at hospital outpatient departments (HOPDs). Section 1833(t)(17)(A) of the Act sets forth that subsection (d) hospitals (as defined under section 1886(d)(1)(B) of the Act) that do not submit data required for measures selected with respect to such a year, in the form and manner required by the Secretary, will incur a 2.0-percentage point reduction to their annual Outpatient Department fee schedule increase factor. We refer readers to the CY 2011 OPPS/ASC final rule with comment period (75 FR 72064 through 72065) for a detailed discussion of the statutory history of the Hospital Outpatient Quality Reporting Program. We have codified certain program requirements at 42 CFR 419.46. We also refer readers to the CMS website at *https://www.cms.gov/medicare/quality/initiatives/hospital-quality-initiative/hospital-outpatient-quality-reporting-program* for general background on the Hospital Outpatient Quality Reporting Program, as well as the CMS QualityNet website at *https://qualitynet.cms.gov/outpatient* for current program requirements and measure specifications.

B. Hospital Outpatient Quality Reporting Program Measure Set

We refer readers to section XIV. of this final rule with comment period where we discuss the removal of the Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients measure from the Hospital Outpatient Quality Reporting and Ambulatory Surgical Center Quality Reporting Programs beginning with the CY 2027 reporting period/CY 2029 payment determination. We did not finalize any other changes to the Hospital Outpatient Quality Reporting Program measure set. Table 97 summarizes the previously finalized and newly finalized Hospital Outpatient Quality Reporting Program measure set for the CY 2028 to CY 2032 payment determinations, which removes the Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients measure.

TABLE 97: HOSPITAL OUTPATIENT QUALITY REPORTING PROGRAM MEASURE SET BY DATA COLLECTION METHOD AND PAYMENT DETERMINATION (PD)

Consensus-Based Entity #	Measure Name	CY 2028 PD	CY 2029 PD	CY 2030 PD	CY 2031 PD	CY 2032 PD
Chart-Abstracted Measures						
0658	Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients*	✓	Removed			
0661	Head Computed Tomography (CT) or Magnetic Resonance Imaging (MRI) Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation Within 45 minutes of Arrival	✓	✓	✓	✓	✓
None	Left Without Being Seen	✓	✓			
None	Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients	✓	✓			
Claims-Based Measures						
None	Abdomen CT - Use of Contrast Material	✓	✓	✓	✓	✓
3490	Admissions and ED Visits for Patients Receiving Outpatient Chemotherapy	✓	✓	✓	✓	✓
None	Breast Cancer Screening Recall Rates	✓	✓	✓	✓	✓
2539	Facility 7-Day Risk-Standardized Hospital Visit Rate After Outpatient Colonoscopy	✓	✓	✓	✓	✓
2687	Risk-Standardized Hospital Visits Within 7 Days After Hospital Outpatient Surgery	✓	✓	✓	✓	✓
Patient-Reported Outcomes-Based Performance Measures (PRO-PMs)						
4210	Patient Understanding of Key Information Related to Recovery After a Hospital-Based Outpatient Procedure or Surgery PRO-PM (Information Transfer PRO-PM)	Voluntary	✓	✓	✓	✓
None	Risk-Standardized PRO–PM Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) in the HOPD Setting (THA/TKA PRO-PM)	Voluntary	Voluntary	Voluntary	✓	✓
None	Cataracts: Improvement in	Voluntary	Voluntary	Voluntary	Voluntary	Voluntary

Consensus-Based Entity #	Measure Name	CY 2028 PD	CY 2029 PD	CY 2030 PD	CY 2031 PD	CY 2032 PD
	Patient's Visual Function within 90 Days Following Cataract Surgery					
Survey-Based Measures						
None	Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS)	✓	✓	✓	✓	✓
Electronic Clinical Quality Measures (eCQMs)						
4625e	Emergency Care Access and Timeliness (ECAT)		Voluntary	✓	✓	✓
3663e	Excessive Radiation Dose or Inadequate Image Quality for Diagnostic CT in Adults (Hospital Level—Outpatient)	Voluntary	Voluntary	Voluntary	Voluntary	Voluntary
None	ST-Segment Elevation Myocardial Infarction (STEMI)	✓	✓	✓	✓	✓

✓Measure is mandatory for the specified payment determination year.
Voluntary: Submission of this measure is optional, and HOPDs that do not report the measure are not subject to a payment reduction.
*Removed in this final rule with comment period beginning with the CY 2029 payment determination.

C. Request for Information on the Advance Care Planning Electronic Clinical Quality Measure

1. Background

In this request for information, we sought feedback on potential inclusion of an Advance Care Planning electronic clinical quality measure (eCQM) and other quality measure concepts related to advance care planning for the Hospital Outpatient Quality Reporting Program. Advance care planning is a continuous process that supports patients in understanding and communicating their goals, values, and preferences regarding future medical care and decision-making. The 1990 Patient Self-Determination Act supports advance care planning by requiring health care facilities to inform patients of their rights regarding medical decision-making and to document in the medical record whether the patient has executed an advance directive; however, it does not require that a copy of the directive itself must always be placed in the medical record.[193]

[193] Patient Self Determination Act of 1990. 42 U.S.C. 1395cc(f) and 1396a(w).

HOPDs provide care for adults with serious and complex conditions, including those receiving cancer treatment, visiting the emergency department (ED), or undergoing surgical procedures. In the CY 2026 OPPS/ASC final rule with comment period (90 FR 53780 through 53786), we finalized the phase-out of the Inpatient-Only (IPO) list over a 3-year period, beginning January 1, 2026, and ending January 1, 2029. As part of the first step of the IPO phase-out, for 2026, we removed 285 HCPCS codes (mostly for musculoskeletal procedures) from the IPO list. As more procedures shift from the inpatient to the outpatient setting, complex procedures may increasingly be furnished in HOPDs. Outpatient encounters can provide repeated opportunities for clinicians to build relationships with patients over time, which may support the initiation or updating of advance care planning documentation, including when patients are relatively stable or before their illness progresses.[194] Many patients assume that their caregivers know their preferences regarding their care; however, research indicates that caregivers incorrectly predict patients' preferences approximately one-third of the time.[195] Additionally, care preferences may change over time,[196] particularly in response to changes in an individual's health status or personal circumstances.[197,198] Regular reassessment and transparent communication are essential to maintaining person-centered care. Advance care planning

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[194] Marshall, K. H., Riddiford-Harland, D. L., Meller, A. E., Caplan, G. A., Naganathan, V., Cullen, J., Gonski, P., Zwar, N. A., O'Keeffe, J. A., Krysinska, K., & Rhee, J. J. (2024). Feasibility and Acceptability of Facilitated Advance Care Planning in Outpatient Clinics: A Qualitative Study of Patient and Caregivers Experiences. *Journal of applied gerontology : the official journal of the Southern Gerontological Society*, *43*(4), 339–348. Available at *https://doi.org/10.1177/07334648231206742.*

[195] National Institute on Aging. (2022). Advance Care Planning: Advance Directives for Health Care. Available at *https://www.nia.nih.gov/health/advance-care-planning/advance-care-planning-advance-directives-health-care*.

[196] Mastropolo, R., Cernik, C., Uno, H., Fisher, L., Xu, L., Laurent, C. A., Cannizzaro, N., Munneke, J., Cooper, R. M., Lakin, J. R., Schwartz, C. M., Casperson, M., Altschuler, A., Kushi, L., Chao, C. R., Wiener, L., & Mack, J. W. (2024). Evolution in Documented Goals of Care at End of Life for Adolescents and Younger Adults With Cancer. *JAMA network open*, *7*(12), e2450489. Available at *https://doi.org/10.1001/jamanetworkopen.2024.50489*.

[197] Shah, M. P., Wenger, N. S., Glaspy, J., Hays, R. D., Sudore, R. L., Rahimi, M., Gibbs, L., Anand, S., Tseng, C. H., & Walling, A. M. (2025). Patient-reported discordance between care goals and treatment intent in advanced cancer. *Cancer*, *131*(17), e35976. Available at *https://doi.org/10.1002/cncr.35976*.

[198] Young Y, Stone A, Perre T. (2022). Are Young Adults Ready to Complete Advance Directives? *American Journal of Hospice & Palliative Medicine, 39*(10), 1188-1193. Available at *https://doi.org/10.1177/10499091211066494.*

facilitates shared decision-making by documenting patient preferences and ensuring that care remains aligned with patients' goals across care settings and transitions.[199]

We sought feedback on whether the Advance Care Planning eCQM is appropriate for use in the hospital outpatient setting, with or without modifications. We requested input on this and on other potential quality measures related to this topic that may be appropriate for the hospital outpatient setting.

2. Advance Care Planning Electronic Clinical Quality Measure Overview

The Advance Care Planning eCQM was finalized for adoption for the Hospital Inpatient Quality Reporting, PPS-Exempt Cancer Hospital Quality Reporting, and Medicare Promoting Interoperability Programs in the FY 2027 IPPS/LTCH PPS final rule (91 FR 49932 through 49942). Potentially adopting the eCQM across our quality reporting programs promotes the use of standardized advance care planning documentation in the electronic health record (EHR). Such documentation helps ensure that care remains aligned with patients' stated preferences, leverages EHRs to facilitate health information exchange, and supports the advancement of person-centered care across the care continuum.

We refer readers to the FY 2027 IPPS/LTCH PPS final rule (91 FR 49932 through 49942) for a complete discussion of adoption of the Advance Care Planning eCQM in certain inpatient quality reporting programs. The eCQM currently calculates the proportion of adult patients with one or more hospitalizations during the measurement period who, by the time of discharge for at least one encounter, have either an advance care planning document in the EHR or documentation of an advance care planning discussion that results in a documented decision in the patient's EHR. The numerator comprises any one of the following: (1) an advance care planning document as evidenced by the following types of documents: designated health care agent (health care proxy or medical power of attorney for health care), advance directive (or

[199] McMahan, R. D., Tellez, I., Sudore, R. L. (2021). Deconstructing the Complexities of Advance Care Planning Outcomes: What Do We Know and Where Do We Go? A Scoping Review. *Journal of the American Geriatrics Society*, *69*(1), 234–244. Available at *https://doi.org/10.1111/jgs.16801*.

living will), or a portable medical order (medical order for life-sustaining treatment [MOLST], physician order for life-sustaining treatment [POLST], or do not resuscitate [DNR] orders);[200] or (2) documentation that an advance care planning discussion resulting in a documented decision occurred during the measurement period.[201,202]

To be counted in the numerator, the advance care planning document must be available in the patient's EHR during any hospitalization in the measurement period. The measure does not require documentation of the date the advance care planning document was originally created or last updated. However, we encourage clinicians to discuss with the patient or their surrogate whether the document accurately reflects the patient's current preferences. To be considered an advance care planning discussion leading to a decision, the documentation of the discussion with a decision must have a date in the EHR that occurs during a hospital encounter in the measurement period. If a patient has multiple encounters during the measurement period, an advance care planning discussion with a decision occurring in any one of the hospital encounters during the measurement period is counted toward the numerator. The denominator includes all patients aged 18 years and older at the start of the measurement period who are discharged from a hospitalization during the 12-month measurement period. The Advance Care Planning eCQM is calculated as a proportion by dividing the number of patients who meet the numerator criterion by the total number of eligible patients who meet the denominator criterion.[203]

There are no exclusions for the Advance Care Planning eCQM as the measure is intended to encourage advance care planning among all adult patients, recognizing that serious illness or injury can occur at any time, regardless of age or baseline health. The measure is designed to

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[200] Some state organizations may refer to a MOLST or POLST form by other terms such as medical orders for scope of treatment (MOST), physician orders for scope of treatment (POST), clinical orders for life-sustaining treatment (COLST), or a transportable physician orders for patient preferences (TPOPP).

[201] Documentation that an advance care planning discussion resulting in a documented decision occurred during the measurement period includes a discussion with the patient or the surrogate. This allows discussion with a surrogate in instances where a patient is unable to participate (e.g., incapacitated) without requiring prior discussion with the patient.

[202] Partnership for Quality Measurement. Advance Care Planning. Available at *https://www.p4qm.org/prmr-measures/muc2025-020*.

[203] Centers for Medicare & Medicaid Services. Electronic Clinical Quality Improvement Resource Center. Advance Care Planning. Measure Guidance. Available at *https://ecqi.healthit.gov/ecqm/hosp-inpt/2028/cms1317v1*.

account for situations where a patient does not have capacity to engage in, declines, or defers advance care planning by recognizing existing advance care planning decisions documented in the EHR, including qualifying advance care planning documents recorded prior to the measurement period, EHR data elements documenting advance care planning discussions with a decision during a hospital encounter (including those conducted with a surrogate when the patient does not have capacity), and documentation that a patient declined or deferred advance care planning.

For additional information on the Advance Care Planning eCQM, including the measure rationale and numerator criteria, refer to *https://www.p4qm.org/prmr-measures/muc2025-020*. We refer readers to the Electronic Clinical Quality Improvement (eCQI) Resource Center for the detailed measure specifications and guidance at *https://ecqi.healthit.gov/ecqm/hosp-inpt/2028/cms1317v1*.

3. Solicitation for Public Comment

We sought input on the importance, relevance, appropriateness, and applicability of including the Advance Care Planning eCQM in the Hospital Outpatient Quality Reporting Program, as well as on other measure concepts related to advance care planning for the hospital outpatient setting. We invited public comment on the following considerations:

- Tools and measures that capture advance care planning processes and outcomes in hospital outpatient settings, including the potential future use of and modifications to the Advance Care Planning eCQM to better tailor it for the Hospital Outpatient Quality Reporting Program.

- Other approaches or measure concepts that may more effectively capture advance care planning activities in the HOPD setting.

- Relevant aspects of advance care planning for the HOPD setting, such as whether an advance care planning measure should focus on specific patient populations, higher-acuity procedures, or select departments (such as oncology, emergency department, and surgical areas).

- Timing and frequency of advance care planning, such as when and how often it should occur in the HOPD setting.

- Other measure development/re-specification ideas or opportunities for addressing advance care planning in the HOPD setting, including but not limited to changes to the current Advance Care Planning eCQM.

We received public comments on these topics, summarized below.

Comment: Many commenters expressed support for advance care planning as a quality measurement concept, describing advance care planning as an important component of patient-centered care and a means of aligning care with patients' values, goals, and preferences. Among these commenters, many supported adopting the Advance Care Planning eCQM specifically in the Hospital Outpatient Quality Reporting Program, while a few commenters supported adoption conditionally based on modifications, additional measure testing, or other considerations.

Many commenters opposed adoption or recommended deferral, citing concerns that the measure may not adequately reflect meaningful advance care planning, may not be appropriate across the broad range of hospital outpatient encounters, and may create administrative, reporting, workflow, or EHR burdens. Many commenters submitted different recommendations on whether the eCQM should be applied broadly across HOPDs, which populations and encounters should be measured, and what changes would be needed before adoption.

Many commenters recommended limiting an outpatient advance care planning measure to patients, procedures, departments, or encounters where advance care planning is clinically relevant and there is sufficient opportunity for meaningful discussion. Their recommendations included focusing on patients with serious illness, oncology patients, and patients undergoing higher-acuity procedures. Commenters identified imaging, laboratory services, emergency care, routine procedures, and other episodic encounters as settings that may warrant exclusion or a different approach.

Several commenters also recommended specific denominator or exclusion criteria to operationalize a more targeted measure. A commenter recommended exclusions when an advance care plan was recently completed, was being managed by another clinician or care setting, or was not clinically appropriate for the encounter. Another commenter recommended excluding patients who decline advance care planning discussions or documentation from performance calculations, and a commenter recommended considering exclusion of patients who lack capacity and do not have an appropriate health care agent or surrogate decision-maker. A commenter proposed more detailed eligibility rules, including limiting the measure to specified outpatient services; excluding emergency department patients, medical observation patients, and certain patients recently hospitalized; requiring at least two visits before applying the measure to some recurring services; and applying episode-level measurement to certain surgical observation and outpatient-in-bed services. In contrast, another commenter supported applying the measure broadly to all adults aged 18 and older rather than limiting it to specific patient populations, higher-acuity procedures, or select departments.

Many commenters emphasized that advance care planning measurement should reflect meaningful, voluntary, patient-centered planning rather than documentation alone. Commenters cautioned against measure specifications or incentives that could result in inappropriate or pressured advance care planning discussions or decisions. Commenters recommended that a measure recognize initiation, review, and updates to advance care planning information; respect a patient's decision to defer or decline; and address patient readiness, communication and language needs, disability-related communication support, caregiver or surrogate participation, cultural or religious considerations, and health literacy. Many commenters also described advance care planning as a longitudinal process and recommended that timing and frequency reflect diagnosis, prognosis, changes in health status or treatment, and patient preferences rather than require a comprehensive discussion during every outpatient encounter.

Many commenters raised questions about attribution and provider roles, noting that advance care planning is often initiated or maintained by clinicians with longitudinal responsibility for a patient, while some HOPD clinicians have episodic or procedure-focused encounters. Commenters recommended changes to measure specifications, including numerator and denominator definitions, qualifying advance care planning activities, unit of measurement, exclusions or exceptions, eligible clinicians, recognition of existing advance care planning information or discussions, and other technical rules. Several commenters also recommended clarifying facility and clinician accountability and tailoring responsibility to providers who can influence the relevant advance care planning processes.

Many commenters emphasized the need for advance care planning information to be available across inpatient, outpatient, physician, post-acute, hospice, and other care settings and cautioned against repeated questioning, duplicate or conflicting documentation, and redundant reporting. Many commenters also raised feasibility and implementation concerns involving EHR capabilities, structured and machine-readable data, data extraction, vendor development, workflow changes, staff training, testing, implementation time, and reporting burden. Recommendations included broader testing across vendors and outpatient settings, adequate lead time, phased or voluntary implementation in some circumstances, technical or implementation assistance, and recognition of existing information so that advance care planning information can be retrieved and used across settings.

Many commenters proposed alternative or complementary approaches to assess advance care planning beyond the presence of documentation, including patient-reported experience, shared decision-making, goal concordance, communication quality, and whether advance care planning information is current, accessible, actionable, understood by clinicians, and reflected in care and outcomes. A few commenters recommended that CMS examine whether measure performance differs across populations or providers facing barriers to advance care planning engagement, including populations experiencing financial or social risk, individuals with limited

English proficiency, underserved communities, dual-eligible beneficiaries, rural providers, and safety-net hospitals. A commenter specifically recommended stratified analysis to identify whether patients with lower incomes or greater social risk receive comparable quality of care planning and caregiver engagement, while another recommended considering demographic data to identify disparities. Commenters who opposed adoption or recommended deferral cited concerns about the breadth of HOPD applicability, feasibility, burden, duplication, testing, and whether documentation-based measurement would meaningfully assess advance care planning quality.

Response: We appreciate all the comments and interest in this topic. While we are not responding to specific comments in response to the RFI in this final rule, we believe that this input is valuable and will continue to take all concerns, comments, and suggestions into account for future development of measures related to advance care planning.

D. Updates to the Validation of Hospital Outpatient Quality Reporting Program Data

We refer readers to previous OPPS/ASC rulemaking[204] and 42 CFR 419.46(f) for our existing policies regarding data validation in the Hospital Outpatient Quality Reporting Program. We also refer readers to our outpatient data validation resources at *https://qualitynet.cms.gov/outpatient/data-management/data-validation/resources.*

In the CY 2027 OPPS/ASC proposed rule (91 FR 41962 through 41966), we proposed to include the validation of eCQM data in the Hospital Outpatient Quality Reporting Program's existing validation process as well as to streamline certain validation processes. In addition, we proposed to: (1) change the validation selection pool from 500 to up to 400 hospitals; (2) clarify

[204] Existing validation policies were adopted for the Hospital Outpatient Quality Reporting Program in the CY 2011 OPPS/ASC final rule with comment period (75 FR 72103 through 72106), CY 2012 OPPS/ASC final rule with comment period (76 FR 74484 through 74487), CY 2013 OPPS/ASC final rule with comment period (77 FR 68484 through 68487), CY 2014 OPPS/ASC final rule with comment period (78 FR 75117), CY 2015 OPPS/ASC final rule with comment period (79 FR 66964 through 66966), CY 2016 OPPS/ASC final rule with comment period (80 FR 70524), CY 2018 OPPS/ASC final rule with comment period (82 FR 59441 through 59443), CY 2021 OPPS/ASC final rule with comment period (85 FR 86185), CY 2022 OPPS/ASC final rule with comment period (86 FR 63870 through 63873), and CY 2023 OPPS/ASC final rule with comment period (87 FR 72115 through 72116).

application of the targeting criteria to eCQMs; (3) update the number of cases for chart-abstracted and eCQM validation; (4) include eCQM validation in the timing and submission of medical record requests; (5) align the submission quarters for chart-abstracted and eCQM validation; (6) establish an eCQM validation scoring method based on data accuracy; and (7) update the educational review process for validation results. We anticipated the cumulative impact of these proposals would reduce burden for hospitals while increasing the accuracy of data reported under the program to better facilitate beneficiary decision-making and hospital quality improvement efforts.

1. Electronic Clinical Quality Measure Data Validation

To include validation of eCQMs in the existing Hospital Outpatient Quality Reporting Program data validation process, we proposed that validation begin with each eCQM when there is a full year of data available (91 FR 41962). For example, hospitals are required to submit all four quarters of data for the ST-Segment Elevation Myocardial Infarction (STEMI) eCQM beginning with data from the CY 2027 reporting period (86 FR 63837 through 63840); therefore, we proposed that validation for the STEMI eCQM would begin with data from the CY 2027 reporting period. Likewise, we proposed that validation for the Emergency Care Access and Timeliness (ECAT) eCQM would begin with data from the CY 2028 reporting period, which is the first year that submitting four quarters of data for this measure is mandatory (90 FR 53925 through 53934). We proposed that any future eCQMs adopted into the measure set would become eligible for validation after mandatory reporting of a full year of data is in effect, and information regarding the measures to be validated would be obtained from the CMS QualityNet website (or other CMS-designated website).

2. Changes to Selection Process for Hospital Outpatient Quality Reporting Program Validation

a. Validation Selection Pool

In the CY 2012 OPPS/ASC final rule with comment period (76 FR 74484 through 74485), we finalized an annual process for the Hospital Outpatient Quality Reporting Program of

selecting a random sample of 450 hospitals for validation purposes and an additional 50 hospitals based on specific targeting criteria. Since this process was finalized, we have found that hospitals randomly selected for validation generally have high accuracy rates for chart-abstracted measures and believe the number of hospitals randomly selected for validation could be reduced without impacting our ability to assess the accuracy of hospital data. At the same time, we believe that increasing the number of hospitals selected for validation based on specific targeting criteria will help to ensure data accuracy by allowing a greater number of hospitals meeting specific targeting criteria to have their data submissions reviewed for accuracy.

Therefore, in the CY 2027 OPPS/ASC proposed rule (91 FR 41962), we proposed that, beginning with hospital selections for validation affecting the CY 2030 payment determination, up to 200 hospitals would be selected at random and up to 200 hospitals would be selected using targeting criteria, for a total of up to 400 hospitals selected for validation. As we have found consistently high agreement rates and relatively low variation among randomly selected hospitals, this change would reduce the total number of hospitals selected for validation each year from 500 to up to 400 hospitals, while maintaining a sufficiently reliable sample size. Since the total number of hospitals required to participate in validation each year would be fewer, this proposed change would also reduce overall burden for hospitals. Re-balancing the number of randomly selected hospitals compared to the number of hospitals selected by targeting criteria would also more effectively and efficiently direct validation program resources to ensure data accuracy. Beginning with validation affecting the CY 2030 payment determination, we would require any hospital selected for validation, either randomly or after meeting targeting criteria, to submit both chart-abstracted measure and eCQM data for validation. Under the current policy, hospitals selected for validation affecting the CY 2029 payment determination would continue to participate only in chart-abstracted measure validation as no eCQMs would yet be eligible for validation. Hospital selections for validation affecting the CY 2029 payment determination would continue under the existing policy. Additionally, hospitals selected for validation

affecting the CY 2030 payment determination would only be required to submit eCQM data for validation when the relevant eCQM is required and eligible for validation for the applicable reporting period. This aligns with the validation process finalized for the Hospital Inpatient Quality Reporting Program, with which hospitals are familiar (85 FR 58946 through 58949). We proposed to update the codified policy at § 419.46(f)(3) to reflect this proposed change (91 FR 41962).

b. Targeting Criteria for Validation Selection Pool

We have previously established several targeting criteria set forth at § 419.46(f)(3)(i) through (v):

- The hospital fails the validation requirement that applies to the previous year's payment determination; or
- The hospital has an outlier value for a measure based on the data it submits. An "outlier value" is a measure value that is greater than 5 standard deviations from the mean of the measure values for other hospitals, and indicates a poor score; or
- Any hospital that has not been randomly selected for validation in any of the previous 3 years; or
- Any hospital that passed validation in the previous year but had a two-tailed confidence interval that included 75 percent; or
- Any hospital with a two-tailed confidence interval that is less than 75 percent, and that had less than four quarters of data due to receiving an extraordinary circumstance exception (ECE) for one or more quarters.

In the CY 2027 OPPS/ASC proposed rule (91 FR 41963), we proposed to apply the targeting criteria at § 419.46(f)(3)(i) through (v) to all measures eligible for validation in the Hospital Outpatient Quality Reporting Program, including but not limited to chart-abstracted measures and eCQMs.

3. Case Selection for Validation

We refer readers to the CY 2012 OPPS/ASC final rule with comment period (76 FR 74485 through 74486) and CY 2013 OPPS/ASC final rule with comment period (77 FR 68486), where we finalized that for each hospital selected through either random sampling or targeting criteria, we will validate up to 48 randomly selected patient cases (12 cases per quarter) from the total number of cases that the hospital successfully submitted to the CMS Clinical Data Warehouse via the Hospital Quality Reporting (HQR) system.

In the CY 2027 OPPS/ASC proposed rule (91 FR 41963 through 41964), we proposed to revise the number and distribution of cases selected for validation under the Hospital Outpatient Quality Reporting Program to ensure a balanced assessment across measure types. Specifically, we proposed to validate up to 32 randomly selected patient cases for each measure, starting with validation of CY 2027 data affecting the CY 2030 payment determination. For each chart-abstracted measure, cases would be submitted quarterly, with up to 8 cases validated per quarter. For each eCQM, up to 32 cases would be submitted annually, allowing validation of up to 8 cases from each quarter. Table 98 illustrates these proposed changes.

TABLE 98: PROPOSED CASE SELECTION FOR VALIDATION IMPACTING CY 2029 TO CY 2031 PAYMENT DETERMINATIONS

Payment Determination Year	Reporting Period Data	Measures Included in Validation	Number of Measures Validated	Number of Cases Validated
CY 2029	CY 2027	● Median Time from ED Arrival to ED Departure for Discharged ED Patients ● Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation Within 45 minutes of Arrival	2	48 cases under the current policy
CY 2030	CY 2027	● Median Time from ED Arrival to ED Departure for Discharged ED Patients ● Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients Who Received Head CT or MRI Scan Interpretation Within 45 Minutes of Arrival ● STEMI eCQM	3	Up to 96 cases under this proposal

Payment Determination Year	Reporting Period Data	Measures Included in Validation	Number of Measures Validated	Number of Cases Validated
CY 2031 (and subsequent years)	CY 2028 (and subsequent years)	● Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients Who Received Head CT or MRI Scan Interpretation Within 45 Minutes of Arrival ● STEMI eCQM ● ECAT eCQM	3	Up to 96 cases under this proposal

We discussed in the proposed rule that this approach could support a more balanced and representative assessment of data accuracy across both chart-abstracted measures and eCQMs, and that broadening the selection of cases would improve our ability to detect potential data inaccuracies and systemic reporting issues.

In the CY 2027 OPPS/ASC proposed rule (91 FR 41963 through 41964), we noted that all hospitals selected for validation purposes would receive a total of five medical record requests for complete supporting medical record documentation from CMS or its designated contractor: four quarterly requests containing randomly selected chart-abstracted cases and one annual request containing randomly selected eCQM cases. We refer readers to § 482.24(c) for a definition of what is expected in a medical record submitted for validation.

4. Timing and Electronic File Submission for Medical Records Requests

a. Chart-Abstracted Measures

We refer readers to the CY 2022 OPPS/ASC final rule with comment period (86 FR 63870 through 63871) and § 419.46(f)(1) for additional information on the use of electronic file submissions for chart-abstracted measure medical records requests and the time period for data validation, including the deadlines for submitting medical records to CMS. In the CY 2027 OPPS/ASC proposed rule (91 FR 41964), we did not propose any changes affecting the time period or deadlines for electronic file submission for chart-abstracted measures under our validation policy.

b. Electronic Clinical Quality Measures

In the CY 2027 OPPS/ASC proposed rule (91 FR 41964), we proposed to apply the same electronic file submissions policy to eCQM medical records requests in alignment with the chart-abstracted measures that hospitals are already familiar with. Upon written request by CMS or its contractor, a hospital would be required to submit portable document format (PDF) copies of medical records using direct electronic file submission via a CMS-approved secure file transmission process (currently, Unified File Management [UFM]/Managed File Transfer [MFT]). A hospital must submit the supporting medical record documentation to CMS or its contractor within 30 days of the date on the written request. We would continue to reimburse hospitals at $3.00 per chart, consistent with current reimbursement for electronic submissions of charts.

5. Submission Quarters

a. Background

Currently, hospitals selected for chart-abstracted validation are required to submit data from 2 years prior to the applicable CY payment determination year, consisting of validation quarter 1 (January 1 through March 31), validation quarter 2 (April 1 through June 30), validation quarter 3 (July 1 through September 30), and validation quarter 4 (October 1 through December 31) (80 FR 70524).

In the CY 2027 OPPS/ASC proposed rule (91 FR 41964 through 41965), we proposed that hospitals selected for eCQM validation for a given payment determination year would be required to submit data from the calendar year that is 3 years prior to the applicable payment determination year because eCQM data are reported annually rather than quarterly. A 3-year cycle allows sufficient time to complete sampling, medical record abstraction, confidence interval calculation, educational reviews, and quality assurance prior to payment determination.

To support the transition to a combined validation process for both chart-abstracted measures and eCQMs, we would shift the payment impact of validation from 2 years after the reporting period to 3 years after the reporting period. During this transition, the validation

results for CY 2027 chart-abstracted data would affect both the CY 2029 and the CY 2030 payment determination, as detailed below.

b. Validation Affecting the CY 2029 Payment Determination

To maintain the continuity of annual validation activities while we shift to a 3-year cycle, CY 2027 chart-abstracted data would continue to be used for the CY 2029 payment determination under the existing 2-year cycle in accordance with existing policy for chart-abstracted measure validation. In other words, there will be no change from our current policy for the CY 2029 payment determination.

c. Validation Affecting the CY 2030 Payment Determination

For the CY 2030 payment determination, CY 2027 chart-abstracted data would be used again in combination with CY 2027 eCQM data for validation. That is, validation results for CY 2027 chart-abstracted data would impact both the CY 2029 and CY 2030 payment determinations. Table 99 illustrates our proposed changes, including a transition year, to align the validation for chart-abstracted and eCQM data.

TABLE 99: PROPOSED VALIDATION PROCESS FOR CY 2029 TO CY 2031 PAYMENT DETERMINATIONS

Payment Determination Year	Reporting Period Data	Data Type	Validation Cycle	Notes
CY 2029	CY 2027	Chart-abstracted	Current: 2-years between reporting period and payment determination	Continues current policy to maintain annual validation continuity.
CY 2030	CY 2027	Chart-abstracted and eCQM	Proposed: 3-years between reporting period and payment determination	Supports transition to combined validation process. CY 2027 chart-abstracted data are used again for CY 2030 payment. This overlap ensures no gap in annual validation activities during the transition.
CY 2031 (and subsequent years)	CY 2028 (and subsequent years)	Chart-abstracted and eCQM	Proposed: 3-years between reporting period and payment determination	Steady state begins after transition year.

For the transition year affecting the CY 2030 payment determination, we proposed a one-time modification of the hospital selection and targeting methodology such that hospitals

selected for validation based on CY 2027 data, affecting the CY 2029 payment determination, would not be selected again, either randomly or through targeted selection, for validation of the same data affecting the CY 2030 payment determination (91 FR 41964 through 41965). For example, we would not automatically reselect a hospital that failed to meet the validation requirements for the CY 2029 payment determination under the targeting criterion at § 419.46(f)(3)(i) for validation affecting the CY 2030 payment determination. This approach is intended to eliminate the potential burden to hospitals that would have gone through the validation process for the CY 2029 payment determination while allowing validation activities to continue during the transition year.

d. Validation Affecting the CY 2031 Payment Determination and for Subsequent Years

As seen in Table 99, following the transition period, we would adopt a 3-year validation cycle, under which validation results for an annual reporting period would be applied to the applicable payment determination 3 years later. That is, beginning with CY 2028 chart-abstracted and eCQM data, validation results would impact the payment determination 3 years following the reporting period, which for CY 2028 reporting period data is the CY 2031 payment determination. Following the transition year, we would proceed with validation policies under the 3-year validation cycle, including the use of aligned data submission periods and the application of established hospital selection and targeting methodologies. We believe aligning the quarters of submission data used for both chart-abstracted measures and eCQM validation would allow hospitals selected for validation to more easily track and meet validation requirements.

6. Scoring Method

a. Chart-Abstracted Measures

In the CY 2011 OPPS/ASC final rule with comment period (75 FR 72103 through 72106), we finalized the calculation of validation scores under the Hospital Outpatient Quality Reporting Program using the upper bound of a 90 percent two-sided confidence interval with a

75 percent lower bound threshold level. In the CY 2027 OPPS/ASC proposed rule (91 FR 41965), we did not propose any changes to this threshold.

b. Electronic Clinical Quality Measures

In the CY 2027 OPPS/ASC proposed rule (91 FR 41965 through 41966), we proposed that eCQM validation scores would be determined using the same methodology currently used to score chart-abstracted measure validation, such that eCQM validation scoring would be based on the accuracy of eCQM data (the extent to which data abstracted for validation match the data submitted to CMS), beginning with CY 2027 eCQM data affecting the CY 2030 payment determination. Consistent with the data validation scoring threshold currently applied to chart-abstracted measures and codified at § 419.46(f)(2), a minimum score of 75 percent accuracy would be required for the hospital to pass the eCQM validation requirement. Applying an upper bound of a 90 percent two-sided confidence interval with a 75 percent lower bound threshold level is appropriate because it accounts for sampling variability, reflects a reasonable standard of data accuracy, and aligns with existing validation thresholds for chart-abstracted measures while allowing for legitimate differences in hospital data implementation.

To incentivize the timely and complete submission of requested medical records, we proposed that any missing medical records would be treated as mismatches, beginning with the validation of the CY 2027 eCQM data affecting the CY 2030 payment determination and for subsequent years. Because mismatches would count against the agreement rate, treating any missing medical records as mismatches would encourage submission of complete medical records and disincentivize selective medical record submissions. We note that this approach is consistent with our existing policy for chart-abstracted measure validation, under which missing records are treated as mismatches.

Using this approach, at the end of each calendar year, we would compute an eCQM confidence interval using the results of all four quarters to determine the final eCQM validation score. Hospital-submitted eCQM data and the submitted medical records would be used to

compute an agreement rate and the associated confidence interval around the score. The upper bound of the 90 percent two-sided confidence interval would be used as the final eCQM validation score for the selected hospital. We would then compare this final validation score to the 75 percent accuracy threshold to determine whether the hospital meets the eCQM validation requirement. Data validation scoring is at the measure level, not the individual data element level. If CMS or its contractor does not reach the same outcome as the hospital's original submission, then the case may be considered a mismatch. We selected 75 percent as the threshold for the validation score because we believe this level is reasonable to reflect accurate performance, but still realistic for hospitals to achieve. It also allows for legitimate differences in how hospitals implement measures and map their data. We note that we adopted the same eCQM scoring method for the Hospital Inpatient Quality Reporting Program (89 FR 69574 through 69577).

c. Annual Payment Update

Beginning with the validation of CY 2027 data affecting the CY 2030 payment determination, hospitals would receive two validation scores: one for chart-abstracted measure data and one for eCQM data. As we finalized in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66873 through 66874), a hospital that does not meet validation requirements will not receive the full annual payment update under the OPPS. Therefore, if a hospital does not meet either chart-abstracted validation requirements or eCQM validation requirements, we proposed the hospital would not receive the full OPPS annual payment update. In other words, to be eligible for a full annual payment update, provided all other Hospital Outpatient Quality Reporting Program requirements are met, a hospital selected for validation would need to attain at least a 75 percent validation score for chart-abstracted measure validation and at least a 75 percent validation score for eCQM data validation. In the CY 2027 OPPS/ASC proposed rule (91 FR 41965 through 41966), we also proposed to codify this policy by updating the regulatory text at § 419.46(f)(2).

7. Educational Review Process

a. Chart-Abstracted Measures

We refer readers to the CY 2018 OPPS/ASC final rule with comment period (82 FR 59441 through 59443) and the CY 2021 OPPS/ASC final rule with comment period (85 FR 86185) where we finalized and codified a policy to formalize the Educational Review Process for Chart-Abstracted Measures, including Validation Score Review and Correction. We also refer readers to § 419.46(f)(4) for our policies regarding the educational review process, including validation score review and correction, for chart-abstracted measures. As described in the CY 2018 OPPS/ASC final rule with comment period (82 FR 59441 through 59443), for CY 2020 and subsequent years, if a hospital requests an educational review for any of the first three quarters of validation and this review yields incorrect CMS validation results for chart-abstracted measures, the corrected quarterly score will be used to compute the final confidence interval.

In the CY 2027 OPPS/ASC proposed rule (91 FR 41966), we proposed to revise our policy to allow the results of educational reviews for all four quarters of chart-abstracted measure validation to be reflected in the final validation score prior to the calculation of the confidence interval, beginning with the CY 2030 payment determination. Under our current policy, due to time constraints, educational reviews for the final quarter of data are not completed in time to affect validation results, and hospitals must use the reconsideration process. Under the proposal to extend the validation timeline from a 2-year cycle to a 3-year cycle, sufficient time would become available to complete educational reviews for all four quarters. As a result, any corrected scores from educational reviews across all quarters would be used in calculating the final confidence interval.

b. Electronic Clinical Quality Measures

In the CY 2027 OPPS/ASC proposed rule (91 FR 41966), we proposed extending the educational review process established for chart-abstracted measure validation to eCQM validation beginning with validation affecting the CY 2030 payment determination (that is,

starting with validated data from CY 2027). We believe that expanding the educational review process to include eCQMs would allow hospitals to better understand the processes and data for eCQM validation.

Hospitals may request an educational review if they believe they have been scored incorrectly or if they have questions about their validation of eCQMs. A hospital would have 30 calendar days from the date the validation results are made available to contact CMS' Validation Support Contractor requesting a written explanation of its performance. Because hospitals receive eCQM validation results on an annual basis, they would have the opportunity to request an educational review once annually. Upon receipt of an educational review request, we would review the requested data elements and written justifications provided by the hospital. We would also provide the results of the eCQM validation educational review to the requesting hospital, including our findings of whether the scores were correct or incorrect, through a CMS-approved secure file transmission process (currently, UFM/MFT). If the results of a validation educational review determine that the original validation score was incorrect, the corrected score would be used to compute the final validation score and confidence interval at the end of each calendar year.

In the CY 2027 OPPS/ASC proposed rule (91 FR 41966), we proposed to codify this policy by revising § 419.46(f)(4) to include eCQMs. As proposed, § 419.46(f)(4) would indicate that hospitals selected for validation may request an educational review within 30 calendar days from the date validation results are made available. Under the proposed revisions to § 419.46(f)(4), if the results of an educational review indicate one or more measures were incorrectly scored, the corrected validation score would be used to compute the final validation score used for payment determination. We refer readers to section XXIV.A. of this final rule with comment period for more information on the burden estimates associated with these proposals.

We invited public comment on these validation of Hospital Outpatient Quality Reporting Program data proposals, including eCQM validation into the existing validation processes for chart-abstracted measures, reducing the validation selection pool from 500 to up to 400 hospitals, applying targeting criteria to eCQMs, updating the number of cases for chart-abstracted and eCQM validation, transitioning from a 2-year to a 3-year cycle between the reporting period and the payment determination year to align submission quarters, extending the electronic file submissions policy to eCQM medical records requests, establishing the eCQM validation scoring method, and expanding the educational review process.

Comments Regarding Electronic Clinical Quality Measure Data Validation

Comment: Many commenters supported efforts to reduce reporting burden and streamline Hospital Outpatient Quality Reporting Program requirements to improve facility accountability and the reliability of submitted data, especially as CMS continues to expand the use of electronic measures. Some commenters appreciated CMS' efforts to use consistent definitions, confidence intervals, sampling methodologies, and reconsideration procedures across inpatient and outpatient programs to reduce administrative complexity, promote greater consistency in program oversight, and allow hospitals to focus resources on improving data quality and patient care rather than navigating varying validation requirements.

Response: We thank commenters for their support and agree that streamlining our requirements and aligning them across programs reduces burden while promoting data accuracy and reliability across measure types.

Comment: A commenter stated that the administrative workload associated with eCQM reporting and validation can be substantial, particularly for small and rural facilities with limited staff to support internal compliance, information technology, data analytics, or quality reporting, and recommended that CMS should provide special support for these facilities.

Response: We understand concerns regarding the impact on hospitals with limited health IT resources available. We acknowledge that introducing eCQM validation affects burden;

however, we believe the benefits of ensuring that hospitals report accurate data outweigh the increase in burden as these data are made publicly available for consumer use. We refer readers to section XXIV.A. of this final rule with comment period for more information on the burden estimates associated with our validation policies. We have sought to reduce overall burden by reducing the total number of hospitals selected and focusing on a more targeted selection of hospitals via our targeting criteria.

Comment: A commenter suggested expanding the scope of data validation to include claims-based measures as the commenter stated CMS' existing audit processes are focused on improper payment identification rather than measure validity.

Response: We appreciate the commenter's recommendation. Our validation processes relate to assessing the accuracy of quality data that hospitals themselves abstract, calculate, or submit to CMS based on agreement rate. For claims-based measures, we can retrieve necessary information to calculate the quality measures from our own claims databases. Medicare claims are subject to audit for improper payment, system edits, and other program integrity activities to help ensure claims data are supported, compliant, and suitable for payment and secondary uses including quality measure calculations. Additionally, all our measures, including claims-based measures, undergo the rigorous measure development lifecycle outlined at the CMS Measures Management System website,[205] which includes measure testing and reliability analysis which evaluates whether a measure is repeatable and stable.

We are finalizing the proposal to begin validating each eCQM in the Hospital Outpatient Quality Reporting Program when there is a full year of data available for that measure.

Comments Regarding Changes to Selection Process for Hospital Outpatient Quality Reporting Program Validation

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[205] Centers for Medicare & Medicaid Services. Blueprint Measure Lifecycle. Measures Management System. Available at *https://mmshub.cms.gov/blueprint-measure-lifecycle-overview.*

Comment: Many commenters supported reducing the hospital selection pool from 500 to up to 400 hospitals, of which up to 200 hospitals are randomly selected and up to 200 hospitals are selected based on targeting criteria. Several commenters stated that the change to more targeted selection would help lower-performing hospitals improve based on targeted interventions, while allowing already higher-performing hospitals to continue performing well without additional burden.

Response: We thank commenters for their support and agree that rebalancing the number of hospitals selected by targeting criteria would more effectively and efficiently direct validation program resources to assessing agreement rates for hospitals that evidence data accuracy concerns.

Comment: A commenter expressed concern that a smaller overall validation sample would not provide the same level of confidence in program-wide data quality and recommended that CMS ensure that there are no unintended consequences.

Response: We recognize that sampling a smaller number of hospitals increases the estimate of variability for the overall data. Since the overall performance on chart-abstracted measures is consistently high across hospitals, there is little true variation to detect for those measures, and confidence remains high regarding overall data quality for chart-abstracted reporting. As eCQMs are newer to the validation process, we have less historical experience to draw upon; this is one of the reasons we believe it is important to begin validating eCQM data now, so that we can build a similar evidentiary basis over time. In determining the number of hospitals eligible for selection for validation, we seek to balance burden with a validation approach that assesses data quality across both measure types. Our many years of experience validating hospital measure data in the Hospital Outpatient Quality Reporting Program, Hospital Inpatient Quality Reporting Program, and Hospital-Acquired Condition Reduction Program, including observed validation results and failure rates based on agreement rates, demonstrates that a larger selection pool is not necessary. Additionally, retaining the selection pool at its

current size of up to 500 hospitals would yield only a marginal improvement in the precision of our population-level confidence estimate, while placing additional administrative burden on approximately 100 more hospitals each year. Consistent with the statistical principle underlying our approach to Hospital Inpatient Quality Reporting Program sample sizing, the precision gained from increasing a sample size beyond a certain point diminishes relative to the administrative burden of doing so. We believe the pool of up to 400 hospitals appropriately balances maintaining robust program-wide confidence with minimizing unnecessary burden on additional hospitals.

We will continue to monitor the number of hospitals passing validation and if the pass rate falls to a level where we can no longer be confident in the agreement rates of hospitals participating in the Hospital Outpatient Quality Reporting Program, we will address this issue in future rulemaking.

Comment: A few commenters did not support the requirement that any hospital selected for validation must submit both chart-abstracted and eCQM data as this could increase administrative burden on health systems. Instead, a commenter recommended limiting the audit of hospitals selected under targeted criteria to the specific data modality that triggered the selection.

Response: We interpret these comments to mean that commenters are concerned about the burden of submitting data required to validate both eCQMs and chart-abstracted measures. While there may be some instances of increased burden for specific hospitals, we disagree with the commenters that this approach is more burdensome for the majority of hospitals. Requiring selected hospitals to submit documentation for both measure types allows us to maintain oversight of data quality across the full range of measures subject to validation and helps ensure that the continued expansion of eCQMs in the measure set of the Hospital Outpatient Quality Reporting Program does not result in reduced attention to the accuracy and reliability of chart-abstracted data. While our proposed policy would add the requirement for selected hospitals to

submit eCQMs in addition to chart-abstracted measures, the total number of validated measures remains low as chart-abstracted measures have been phased out and eCQMs are phased in. We note in section XIV. of this final rule with comment period, we are removing the Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients measure which, while not validated, will reduce hospital burden. After this removal, there will be one remaining chart-abstracted measure in the Hospital Outpatient Quality Reporting Program, the Head Computed Tomography (CT) or Magnetic Resonance Imaging (MRI) Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation Within 45 minutes of Arrival measure.

We are finalizing the proposal to update the validation selection pool and application of existing targeting criteria to eCQMs.

Comments Regarding Case Selection for Validation

Comment: A few commenters supported reducing the quarterly validation requirements for chart-abstracted measures from 12 cases and validating up to 8 cases per measure to accommodate validation of both chart-abstracted measures and eCQMs.

Response: We thank commenters for their support and agree that the change promotes data accuracy while balancing burden. As discussed further in our response to comments below, based on the results of a power analysis, we are finalizing an even greater reduction — up to 7 cases per quarter (28 cases annually) per applicable measure, rather than the up to 8 cases per quarter (32 cases annually) that was proposed.

Comment: A commenter opposed establishing a validation sample size of up to 32 cases per measure annually due to the commenter's concern regarding the increase in burden as new measures are added to the program. Instead, the commenter advised implementing a fixed, aggregate hospital-level cap across all measures combined to maintain rigorous, statistically sound audit oversight without placing increasing strain on health care operations.

Response: We appreciate the commenter's concern regarding the cumulative burden associated with validating an increasing number of measures over time. We note that one of the goals of the Hospital Outpatient Quality Reporting Program is to move forward in the least burdensome manner possible, while maintaining a parsimonious set of the most meaningful quality measures and continuing to incentivize improvement in the quality of care provided to patients. We carefully evaluate each measure proposed for adoption to ensure that its benefits outweigh the cumulative burden of requirements across the program, including data validation policies.

In light of this comment, and consistent with a power analysis conducted to evaluate whether the proposed sample size could be reduced without compromising validation accuracy, we are finalizing a sample size of up to 28 cases annually per applicable measure (up to 7 cases per quarter), rather than the up to 32 cases per measure (up to 8 cases per quarter) that was proposed. This represents a 12.5 percent reduction in the annual case burden relative to our proposal. Our analysis found that a sample size of 28 cases produced agreement with historical hospital classifications of 98.4 percent, with a false-pass rate of 0.1 percent and a false-fail rate of 1.6 percent, indicating that this reduced sample size continues to provide a reliable and statistically sound basis for validation while reducing burden on hospitals. We also note that our analysis found that approximately 89.9 percent of requested cases were available for sampling in the modeled scenario; we will continue to monitor case availability as we implement this change and will address any issues in future rulemaking if warranted.

We decline to adopt the commenter's alternative recommendation of a fixed, aggregate hospital-level cap across all measures combined. While our validation scoring methodology computes a confidence interval using the results from a hospital's applicable measures combined at the hospital level, we continue to believe that establishing a minimum number of cases per measure, rather than a single aggregate cap, better ensures that each individual measure is adequately represented within that combined sample, particularly as additional eCQMs become

eligible for validation over time. A fixed aggregate cap could result in a disproportionately small number of cases being drawn from any individual measure, which would reduce our ability to detect measure-specific reporting or specification issues even though the overall hospital-level score remains statistically sound. We will continue to monitor the cumulative impact of this policy as new measures are added to the program and will consider further refinements in future rulemaking as appropriate.

Comments Regarding the Timing and Electronic File Submission for Medical Records Requests

Comment: A few commenters supported applying the same file submission process to eCQMs as chart-abstracted measures as it facilitates administrative simplicity.

Response: We thank commenters for their support and agree that this alignment creates simplicity.

Comment: A commenter stated that reimbursement of $3.00 per chart does not approximate the cost of retrieving, reviewing, redacting, and transmitting a complete record.

Response: We understand the commenter's concern that $3.00 per chart may not cover the full time and materials associated with record submission. We note that this reimbursement is consistent with the existing reimbursement rates for submitting charts for validation in the Hospital Outpatient Quality Reporting Program (86 FR 63871) as well as the reimbursement rate across other quality reporting programs, such as the Hospital Inpatient Quality Reporting Program (78 FR 50956) and Inpatient Psychiatric Facilities Quality Reporting Program (88 FR 51143). We will continue to consider the burden associated with medical record submission as we evaluate and refine our validation policies.

We are finalizing the same file submission process for eCQMs as chart-abstracted measures.

Comments Regarding Submission Quarters

Comment: A few commenters supported aligning submission quarters across both measure types by moving to a 3-year cycle as this alignment should make it easier for hospitals

to track their validation activities and allow CMS sufficient time to complete the validation and review process.

Response: We thank commenters for their support and agree that this alignment adds simplicity while allowing sufficient time to complete validation activities.

Comment: A commenter stated that moving from a 2-year to a 3-year cycle between the reporting period and payment determination appears unnecessary, particularly as CMS continues to transition toward more eCQMs.

Response: The shift to a 3-year cycle between the reporting period and payment determination is operationally necessary as we adopt eCQMs. Since eCQMs are reported on an annual basis, a 3-year cycle allows sufficient time to complete sampling, medical record abstraction, confidence interval calculation, and educational reviews following the data reporting deadline. As the annual eCQM submission deadline for the Hospital Outpatient Quality Reporting Program is May 15, there is not enough time to request and receive records from selected hospitals, validate an entire year's worth of eCQM data, and calculate the confidence interval by August when we select hospitals for the next payment determination's validation cycle. By shifting to a 3-year cycle, we can effectively include eCQMs and provide an educational review opportunity for eCQMs and the last quarter of chart-abstracted measures. Currently, if a hospital's Q4 educational review determines that a record was incorrectly scored, there is not sufficient time to include that corrected score into the end-of-year confidence interval calculation before the calculation must be finalized for payment determination. As we further leverage Fast Healthcare Interoperability Resources® (FHIR®)[206] for eCQMs, we will consider opportunities to expedite the data validation cycle in the future.

Comment: A commenter supported CMS' effort to reduce administrative burden by exempting hospitals for validation from being reselected within the subsequent year but believed

[206] FHIR® is the registered trademark of Health Level Seven International (HL7), and its use does not constitute endorsement by HL7.

many hospitals would prefer the possibility of consecutive year selection rather than having a single set of validation results place their annual payment update at risk across multiple payment determinations. Another commenter stated that applying CY 2029 validation findings for chart-abstracted measures to CY 2030 validation findings creates a double jeopardy concern for a single year's validation results.

Response: We interpret these comments to mean the commenters are concerned about CY 2027 chart-abstracted data validation impacting their annual payment update for CY 2029 and CY 2030. We wish to clarify that a hospital would not be validated again for the CY 2030 payment determination if they were already selected for CY 2029 payment determination data validation so that validation findings of CY 2027 chart-abstracted data would not affect more than one year's payment determination.

Comment: A commenter asked CMS to provide a clear explanation of how hospitals selected during the transition year will be treated. Another commenter asked CMS to ensure that the criteria used to select hospitals for eCQM validation are transparent, consistently applied, and clearly communicated in advance.

Response: For the transition year (that is, validation of CY 2027 data for the CY 2030 payment determination), up to 200 hospitals would be randomly selected and up to 200 hospitals would be selected using the targeting criteria at § 419.46(f)(3)(i) through (v), but only if the hospital did not participate in validation affecting the CY 2029 payment determination. In other words, all hospitals selected for validation affecting the CY 2029 payment determination would be excluded from reselection for validation affecting the CY 2030 payment determination to avoid validating the same CY 2027 chart-abstracted data over again. After the transition year affecting the CY 2030 payment determination, up to 200 hospitals would be randomly selected and up to 200 hospitals would be selected using the targeting criteria at § 419.46(f)(3)(i) through (v).

We are finalizing the transition from validation results affecting payment 2 years after the reporting period to 3 years after the reporting period beginning with the CY 2030 payment determination.

Comments Regarding the Scoring Method

Comment: A few commenters supported applying the same scoring methodology process to eCQMs as chart-abstracted measures as it balances administrative simplicity while acknowledging that eCQMs and the data that inform them are different in nature from chart-abstracted measures.

Response: We thank commenters for their support and agree that this alignment creates simplicity.

Comment: A commenter suggested shifting the focus of assessing the validity of the data elements to evaluating whether the level of data accuracy is sufficient for a measure to produce valid results. They stated that a minimum threshold at a 75 percent level of data accuracy may not result in a measure with either reasonable validity or reliability, and the public and the provider community need a higher level of assurance that the measure results reflect the quality of care of a facility as opposed to the accuracy of a number of data elements. A commenter asked for clarity on which record elements CMS will use to adjudicate a match.

Response: We confirm that data validation scoring is at the measure level as the commenter recommends, not the individual data element level. While individual data elements are assessed during the data validation process to confirm that a clinical event actually occurred, was documented appropriately in the source records, was interpreted correctly, and was mapped correctly into reporting fields, the validation score for the measure reflects whether the CMS validation process obtained the same measure outcome as the hospital's original submission. If the CMS validation process does not obtain the same measure outcome, then the case may be considered a mismatch. Applying an upper bound of a 90 percent two-sided confidence interval with a 75 percent lower bound threshold level accounts for sampling variability, reflects a

reasonable standard of data accuracy, and aligns with existing validation thresholds for chart-abstracted measures while allowing for legitimate differences in hospital data implementation. However, we will consider increasing the threshold in future rulemaking as hospitals gain further experience with eCQM reporting over time.

Comment: Many commenters supported validation overall but recommended modifications to the validation processes to include eCQMs. Several commenters recommended validating eCQMs after one or two full years of mandatory reporting of data or providing an initial reporting-only year as a phased implementation to provide health systems with the necessary operational runway to establish, test, and stabilize electronic data extraction workflows before being subjected to formal audits and financial penalties. If CMS did a reporting-only year as recommended, commenters also suggested that CMS conduct targeted validation activities. These commenters indicated that results from an initial reporting-only year could provide hospitals with educational feedback regarding identified issues to allow hospitals to identify documentation deficiencies, data abstraction concerns, measure logic inconsistencies, and submission errors and better ensure that validation results accurately reflect performance rather than implementation challenges. A commenter emphasized that clear communication regarding expectations, common validation errors, and areas requiring corrective action will improve reporting accuracy and help ensure validation activities function as a quality improvement tool rather than solely a compliance exercise.

Many commenters expressed concern with beginning validation with CY 2027 reporting period data for the STEMI eCQM due to issues in accurately identifying patients in the numerator and denominator and concerns that the current measure logic is not designed well for electronic data capture. Several commenters stated that the two denominator exceptions for the CY 2026 reporting period are helpful, but challenging to implement, which further complicates efforts to improve accuracy of STEMI data capture. A few commenters asked CMS to ensure that validation methodologies adequately account for the complexity of emergency

cardiovascular care workflows, including data originating from emergency medical service systems, transferring facilities, emergency departments, and cardiac catheterization laboratories.

Several commenters who were concerned about beginning validation of the STEMI eCQM with CY 2027 reporting period data also supported a reporting-only period or delaying scoring until electronic capture of STEMI is mature. Another commenter recommended delaying validation activities until hospitals have completed at least one full reporting cycle using the revised STEMI eCQM specifications.

Response: We appreciate commenters raising these concerns and sharing their recommendations. We agree with commenters that delaying the timeline for eCQM validation and providing an opportunity for educational review would allow hospitals to gain experience with measure requirements and identify deficiencies before validation scores affect payment. We also recognize that STEMI care, by its nature, is fast-moving and frequently spans multiple clinicians and care settings, including the emergency department, the cardiac catheterization laboratory, and interpreting cardiology services, which can present documentation and systems integration challenges. We believe the measure is appropriately designed for electronic capture as the eCQM is endorsed by the consensus-based entity[207] and underwent the rigorous measure development lifecycle outlined at the CMS Measures Management System website,[208] to ensure the measure is precisely specified, feasible, valid, and reliable. However, we acknowledge that the STEMI eCQM specifications were recently revised, and we agree with commenters that payment penalties associated with validation scores should be delayed for the STEMI eCQM as initial scores may reflect challenges with implementing recent measure updates rather than the true accuracy of hospital STEMI eCQM submissions.

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[207] Partnership for Quality Measurement. Appropriate Treatment for ST-Segment Elevation Myocardial Infarction (STEMI) Patients in the Emergency Department (ED). Available at *https://p4qm.org/measures/3613e.*

[208] Centers for Medicare & Medicaid Services. Blueprint Measure Lifecycle. Measures Management System. Available at *https://mmshub.cms.gov/blueprint-measure-lifecycle-overview.*

Based on commenter concerns about the STEMI eCQM and data issues during the first year of mandatory implementation of any eCQM, we are finalizing the data validation policy with a modification to delay payment penalties associated with validation scores until an eCQM has been mandatory in the program for one year of reporting. During the first full year of mandatory reporting, validation scores will only be used to provide selected hospitals with an opportunity for educational review, and payment penalties will only be assessed if a hospital does not submit requested records. If a hospital does not submit at least 75 percent of the requested records for the applicable eCQM under validation, the hospital will fail validation even during this unscored period. This modification allows at least one full reporting cycle using the revised STEMI eCQM specifications before a payment impact and provides an opportunity for educational feedback to identify and resolve errors before validation score results may affect payment.

As an example of how the finalized policy will be applied, the STEMI eCQM validation for the CY 2027 reporting period impacting the CY 2030 payment determination will serve as an educational review opportunity, with a payment penalty only for failure to submit at least 75 percent of the requested records. For the CY 2028 reporting period impacting the CY 2031 payment determination, payment penalties for the STEMI eCQM validation will be based on attaining at least a 75 percent validation score for eCQM data validation.

Comment: Several commenters expressed that eCQM performance and reporting are heavily dependent upon EHR configuration, vendor programming, data mapping, and interoperability among health information systems. These commenters stated that this means CMS should ensure that validation findings appropriately distinguish hospital reporting issues from technology-related discrepancies that may be outside a hospital's direct control, particularly as CMS moves towards automated and FHIR®-based measurement.

Specifically, a few commenters did not support treating missing or flawed medical records as mismatches, stating that eCQM discrepancies often stem from vendor specification

updates, structured data mapping, or electronic file transmission protocols, which would unfairly penalize facilities for circumstances unrelated to actual measure accuracy. A commenter recommended that CMS instead establish an eCQM-specific validation scoring framework that accommodates electronic data architecture nuances and provide a technical remediation window prior to impacting annual payment determinations. Another commenter encouraged CMS to consider alternative approaches, including a grace period, an exception process for circumstances outside a hospital's control, or, in the case of unavailable records, a separate classification that does not automatically equate unavailable records with measure inaccuracy.

Response: We understand that hospitals rely on measure developers and EHR vendors for eCQM reporting. However, we do not agree that records unavailable for validation should be excluded from the calculation of the validation score. The purpose of validation is to assess whether the CMS validation process obtains the same measure outcomes as the hospital's original submission. If a record is not received or does not contain the necessary information, then we cannot determine that the reported result agrees with the medical records, so it causes a mismatch. Yet, we recognize that data mapping and data quality issues may arise with eCQM implementation. The 75 percent scoring threshold is intended to account for sampling variability and reasonable differences in hospital data implementation while maintaining a reasonable standard for data accuracy. Our modification to delay any payment penalties associated with validation scores until an eCQM has been mandatory in the program for one year of reporting also allows additional time for hospitals and their vendors to resolve data reporting issues.

After consideration of the public comments we received, we are finalizing our proposal that a minimum score of 75 percent accuracy will be required for the hospital to pass the eCQM validation requirement with a modification to delay the payment penalties associated with the eCQM validation score until the second full year an eCQM has been mandatory in the program. During the first full year of mandatory reporting, validation scores will only be used to provide selected hospitals with an opportunity for educational review, and payment penalties will only be

assessed if a hospital does not submit requested records. If a hospital does not submit at least 75 percent of the requested records for the applicable eCQM under validation, the hospital will fail validation even during this unscored period.

Comments Regarding the Educational Review Process

Comment: A few commenters supported expanding the educational review process to eCQMs and allowing educational results from all four quarters of chart-abstracted measure validation to be included in the final validation scores. These commenters stated that hospitals should have a meaningful opportunity to identify and resolve questions or errors in their validation results before those results affect payment.

Response: We thank commenters for their support and agree that educational reviews are a meaningful opportunity to address questions and errors in validation results.

We are finalizing the educational review process to include the last quarter of chart-abstracted measures and to integrate eCQMs into the final validation scores.

Table 100 summarizes our finalized validation process for CY 2029 to CY 2032 payment determinations, which includes a modification to validate up to 28 cases annually per measure (up to 7 cases per quarter) and a modification to begin scoring eCQM validation based on data accuracy after one full year of mandatory reporting in the Hospital Outpatient Quality Reporting Program.

TABLE 100: FINALIZED VALIDATION PROCESS FOR CY 2029 TO CY 2032 PAYMENT DETERMINATIONS

Payment Determination	Reporting Period Data	Measure Type	Validation Cycle	Annual Number of Cases Validated	Notes
CY 2029	CY 2027	Chart-Abstracted	Current 2-year cycle	48 cases under current policy	Continues current policy - no change from existing validation process
CY 2030	CY 2027	Chart-Abstracted and eCQM (STEMI)	Finalized 3-year cycle	Up to 84 cases (28 cases per measure × 3 measures)	Hospitals selected for validation affecting the CY 2029 payment determination are excluded from reselection for validation affecting the CY 2030 payment determination, to avoid validating the same CY 2027 data twice.

					STEMI eCQM validation results serve as an educational review opportunity only during this transition year (validation score will not result in a payment penalty).**
CY 2031	CY 2028	Chart-Abstracted and eCQM (STEMI, ECAT)	Finalized 3-year cycle	Up to 84* cases (28 cases per measure × 3* measures)	Transition to 3-year cycle complete; STEMI eCQM validation scoring based on data accuracy and potential impacts to payment begins; ECAT eCQM validation serves as an educational review opportunity only (validation score will not result in a payment penalty).**
CY 2032 (and subsequent years)	CY 2029 (and subsequent years)	Chart-Abstracted and eCQM (STEMI, ECAT)	Finalized 3-year cycle	Up to 84* cases (28 cases per measure × 3* measures)	ECAT eCQM validation scoring based on data accuracy and potential impacts to payment begins.**

*Number of cases and measures for subsequent years will correspond to the sum of the number of chart-abstracted and eCQM measures subject to the validation process for the applicable reporting and payment periods, with a total of up to 28 cases per measure.

**As new eCQMs are added to the program, validation results will serve as an educational review opportunity only for the first mandatory reporting period, and scoring based on data accuracy will begin with the eCQM's second mandatory reporting period. Submission of at least 75 percent of requested medical records is required for the educational review opportunity in addition to when validation with scoring based on data accuracy begins.

E. Updates to the Hospital Outpatient Quality Reporting Program Validation Reconsiderations and Appeals Procedures

1. Reconsiderations and Appeals

We refer readers to § 419.46(g) for our reconsideration and appeals procedures. Under our existing requirements at § 419.46(g)(2)(vii), hospitals submitting reconsideration requests are required to submit a copy of all materials that the hospital submitted to comply with the requirements of the affected payment determination year. In the CY 2022 OPPS/ASC final rule with comment period, we finalized a requirement for hospitals to submit only electronic files rather than paper copies of medical records for validation of chart-abstracted measures, beginning with validation affecting the CY 2024 payment determination and for subsequent years (86 FR 63871).

2. Removal of the Re-Submission of Supporting Medical Documentation for Validation Reconsideration Requests

With the transition to all electronic submission of copies of medical records for Hospital Outpatient Quality Reporting Program data validation, the current reconsideration requirement to resubmit records used for validation results in a validation-related reconsideration request is no longer necessary and creates duplicative files and administrative burden. We note that the Hospital Inpatient Quality Reporting Program finalized a policy in the FY 2025 IPPS/LTCH PPS final rule with comment period to remove the requirement to resubmit medical records as part of their request for reconsideration of a validation determination beginning with CY 2023 discharges affecting the FY 2026 payment determination (89 FR 69577).

In the CY 2027 OPPS/ASC proposed rule (91 FR 41966 through 41967), we proposed to revise existing § 419.46(g)(2)(vii) and (viii) of our regulations to no longer require hospitals to resubmit materials previously submitted to CMS for validation reconsideration requests, unless specifically requested by CMS, and to require only that the hospital provide any evidence supporting its validation reconsideration request. Under this proposal, hospitals that need to submit a revised medical record may still do so, but those hospitals that would otherwise be submitting copies of previously submitted records would no longer be required to submit them. Removing resubmission of medical documentation as a requirement for validation reconsideration would reduce administrative burden for most hospitals that do not have revised records to submit, as well as for CMS to collect and track medical records that are already available. Please refer to section XXIV.A.5. of this final rule with comment period for more information on the burden estimates associated with this proposed removal.

We invited public comment on this proposal to remove the requirement for hospitals to resubmit medical documentation as part of their request for reconsideration of validation, beginning with data from the CY 2026 reporting period affecting the CY 2028 payment determination. We also proposed to codify this policy by updating the regulatory text at § 419.46(g).

Comment: Many commenters supported the removal of the requirement for hospitals to resubmit medical documentation as part of their request for reconsideration of validation as part of CMS' efforts to streamline and modernize requirements. Several commenters stated that with the transition to electronic medical record submission and CMS' existing access to these records, the resubmission requirement imposes unnecessary administrative burden without providing meaningful programmatic value. A few commenters remarked that the proposal preserves hospitals' ability to submit additional information relevant to a reconsideration request when necessary. A commenter supported aligning the Hospital Outpatient Quality Reporting Program's policies with established Hospital Inpatient Quality Reporting Program procedures.

Response: We thank commenters for their support and agree that resubmission is no longer necessary and creates duplicative files and work. Removing this requirement would align with the Hospital Inpatient Quality Reporting Program reconsideration processes.

After consideration of the public comments we received, we are finalizing the removal of the reconsideration requirement to resubmit records used for validation results in a validation-related reconsideration request as proposed.

F. Payment Reduction for Hospitals That Fail to Meet the Hospital Outpatient Quality Reporting (OQR) Program Requirements for the CY 2027 Payment Determination

1. Background

Section 1833(t)(17) of the Act, which applies to subsection (d) hospitals (as defined under section 1886(d)(1)(B) of the Act), states that hospitals that fail to report data required to be submitted on measures selected by the Secretary, in the form and manner, and at a time, specified by the Secretary will incur a 2.0-percentage point reduction to their OPD fee schedule increase factor; that is, the annual payment update factor. Section 1833(t)(17)(A)(ii) of the Act specifies that any reduction applies only to the payment year involved and will not be taken into account in computing the applicable OPD fee schedule increase factor for a subsequent year.

The application of a reduced OPD fee schedule increase factor results in reduced national unadjusted payment rates that apply to certain outpatient items and services provided by hospitals that are required to report outpatient quality data in order to receive the full payment update factor and that fail to meet the Hospital OQR Program requirements. Hospitals that meet the reporting requirements receive the full OPPS payment update without the reduction. For a more detailed discussion of how this payment reduction was initially implemented, we refer readers to the CY 2009 OPPS/ASC final rule with comment period (73 FR 68769 through 68772).

The national unadjusted payment rates for many services paid under the OPPS equal the product of the OPPS conversion factor and the scaled relative payment weight for the APC to which the service is assigned. The OPPS conversion factor, which is updated annually by the OPD fee schedule increase factor, is used to calculate the OPPS payment rate for services with the following status indicators (listed in Addendum B to this final rule with comment period, which is available via the Internet on the CMS website): "J1", "J2", "P", "Q1", "Q2", "Q3", "R", "S", "T", "V", or "U". Payment for all services assigned to these status indicators will be subject to the reduction of the national unadjusted payment rates for hospitals that fail to meet Hospital OQR Program requirements, with the exception of services assigned to New Technology APCs with assigned status indicator "S" or "T". We refer readers to the CY 2009 OPPS/ASC final rule with comment period (73 FR 68770 through 68771) for a discussion of this policy. In the CY 2017 OPPS/ASC final rule with comment period (81 FR 79796), we clarified that the reporting ratio does not apply to codes with status indicator "Q4" because services and procedures coded with status indicator "Q4" are either packaged or paid through the Clinical Laboratory Fee Schedule and are never paid separately through the OPPS.

The OPD fee schedule increase factor is an input into the OPPS conversion factor, which is used to calculate OPPS payment rates. To reduce the OPD fee schedule increase factor for hospitals that fail to meet reporting requirements, we calculate two conversion factors—a full

market basket conversion factor (that is, the full conversion factor), and a reduced market basket conversion factor (that is, the reduced conversion factor). We then calculate a reduction ratio by dividing the reduced conversion factor by the full conversion factor. We refer to this reduction ratio as the "reporting ratio" to indicate that it applies to payment for hospitals that fail to meet their reporting requirements. Applying this reporting ratio to the OPPS payment amounts results in reduced national unadjusted payment rates that are mathematically equivalent to the reduced national unadjusted payment rates that would result if we multiplied the scaled OPPS relative payment weights by the reduced conversion factor. For example, to determine the reduced national unadjusted payment rates that applied to hospitals that failed to meet their quality reporting requirements for the CY 2010 OPPS/ASC final rule with comment period, we multiplied the final full national unadjusted payment rate found in Addendum B of the CY 2010 OPPS/ASC final rule with comment period by the CY 2010 OPPS final rule with comment period reporting ratio of 0.980 (74 FR 60642).

We note that the only difference in the calculation for the full conversion factor and the calculation for the reduced conversion factor is that the full conversion factor uses the full OPD update, and the reduced conversion factor uses the reduced OPD update. The baseline OPPS conversion factor calculation is the same since all other adjustments would be applied to both conversion factor calculations. Therefore, our standard approach of calculating the reporting ratio as described earlier in this section is equivalent to dividing the reduced OPD update factor by that of the full OPD update factor. In other words:

Full Conversion Factor = Baseline OPPS conversion factor * (1 + OPD update factor)

Reduced Conversion Factor = Baseline OPPS conversion factor * (1 + OPD update factor – 0.02)

Reporting Ratio = Reduced Conversion Factor / Full Conversion Factor

Which is equivalent to:

Reporting Ratio = (1 + OPD Update factor – 0.02) / (1 + OPD update factor)

In the CY 2009 OPPS/ASC final rule with comment period (73 FR 68771 through 68772), we established a policy that the Medicare beneficiary's minimum unadjusted copayment and national unadjusted copayment for a service to which a reduced national unadjusted payment rate applies would each equal the product of the reporting ratio and the national unadjusted copayment or the minimum unadjusted copayment, as applicable, for the service. Under this policy, we apply the reporting ratio to both the minimum unadjusted copayment and national unadjusted copayment for services provided by hospitals that receive the payment reduction for failure to meet the Hospital OQR Program reporting requirements. This application of the reporting ratio to the national unadjusted and minimum unadjusted copayments is calculated according to § 419.41 of our regulations, prior to any adjustment for a hospital's failure to meet the quality reporting standards according to § 419.43(h). Beneficiaries and secondary payers thereby share in the reduction of payments to these hospitals.

In the CY 2009 OPPS/ASC final rule with comment period (73 FR 68772), we established the policy that all other applicable adjustments to the OPPS national unadjusted payment rates apply when the OPD fee schedule increase factor is reduced for hospitals that fail to meet the requirements of the Hospital OQR Program. For example, the following standard adjustments apply to the reduced national unadjusted payment rates: the wage index adjustment, the multiple procedure adjustment, the interrupted procedure adjustment, the rural sole community hospital adjustment, and the adjustment for devices furnished with full or partial credit or without cost. Similarly, OPPS outlier payments made for high cost and complex procedures will continue to be made when outlier criteria are met. For hospitals that fail to meet the quality data reporting requirements, the hospitals' costs are compared to the reduced payments for purposes of outlier eligibility and payment calculation. We established this policy in the OPPS beginning in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60642). For a complete discussion of the OPPS outlier calculation and eligibility criteria, we refer readers to section II.G. of the CY 2023 OPPS/ASC proposed rule (87 FR 44533 through

44534).

2. Reporting Ratio Application and Associated Adjustment Policy for CY 2027

We proposed to continue our established policy of applying the reduction of the OPD fee schedule increase factor through the use of a reporting ratio for those hospitals that fail to meet the Hospital OQR Program requirements for the full CY 2027 annual payment update factor. For the CY 2027 OPPS/ASC proposed rule, the proposed reporting ratio was 0.9805, which, when multiplied by the proposed full conversion factor of $102.004, equaled a proposed conversion factor for hospitals that fail to meet the requirements of the Hospital OQR Program (that is, the reduced conversion factor) of $100.015. We proposed to continue to apply the reporting ratio to all services calculated using the OPPS conversion factor. We proposed to continue to apply the reporting ratio, when applicable, to all HCPCS codes to which we have proposed status indicator assignments of "J1," "J2," "P," "Q1," "Q2," "Q3," "R," "S," "T," "V," and "U" (other than New Technology APCs to which we have proposed status indicator assignments of "S" and "T"). We proposed to continue to exclude services paid under New Technology APCs. We proposed to continue to apply the reporting ratio to the national unadjusted payment rates and the minimum unadjusted and national unadjusted copayment rates of all applicable services for those hospitals that fail to meet the Hospital OQR Program reporting requirements. We also proposed to continue to apply all other applicable standard adjustments to the OPPS national unadjusted payment rates for hospitals that fail to meet the requirements of the Hospital OQR Program. Similarly, we proposed to continue to calculate OPPS outlier eligibility and outlier payment based on the reduced payment rates for those hospitals that fail to meet the reporting requirements. In addition to our proposal to implement the policy through the use of a reporting ratio, we proposed to continue to calculate the reporting ratio to four decimals.

We did not receive public comments on this provision and are finalizing as proposed. For this final rule with comment period, the final reporting ratio is 0.9804, which, when

multiplied by the final full conversion factor of $ 99.970, equals a final conversion factor for hospitals that fail to meet the requirements of the Hospital OQR Program (that is, the reduced conversion factor) of $98.011. We are finalizing our proposal to continue to calculate OPPS outlier eligibility and outlier payment based on the reduced payment rates for those hospitals that fail to meet the reporting requirements. We are also finalizing our proposals to implement the policy through the use of a reporting ratio, and to calculate the reporting ratio to four decimals (rather than the previously used three decimals) to more precisely calculate the reduced adjusted payment and copayment rates for hospitals that fail to meet the Hospital OQR Program requirements for CY 2027 payment.

XVI. Rural Emergency Hospital (REH) Quality Reporting Program

The Rural Emergency Hospital (REH) Quality Reporting Program, implemented under section 1861(kkk)(7) of the Act, ensures transparency and quality for rural emergency hospitals (REHs), defined at section 1861(kkk)(2) of the Act. We refer readers to the CY 2024 OPPS/ASC final rule with comment period (88 FR 82046 through 82047) for a detailed discussion of the history of the REH Quality Reporting Program. The REH Quality Reporting Program requirements are codified at 42 CFR 419.95. We also refer readers to the CMS QualityNet REH Quality Reporting Program website at *https://qualitynet.cms.gov/reh/rehqr* for current program requirements and measure specifications. We did not propose any changes to the REH Quality Reporting Program in the CY 2027 OPPS/ASC proposed rule (91 FR 41968).

XVII. Ambulatory Surgical Center Quality Reporting Program

A. Background

The Ambulatory Surgical Center (ASC) Quality Reporting Program promotes transparency regarding the quality of care provided at ASCs. Section 1833(i)(7)(A) of the Act authorizes the Secretary to reduce any annual increase under the revised ASC payment system by 2.0 percentage points for such year that an ASC fails to submit required data on quality measures specified by the Secretary in accordance with section 1833(i)(7)(B) of the Act. We refer readers to the CY 2012 OPPS/ASC final rule with comment period (76 FR 74492 through 74494) for a detailed discussion of the statutory authority of the ASC Quality Reporting Program. We have codified certain ASC Quality Reporting Program requirements at 42 CFR part 416, subpart H (§§ 416.300 through 416.330). We also refer readers to the CMS website at *https://www.cms.gov/medicare/quality/initiatives/asc-quality-reporting* for general background on the ASC Quality Reporting Program and to the CMS QualityNet ASC Quality Reporting Program website at *https://qualitynet.cms.gov/asc* for current program requirements and measure specifications.

B. ASC Quality Reporting Program Measure Set

We refer readers to section XIV. of this final rule with comment period where we discuss the removal of the Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients measure from the ASC Quality Reporting and Hospital Outpatient Quality Reporting Programs beginning with the CY 2027 reporting period/CY 2029 payment determination. We are not finalizing any other changes to the ASC Quality Reporting Program measure set.

Table 101 summarizes the previously finalized and newly finalized ASC Quality Reporting Program measure set for the CY 2028 to CY 2032 payment determinations, which removes the Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients measure.

TABLE 101: ASC QUALITY REPORTING PROGRAM MEASURE SET BY DATA COLLECTION METHOD AND PAYMENT DETERMINATION (PD)

Consensus-Based Entity #	Measure Name	CY 2028 PD	CY 2029 PD	CY 2030 PD	CY 2031 PD	CY 2032 PD
	Chart-Abstracted Measures					
None	All-Cause Hospital Transfer/Admission	✓	✓	✓	✓	✓
0658	Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients*	✓	Removed			
None	Normothermia Outcome	✓	✓	✓	✓	✓
None	Patient Burn	✓	✓	✓	✓	✓
None	Patient Fall	✓	✓	✓	✓	✓
None	Unplanned Anterior Vitrectomy	✓	✓	✓	✓	✓
None	Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant	✓	✓	✓	✓	✓
	Claims-Based Measures					
2539	Facility 7-Day Risk-Standardized Hospital Visit Rate After Outpatient Colonoscopy	✓	✓	✓	✓	✓
3357	Facility-Level 7-Day Hospital Visits After General Surgery Procedures Performed at ASCs	✓	✓	✓	✓	✓
3366	Hospital Visits After Urology ASC Procedures	✓	✓	✓	✓	✓
3470	Hospital Visits After Orthopedic ASC Procedures	✓	✓	✓	✓	✓
	Patient-Reported Outcomes-Based Performance Measures					
None	Risk-Standardized PRO-PM Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) in the ASC Setting (THA/TKA PRO-PM)	Voluntary	Voluntary	Voluntary	✓	✓
None	Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery	Voluntary	Voluntary	Voluntary	Voluntary	Voluntary
	Survey-Based Measures					
None	Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS)	✓	✓	✓	✓	✓

✓Measure is mandatory for the specified payment determination year.

Voluntary: Submission of this measure is optional, and ASCs that do not report on the measure are not subject to a payment reduction.
* Removed in this final rule with comment period beginning with the CY 2029 payment determination.

C. Request for Information on Stratification of the All-Cause Hospital Transfer/Admission Measure

We previously adopted the All-Cause Hospital Transfer/Admission measure in the ASC Quality Reporting Program in the CY 2012 OPPS/ASC final rule with comment period (76 FR 74499). The All-Cause Hospital Transfer/Admission measure is an outcome measure that assesses the rate of patients receiving care in an ASC who require transfer to a hospital or admission to a hospital upon discharge from the ASC. Currently, the measure does not distinguish the phase of care in which a transfer occurs (pre-procedure, intra-procedure, or post-procedure).[209]

As reported in MedPAC's 2025 Report to Congress, extracapsular cataract removal with intraocular lens insertion was the most common Medicare Fee-for-Service procedure performed by ASCs in 2023, accounting for 19 percent of all ASC Fee-for-Service volume. In addition, a substantial number of ASCs that bill Medicare specialize in a single clinical area, with gastroenterology and ophthalmology among the most common specialties providing services to Medicare beneficiaries.[210] A recent retrospective study which examined the causes and timing of direct hospital transfers from an ophthalmology-specific surgery center over a 2-year period reported that about 77 percent of hospital transfers were associated with concerns identified prior to the induction of anesthesia, including transfers identified in the preoperative area or upon connection to monitoring equipment in the operating room.[211] Nearly 23 percent of these transfers were directly related to anesthesia or the surgical procedure, including events occurring

[209] Partnership for Quality Measurement. All-Cause Hospital Transfer/Admission. Available at https://p4qm.org/measures/0265.
[210] MedPAC. (2025). Report to the Congress: Medicare Payment Policy-Ambulatory Surgical Center Services: Status Report. Available at https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_Ch10_MedPAC_Report_To_Congress_SEC.pdf.
[211] Stange, N. R., & Rauen, M. P. (2025). Evaluating ASC-4 transfer rates in cataract surgery: insights into timing and causes of hospital transfers. *Journal of cataract and refractive surgery*, *51*(5), 376–381. https://doi.org/10.1097/j.jcrs.0000000000001613.

during induction or intraoperatively. These findings suggest that the majority of hospital transfers from ophthalmology-specific ASCs could be occurring preoperatively rather than procedural complications. While many of these events occur prior to anesthesia induction, they are often identified during anesthesia-led pre-procedure evaluation, reflecting important safety checks in patient assessment.[212]

Based on these findings and discussions with interested parties, we considered whether adding a phase-of-care stratification relative to the surgical encounter (for example, pre-procedure, intra-procedure, and post-procedure) could improve the interpretability and usefulness of the All-Cause Hospital Transfer/Admission measure in the ASC Quality Reporting Program. The current measure reports an overall rate of transfers/admissions and does not specify when during the ASC encounter the need for transfer/admission is identified. Stratification by phase of care would improve attribution and interpretability across the diverse range of ASC services, including nonoperative procedures such as those associated with pain management, for hospital transfers/admissions associated with ASC care.

It is important to measure and monitor transfers/admissions that occur pre-procedure, intra-procedure, and post-procedure, as each stratum could provide insight into care processes between facilities. Pre-procedure events may reflect the effectiveness of pre-procedure evaluation, patient selection, and escalation or transfer processes, while intra-procedure and post-procedure events may be more closely associated with anesthesia administration, the procedure itself, and immediate recovery, including complications that arise during or after the ASC encounter. A phase-of-care stratification may also provide more comprehensive information to support beneficiary decision-making and patient safety monitoring.

We sought public comment on clinically meaningful and operationally feasible approaches for including a phase-of-care stratification for the All-Cause Hospital

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[212] Stange, N. R., & Rauen, M. P. (2025). Evaluating ASC-4 transfer rates in cataract surgery: insights into timing and causes of hospital transfers. *Journal of cataract and refractive surgery*, *51*(5), 376–381. https://doi.org/10.1097/j.jcrs.0000000000001613.

Transfer/Admission measure. Specifically, we requested input on potential stratification frameworks, including appropriate time anchors, their operational definitions, and the corresponding time windows that could be used to define each stratification category.

We received public comments on these topics. The following is a summary of the comments we received:

Comment: Many commenters supported stratifying the All-Cause Hospital Transfer/Admission measure by phase of care, stating that the current measure combines events occurring under different clinical circumstances and therefore provides limited information about when or why a transfer or admission occurred. Many commenters stated that phase-of-care stratification could improve the measure's usefulness and ease of interpretation, support attribution and quality improvement, and provide more meaningful information about patient safety and the circumstances surrounding transfers. Several commenters specifically noted that preoperative transfers may reflect the identification of previously unrecognized clinical conditions, appropriate patient selection, or other safety-related clinical decisions rather than complications associated with the procedure.

Many commenters recommended distinguishing transfers occurring during the pre-procedure, intra-procedure, and post-procedure phases, although commenters differed regarding the precise definitions and boundaries. Several commenters recommended using specific clinical or workflow events, including anesthesia or procedure start, procedure completion, entry into or exit from the operating or procedural setting, arrival in recovery, and discharge, as phase boundaries. A commenter specifically recommended using procedure start and stop times rather than anesthesia start and stop times because not all procedures involve anesthesia and an anesthesia-based anchor could limit completeness and comparability. A few commenters recommended determining the phase based on when the condition or need for transfer is first identified rather than when the patient physically leaves the ASC, while a few commenters proposed broader groupings, including combining intra- and post-procedure events. A

commenter also recommended that CMS partner with measure developers and other interested parties to design and test methods for stratification.

Many commenters supported stratification while emphasizing that CMS should address potential unintended consequences in developing and using the measure. Several commenters recommended accounting for patient complexity, case mix, procedural risk, clinical context, or differences among patients, procedures, and facilities to avoid misleading comparisons or inappropriate attribution. Several commenters also emphasized that the measure should not create incentives to avoid, delay, or otherwise discourage medically appropriate transfers or treatment of patients with greater clinical complexity. A commenter further cautioned against attributing events to ASCs when they are not reasonably within the facility's control, noting that pre-procedure transfers may result from incomplete clearance, changes in patient condition, or appropriate referral decisions, while post-discharge hospital encounters may reflect unrelated acute illness, patient non-adherence, chronic conditions, or other events not reasonably predictable or preventable by the ASC. Several commenters raised concerns about validity, reliability, attribution, statistical stability, or the need for testing before phase-specific results are used for comparison, payment, public reporting, or other consequential purposes; a few commenters specifically raised concerns about small numbers or statistically unstable phase-specific rates.

Several commenters recommended considering information beyond phase of care to provide additional context for interpreting transfers and admissions. A few commenters recommended including information about the reason for or appropriateness of a transfer, including distinctions between potentially preventable events and medically appropriate escalation of care. A few commenters recommended consideration of downstream outcomes or information available from other care settings, while a few commenters recommended including additional patient, procedure, facility, or other characteristics because phase of care alone may not fully explain differences in transfer or admission rates. Several commenters also addressed

implementation and data requirements. A few commenters recommended using information already available in clinical documentation, claims, or other existing data infrastructure where possible to limit additional reporting requirements. A few commenters recommended clear definitions, guidance, or examples to support consistent implementation, and a few commenters emphasized the need for consistently recorded or structured data to support reliable phase classification.

Several commenters raised concerns about how phase-specific results would be reported and used. A few commenters recommended limiting public reporting, comparison, payment, or other consequential uses until the methodology is established or the results are sufficiently reliable, while a few commenters expressed concern that patients or other users could misunderstand phase-specific results and recommended clear explanations to support appropriate interpretation. A few commenters recommended retaining the overall All-Cause Hospital Transfer/Admission measure while adding phase-of-care stratified results. A commenter stated that retaining the overall measure would preserve information for public reporting and consumer decision-making, while another commenter stated that it would preserve a broad patient-safety signal while providing additional context about the circumstances contributing to that signal.

A few commenters did not support phase-of-care stratification at this time or questioned whether stratification by phase of care alone would provide sufficiently meaningful or actionable information. A few commenters cited differences in phase-specific transfer rates across datasets. Specifically, a commenter cited their own internal data aggregated across more than a thousand ASCs where most transfers occurred postoperatively, which contrasted from the study from a single-specialty ophthalmology ASC in which the majority occurred preoperatively.[213] The commenter stated that these differences raised questions about whether phase-only stratification alone would be meaningful, and suggested further stratification by single-specialty or multi-

[213] Stange, N. R., & Rauen, M. P. (2025). Evaluating ASC-4 transfer rates in cataract surgery: insights into timing and causes of hospital transfers. *Journal of cataract and refractive surgery*, *51*(5), 376–381. https://doi.org/10.1097/j.jcrs.0000000000001613.

specialty status, case type, and characteristics of the patient population may be needed to produce actionable information. One of these commenters supplied the example of a single facility with a high pre-surgery transfer rate to support this view. The same commenter also questioned whether the additional burden of phase-of-care stratification would provide information sufficiently useful and valuable to warrant the effort. A commenter recommended that CMS remove the All-Cause Hospital Transfer/Admission measure altogether to reduce administrative burden and streamline reporting requirements.

Response: We appreciate all the comments on this topic. While we are not responding to specific comments in response to the RFI in this final rule, we believe that this input is very valuable and will continue to take such comments into account for a potential future stratification of the All-Cause Hospital Transfer/Admission measure that may be proposed in future rulemaking.

D. Form, Manner, and Timing of Data Submission

We refer readers to prior OPPS/ASC final rules with comment period identified in footnotes below and § 416.310 for information regarding the data submission and reporting requirements for claims-based[214], survey-based[215], web-based[216] (that is, data submitted via a CMS-designated information system), and patient-reported outcome-based performance measures[217] in the ASC Quality Reporting Program. We maintain measure technical specification manuals (referred to as Specifications Manuals) that can be found on the CMS website at *https://qualitynet.cms.gov/asc/specifications-manua*ls.

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[214] We refer readers to §§ 416.310(a) and (b) and the CY 2016 OPPS/ASC final rule with comment period (80 FR 70534 through 70536) for information regarding the claims-based measure data submission and reporting requirements.

[215] We refer readers to § 416.310(e) and the CY 2022 OPPS/ASC final rule with comment period (86 FR 63905 through 63909) for information regarding the survey-based data submission and reporting requirements.

[216] We refer readers to § 416.310(c)(1) and the CY 2025 OPPS/ASC final rule with comment period (89 FR 94435 and 94436) for details regarding submission of web-based data via a CMS-designated information system (currently the Hospital Quality Reporting (HQR) system).

[217] We refer readers to the CY 2024 OPPS/ASC final rule with comment period (88 FR 82041 through 82045) for information regarding the patient-reported outcome-based performance measure data submission and reporting requirements.

In the CY 2027 OPPS/ASC proposed rule (91 FR 41972), we did not propose any changes to these policies.

E. Payment Reduction for ASCs That Fail to Meet the ASCQR Program Requirements

1. Statutory Background

We refer readers to the CY 2012 OPPS/ASC final rule with comment period (76 FR 74492 through 74493) for a detailed discussion of the statutory background regarding payment reductions for ASCs that fail to meet the ASCQR Program requirements.

2. Policy Regarding Reduction to the ASC Payment Rates for ASCs That Fail to Meet the ASCQR Program Requirements for a Payment Determination Year

The national unadjusted payment rates for many services paid under the ASC payment system are equal to the product of the ASC conversion factor and the scaled relative payment weight for the APC to which the service is assigned. For CY 2027, the ASC conversion factor is equal to the conversion factor calculated for the previous year updated by the productivity-adjusted hospital market basket update factor. The productivity adjustment is set forth in section 1833(i)(2)(D)(v) of the Act. The productivity-adjusted hospital market basket update was the annual update for the ASC payment system for a 5-year period (CY 2019 through CY 2023), which was extended an additional 2 years (through CY 2025) in the CY 2024 OPPS/ASC final rule with comment period (88 FR 81960). In the CY 2026 OPPS/ASC final rule with comment period (90 FR 53915), we extended the interim period an additional year (through the end of CY 2026). As discussed in section XIII. of this final rule with comment period, we proposed to continue using the productivity-adjusted hospital market basket update as the update factor for the ASC payment system for CY 2027. Under the ASCQR Program, in accordance with section 1833(i)(7)(A) of the Act and as discussed in the CY 2013 OPPS/ASC final rule with comment period (77 FR 68499), any annual increase in certain payment rates under the ASC payment system shall be reduced by 2.0 percentage points for ASCs that fail to meet the reporting requirements of the ASCQR Program. This reduction applied beginning with the CY 2014

payment rates (77 FR 68500). For a complete discussion of the calculation of the ASC conversion factor and our finalized proposal to update the ASC payment rates using the inpatient hospital market basket update for CYs 2019 through 2023, we refer readers to the CY 2019 OPPS/ASC final rule with comment period (83 FR 59073 through 59080).

In the CY 2013 OPPS/ASC final rule with comment period (77 FR 68499 through 68500), in order to implement the requirement to reduce the annual update for ASCs that fail to meet the ASCQR Program requirements, we finalized the following policies: (1) to calculate a full update conversion factor and an ASCQR Program reduced update conversion factor; (2) to calculate reduced national unadjusted payment rates using the ASCQR Program reduced update conversion factor that would apply to ASCs that fail to meet their quality reporting requirements for that calendar year payment determination; and (3) that application of the 2.0 percentage point reduction to the annual update may result in the update to the ASC payment system being less than zero prior to the application of the productivity adjustment. The ASC conversion factor is used to calculate the ASC payment rate for services with the following payment indicators (listed in Addenda AA and BB to this proposed rule, which are available via the Internet on the CMS website): "A2", "D2", "G2", "P2", "R2", and "Z2", as well as the service portion of device-intensive procedures identified by "J8" (77 FR 68500). We finalized our proposal that payment for all services assigned the payment indicators listed would be subject to the reduction of the national unadjusted payment rates for applicable ASCs using the ASCQR Program reduced update conversion factor (77 FR 68500).

The conversion factor is not used to calculate the ASC payment rates for separately payable services that are assigned status indicators other than payment indicators "A2", "D2", "G2," "J8", "P2", "R2", and "Z2." These services include separately payable drugs, biologicals, and radiopharmaceuticals, skin substitute supplies, pass-through devices that are contractor-priced, brachytherapy sources that are paid based on the OPPS payment rates, and certain office-based procedures, radiology services, and diagnostic tests where payment is based on the PFS

nonfacility PE RVU-based amount, and a few other specific services that receive cost-based payment (77 FR 68500). As a result, we also finalized our proposal that the ASC payment rates for these services would not be reduced for failure to meet the ASCQR Program requirements because the payment rates for these services are not calculated using the ASC conversion factor and, therefore, are not affected by reductions to the annual update (77 FR 68500).

Office-based surgical procedures (generally those performed more than 50 percent of the time in physicians' offices) and separately paid radiology services (excluding covered ancillary radiology services involving certain nuclear medicine procedures or involving the use of contrast agents) are paid at the lesser of the PFS nonfacility PE RVU-based amounts or the amount calculated under the standard ASC ratesetting methodology. Similarly, in the CY 2015 OPPS/ASC final rule with comment period (79 FR 66933 through 66934), we finalized our proposal that payment for certain diagnostic test codes within the medical range of CPT codes for which separate payment is allowed under the OPPS will be at the lower of the PFS nonfacility PE RVU-based (or technical component) amount or the rate calculated according to the standard ASC ratesetting methodology when provided integral to covered ASC surgical procedures. In the CY 2013 OPPS/ASC final rule with comment period (77 FR 68500), we finalized our proposal that the standard ASC ratesetting methodology for this type of comparison would use the ASC conversion factor that has been calculated using the full ASC update adjusted for productivity. This is necessary so that the resulting ASC payment indicator, based on the comparison, assigned to these procedures or services is consistent for each HCPCS code, regardless of whether payment is based on the full update conversion factor or the reduced update conversion factor.

For ASCs that receive the reduced ASC payment for failure to meet the ASCQR Program requirements, we have noted our belief that it is both equitable and appropriate that a reduction in the payment for a service should result in proportionately reduced coinsurance liability for beneficiaries (77 FR 68500). Therefore, in the CY 2013 OPPS/ASC final rule with comment

period (77 FR 68500), we finalized our proposal that the Medicare beneficiary's national unadjusted coinsurance for a service to which a reduced national unadjusted payment rate applies will be based on the reduced national unadjusted payment rate.

In the CY 2013 OPPS/ASC final rule with comment period, we finalized our proposal that all other applicable adjustments to the ASC national unadjusted payment rates would apply in those cases when the annual update is reduced for ASCs that fail to meet the requirements of the ASCQR Program (77 FR 68500). For example, the following standard adjustments would apply to the reduced national unadjusted payment rates: the wage index adjustment; the multiple procedure adjustment; the interrupted procedure adjustment; and the adjustment for devices furnished with full or partial credit or without cost (77 FR 68500). We believe that these adjustments continue to be equally applicable to payment for ASCs that do not meet the ASCQR Program requirements (77 FR 68500).

In the CY 2015 through CY 2026 OPPS/ASC final rules with comment period, we did not make any other changes to these policies. We proposed to continue applying these policies for the CY 2027 reporting period/CY 2029 payment determination and for subsequent years.

We did not receive public comments on this provision, and therefore, we are finalizing as proposed the continuation of these policies for the CY 2027 reporting period / CY 2029 payment determination and for subsequent years.

XVIII. Accrediting Organization (AO) Deeming Authority for the Emergency Medical Treatment and Labor Act (EMTALA)

A. Background

The Emergency Medical Treatment and Labor Act (EMTALA) was enacted in 1986 and codified at section 1867 of the Act (42 U.S.C. 1395dd) to address concerns regarding the inappropriate transfer of, or refusal to treat individuals with emergency medical conditions who are seeking emergency department care, commonly referred to as "patient dumping." EMTALA applies to hospitals that participate in Medicare and operate emergency departments, including critical access hospitals (CAHs) and rural emergency hospitals (REHs). For purposes of this discussion, the term "hospitals" includes CAHs and REHs. To enroll and be qualified to participate in Medicare under section 1866(a)(1)(I) of the Act (42 U.S.C. 1395cc(a)(1)(I)), all such hospitals must agree to comply with EMTALA's statutory and regulatory requirements, among other applicable requirements.

Section 1867 of the Act establishes the three core obligations of EMTALA.

- First, when an individual comes to a hospital's emergency department and requests examination or treatment, the hospital must provide an appropriate medical screening examination to determine whether an emergency medical condition exists.
- Second, if the hospital determines that the individual has an emergency medical condition, the hospital must provide either necessary stabilizing treatment within its capability or arrange for an appropriate transfer to another medical facility. Note, when assessing whether there is an emergency medical condition with respect to a pregnant woman, consideration has to be given to whether the condition places the health of the woman or the unborn child in serious jeopardy, and with respect to a pregnant woman having contractions, it requires consideration of whether a transfer would pose a threat to the health or safety of the woman or the unborn child.
- Third, hospitals with specialized capabilities or facilities shall not refuse to accept appropriate transfers of individuals requiring such capabilities or facilities if the receiving hospital

has the capacity to treat the individual. The statute also authorizes the imposition by the Office of Inspector General (OIG) of civil monetary penalties against hospitals and physicians and, for physicians, exclusion from participation in Federal health care programs for violations, and permits the Centers for Medicare & Medicaid Services (CMS) to impose involuntary termination of a hospital's Medicare provider agreement for non-compliance in accordance with 42 CFR 489.53.

CMS has implemented EMTALA through regulations at 42 CFR 489.20 and 489.24, which address two distinct categories of obligations. Section 489.20(l), (m), (q) and (r) sets forth administrative requirements, including to post EMTALA signage, maintain a central log of individuals who present to the emergency department, retain transfer records for 5 years, and maintain an on-call physician list. These administrative obligations support transparency, documentation, and accountability in emergency care operations. These requirements are provider agreement commitments and obligations hospitals accept as a condition of Medicare participation under section 1866(a)(1)(I) of the Act. They are distinct from the substantive individual care protections at § 489.24.

Section 489.24 implements the statute's substantive protection requirements for individuals who present to the emergency department and request examination or treatment, including detailed provisions governing the provision of appropriate medical screening examinations, stabilizing treatment, appropriate transfers, and receiving hospital responsibilities. These requirements reflect the core protections established by section 1867 of the Act and are directly enforceable by CMS and/or the OIG.

Enforcement of EMTALA has historically occurred through complaint investigations conducted by State Survey Agencies (SAs) under CMS direction. Pursuant to § 488.6, CMS "deems" a hospital to meet Medicare requirements if it is accredited by an AO with a hospital accreditation program approved by CMS. CMS will approve such organizations if it finds that its standards and survey processes provide reasonable assurance that accredited entities meet or exceed

applicable Medicare requirements. Hospitals accredited by such AOs are deemed to meet the Medicare Conditions of Participation (CoPs) but are subject to CMS validation surveys and complaint investigations in accordance with existing CMS policies and procedures. More than 90 percent of Medicare-participating hospitals (excluding CAHs and REHs) and more than 40 percent of CAHs, independent of hospitals, are accredited by AOs with CMS-approved accreditation programs. At this time, no REHs are deemed to meet requirements through a CMS-approved accreditation program.

We proposed that if an AO identifies EMTALA deficiencies at § 489.24 during an accreditation or reaccreditation survey, the matter must be referred to the CMS location for further review and possible SA investigation. If an AO identifies EMTALA deficiencies at § 489.20(l), (m), (q) and (r), they would require the hospital or CAH to submit an acceptable Plan of Correction (PoC) addressing how it would come into compliance with the cited EMTALA requirements. If the PoC is accepted and the hospital has returned to compliance, then no further enforcement action would be taken. If the PoC is rejected, the AO would be required to contact the CMS location for further review. Under § 488.5(a)(4)(ix), AOs are already required to notify CMS timely if an AO survey identifies an "immediate jeopardy." The proposed EMTALA requirement would augment the already-existing reporting requirement. If a complaint alleging an EMTALA violation is received by CMS (or the SA acting under an agreement pursuant to section 1864 of the Act), it would be triaged to determine its investigation priority level. The SA or CMS conducts an onsite investigation, and if a violation is identified, a deficiency is cited and the survey findings are documented. Currently the CMS location refers § 489.24 violations to the OIG, which has independent statutory authority to impose civil money penalties against hospitals and physicians, and potential exclusion of physicians from Federal health care programs. CMS retains the authority to terminate a hospital's Medicare provider agreement for EMTALA noncompliance at § 489.53.

In CY 2025, we issued 1,071 EMTALA citations for violations of the two applicable regulations, underscoring the need for Medicare-participating hospitals to comply with emergency

care obligations. Of these, 521 citations were issued under § 489.20 requirements, 530 citations were issued under § 489.24, and 20 citations were issued under both §§ 489.20 and 489.24. Section 489.24 is the more expansive regulation governing the specific medical screening, stabilization, and transfer requirements hospitals must fulfill when an individual requests emergency care. Administrative compliance under § 489.20 appears to be a leading indicator of overall EMTALA program integrity. A hospital that cannot maintain accurate on-call logs, post required notices, or retain transfer documentation is a hospital whose broader EMTALA compliance posture warrants closer scrutiny. Including a structured, thorough review of § 489.20 requirements into every hospital survey is essential to fulfilling the protective intent of EMTALA. The inclusion of the requirements at § 489.20(l), (m), (q) and (r) into the accreditation and reaccreditation survey process mean that AOs would assess whether hospitals are maintaining the documentation, recordkeeping, and operational safeguards that support transparency and accountability in emergency care. Because these obligations are record-based and procedural, we proposed to review AO survey processes as part of our hospital accreditation program approval to check that EMTALA requirements are included within the existing accreditation framework.

It should be noted that findings related to potential § 489.24 violations must be referred to CMS for SA investigation and those findings would continue to follow existing public disclosure procedures applicable to complaint-based SA investigations, which are separate from AO accreditation survey reports. Section 1865(b) of the Act explicitly permits the Secretary to publicly disclose AO surveys and information related to them to the extent that such surveys and information relate to an enforcement action taken by the Secretary.

Our regulations at 42 CFR part 488 govern AO approval and oversight. The proposal we are finalizing in this rule will operate within section 1865 of the Act and part 488 statutory and regulatory structures by integrating review of EMTALA's administrative requirements into existing accreditation organization processes for accrediting and re-accrediting hospitals, while preserving CMS and OIG enforcement authority over EMTALA's core statutory protections under section

1867 of the Act. We anticipate several benefits associated with this change. First, integrating EMTALA administrative review into accreditation and CMS or state survey agency certification surveys would minimize operational disruption for hospitals. Rather than undergoing separate review processes triggered by administrative deficiencies, hospitals will be able to address these requirements within the structured accreditation or state survey framework.

Second, this policy may improve compliance consistent with the documentation and operational safeguards at § 489.20(l), (m), (q) and (r). Because these requirements are record-based and procedural in nature, they are well-suited to routine survey evaluation. Regular review during accreditation and recertification surveys may enhance sustained compliance.

Third, this final rule with comment period will allow SAs to concentrate more resources on complaint-based investigations involving potential violations of § 489.24, including issues related to appropriate medical screening examinations, stabilizing treatment, and appropriate transfers. These investigations often require case-specific fact-finding and clinical review, and preserving SA capacity for these activities supports effective enforcement of EMTALA's core protections.

Nothing in this final rule with comment period alters a hospital's obligations under Federal civil rights conscience (protections) laws, or the authority of the HHS Office for Civil Rights to enforce those laws.

B. CMS Approval of Accreditation Organizations

We proposed to clarify at § 488.5(a) that an AO with a CMS-approved accrediting program for hospitals under section 1865 of the Act may assess compliance with the EMTALA-related administrative requirements set forth at § 489.20(l), (m), (q) and (r) as part of their hospital initial accreditation and reaccreditation surveys, which must be completed no later than 36 months after the prior accreditation effective date consistent with § 488.5(a)(4), for those provider types. This proposal was limited to AOs conducting initial accreditation or reaccreditation surveys within the scope of their existing CMS-approved accrediting programs. This amendment would formally require CMS-approved AOs to include review of these specified EMTALA obligations into the

existing accreditation framework, while preserving CMS' direct enforcement authority over EMTALA's core statutory protections.

As proposed, AOs would evaluate hospital compliance with the administrative commitments codified at § 489.20(l), (m), (q) and (r), including requirements to post appropriate EMTALA signage; maintain a central log of individuals who present to the emergency department; retain transfer records for a period of 5 years; and maintain an on-call physician list to ensure availability of specialty services. These obligations are documentary and administrative in nature, are well-established in regulation, and are conducive to structured review within the context of accreditation and reaccreditation surveys.

If an AO identified noncompliance with any of the EMTALA administrative requirements at § 489.20(l), (m), (q) and (r), the AO would cite the deficiency and address it through its established procedures, consistent with the procedures it used to address other Medicare deficiencies identified during accreditation and reaccreditation surveys. This would include requiring corrective action plans, monitoring compliance, and reporting findings to CMS in accordance with existing oversight and validation protocols. CMS would retain ultimate oversight responsibility and could take additional action as appropriate under its survey and enforcement authorities.

We believe that the administrative requirements at § 489.20(l), (m), (q) and (r) are appropriate for evaluation during initial accreditation and reaccreditation surveys. Integrating review of these provisions into the AO survey process would promote more consistent monitoring of established documentation and recordkeeping obligations, reduce duplicative investigations triggered solely by administrative concerns, and minimize disruption to hospital operations. At the same time, this approach would allow SAs to concentrate their resources on complaint-based investigations involving potential violations of § 489.24.

To implement this proposal, we proposed to revise § 488.5 by adding a new paragraph (a)(23), laying out the AO's responsibility to include the EMTALA administrative requirements

into its accreditation standards and survey processes and to identify and address noncompliance with those provisions within the deeming framework.

C. Evaluation of Accreditation Authority Request

AOs would have to document the procedures used to assess compliance with these requirements and would be required to cite and address any identified deficiencies through their established accreditation procedures, consistent with the procedures used to address Medicare deficiencies identified during accreditation and reaccreditation surveys.

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: Commenters generally supported CMS's proposal to have AOs review administrative EMTALA requirements (signage, logs, transfer records, and on-call lists) during accreditation surveys, provided CMS retains ultimate enforcement authority over substantive EMTALA protections.

Response: We appreciate the broad support for this proposal and confirm that this rule does not delegate authority over substantive EMTALA determinations, including allegations involving inadequate screening, failure to stabilize, or improper transfer to AOs. CMS and SAs will continue to investigate and adjudicate all substantive EMTALA complaints and immediate jeopardy findings as well as review and investigate AO referrals regarding the administrative EMTALA requirements. The scope of AO review under this rule is limited to the administrative elements specified in the proposed rule. We are finalizing as proposed, with the clarifications discussed below.

Comment: Two commenters recommended a transition period, suggesting through at least CY2028 before full implementation, to allow AOs, SAs, and hospitals time to align processes.

Response: The AOs with hospital deeming programs will need to first submit applications to update their accreditation programs to include review of the EMTALA administrative requirements and submit them to CMS for approval before an AO can start surveying for the EMTALA administrative requirements. Accordingly, we do not believe a transition period is

needed.

Comment: Two commenters raised concerns that expanded AO survey responsibilities could result in duplicative or conflicting requirements if not applied consistently across AOs and SAs.

Response: We intend to issue standardized interpretive guidance and survey protocols specific to the administrative EMTALA elements, which all approved AO accreditation programs should include in their own standards. This guidance will clearly delineate the respective roles of AOs, SAs, and hospitals: AOs with hospital deeming programs will assess the specified administrative documentation and postings during regular accreditation and reaccreditation surveys, while SAs will retain jurisdiction over complaint-driven and substantive EMTALA investigations.

In addition, our guidance will affirm that compliance with the administrative requirements at § 489.20(l), (m), (q), and (r) is distinct from, and does not establish compliance with, Federal civil rights conscience (protections) laws; and that individuals retain the right to file a complaint with the HHS Office for Civil Rights. OCR staff are available to review the civil rights content of that material at CMS's request.

Comment: One commenter requested rigorous reviewer qualifications and EMTALA-specific training for AO surveyors and cautioned against shifting hospital-level administrative compliance burden onto individual physicians.

Response: We agree that surveyor competency is essential to consistent application of these requirements. We will require AOs to demonstrate that surveyors assigned to EMTALA administrative reviews have completed CMS-approved EMTALA training prior to conducting these assessments, as a condition of AO approval. We also clarify that the administrative requirements addressed by this rule are hospital-level requirements. Nothing in this rule shifts EMTALA compliance responsibility from the hospital to individual physicians, and we do not intend for AO findings related to these administrative requirements to be used as a basis for adverse action against individual practitioners.

Comment: Several commenters cautioned against "scope creep," urging that AO reviews remain confined to administrative requirements and not expand into substantive EMTALA screening or stabilization determinations, and called for a single, nationally standardized enforcement framework.

Response: We confirm that the scope of AO survey activity under this rule is limited to the administrative requirements and does not extend to clinical screening, stabilization, or transfer-decision review requirements at § 489.24, which remain within CMS and SA exclusive investigation authority.

Comment: One commenter recommended that CMS apply lessons learned from AOs' prior experience with EMTALA-adjacent survey activity.

Response: We will draw on existing AO deeming experience, including prior CMS validation surveys and complaint outcome data, to inform the interpretive guidance and training requirements discussed previously, and will continue to use our validation survey process to monitor AO performance on these administrative EMTALA elements after implementation.

After consideration of public comments, we are finalizing these provisions as proposed.

XIX. Expansion of Botulinum Toxin Injection Codes for Hospital Outpatient Department (OPD) Prior Authorization Process

A. Background

In the CY 2020 OPPS/ASC final rule with comment period, we established a prior authorization process for certain hospital OPD services (84 FR 61142, 61446 through 61456) using our authority under section 1833(t)(2)(F) of the Act, which requires the Secretary to develop "a method for controlling unnecessary increases in the volume of covered OPD services".[218] As part of the CY 2021 OPPS/ASC final rule with comment period, we added two additional service categories to the prior authorization process for certain hospital OPD services (85 FR 85866, 86236 through 86248). Through the CY 2023 OPPS/ASC final rule with comment period, we added one more service category to the prior authorization process for certain hospital OPD services (87 FR 71748, 72224 through 72233). The regulations governing the prior authorization process for certain hospital OPD services are located in subpart I of 42 CFR part 419, specifically at §§ 419.80 through 419.89, with the specific service categories listed in § 419.83.

Section 419.83(a)(1) lists the specific service categories for which prior authorization must be obtained for service dates on or after July 1, 2020: blepharoplasty, botulinum toxin injections, panniculectomy, rhinoplasty, and vein ablation. Section 419.83(a)(2) lists two additional service categories for which prior authorization must be obtained for service dates on or after July 1, 2021: cervical fusion with disc removal and implanted spinal neurostimulators. Section 419.83(a)(3) lists Facet Joint Interventions as an additional service category for which prior authorization must be obtained for service dates on or after July 1, 2023. Section 419.83(b) states that CMS will adopt the list of hospital outpatient department service categories requiring prior authorization, and any updates or geographic restrictions, through formal notice-and-comment rulemaking. Section 419.83(c) describes the circumstances under which CMS may

[218] See also correction notice issued January 3, 2020 (85 FR 224).

elect to exempt a provider from the prior authorization process, and § 419.83(d) states that CMS may suspend the prior authorization process requirements generally or for a particular service at any time by issuing a notification on the CMS website.

B. Controlling Unnecessary Increases in the Volume of Covered OPD Services

In accordance with § 419.83(b), we proposed to expand prior authorization requirements to include additional Botulinum Toxin Injection services. The eight additional Botulinum Toxin Injection codes would be included in the existing list at proposed revised § 419.83(a)(2) and would require prior authorization for services provided on or after July 1, 2027. Additionally, to improve readability and brevity, we proposed to remove effective date language from the regulatory text and revise the section numbering. The former paragraphs (a)(1)(i) through (v), (a)(2)(i) and (ii), and (a)(3) would be redesignated as paragraphs (a)(1) through (8).

1. Expansion of Service Category

The additional Botulinum Toxin Injection codes that would require prior authorization beginning on July 1, 2027, are those identified by the HCPCS codes in Table 102. For ease of reference, in Table 102 we have included the 2020, 2021, and 2023 Final Lists of Outpatient Services that Require Prior Authorization, covering the five initial service categories, two additional service categories, and one more service category, respectively. As we mentioned previously, we proposed to include additional codes in the existing Botulinum Toxin Injections service category that was established through the CY 2020 OPPS/ASC final rule with comment period.

2. Basis for Expanding Service Category

As part of our responsibility to protect the Medicare Trust Funds, we routinely analyze data associated with all aspects of the Medicare program. This responsibility includes monitoring the total amount or types of claims submitted by providers; analyzing the claims data to assess the growth in the number of claims submitted over time (for example, monthly and annually, among other intervals); and conducting comparisons of the data with other relevant

data, such as the total number of Medicare beneficiaries served by providers, to help ensure the continued appropriateness of payment for services furnished in the hospital OPD setting.

In proposing the addition of these new services, we reviewed over 100 million OPD claims from 2017 through 2024. We determined that, on average, the number of OPD claims submitted for payment to the Medicare program decreased yearly by 1.1 percent. This reflects a decrease from approximately 114 million OPD claims submitted for payment in 2017 to approximately 104 million claims submitted for payment in 2024, with claim counts rounded for reporting purposes. The 1.1 percent decrease in overall OPD claims annually represents a decrease compared to the 0.6 percent increase identified in the CY 2023 OPPS/ASC proposed rule when we looked at the period from 2012 through 2021. Our analysis also showed that the Medicare allowed amount (the amount Medicare would pay for services regardless of external variables, such as beneficiary plan differences, deductibles, and appeals) for overall OPD claims increased from approximately $53.1 billion in 2017 to approximately $69.8 billion in 2024, representing an average annualized growth rate of 3.5 percent. Again, this is a decrease when compared to the 4.2 percent rate of growth identified in the CY 2023 OPPS/ASC proposed rule from 2012 through 2021. This analysis provides a benchmark regarding overall Medicare spending trends for OPD services during the same period.

In contrast to overall OPD utilization trends, utilization of all Botulinum Toxin Injection codes listed in Table 102 (2027 List of Additional Outpatient Department Services That Require Prior Authorization) has grown at a notably higher rate. This difference suggests that these services are increasing faster than overall OPD utilization, which warrants further review to ensure appropriate utilization. Our analysis of Integrated Data Repository (IDR)[219] data showed that claim volume for Botulinum Toxin Injection codes listed in Table 102 increased by 42.8

[219] The IDR is a high-volume data warehouse integrating Medicare Parts A, B, C, and D, and durable medical equipment claims, beneficiary and provider data sources, along with ancillary data such as contract information and risk scores. Additional information is available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/IDR/index.html.*

percent overall between 2017 and 2024[220], based on a direct comparison of claims volume in 2017 and 2024, and there was a 4.6 percent average annualized growth rate increase during the same time period. Specifically, claims volume for the additional Botulinum Toxin Injection codes increased from approximately 43,500 claims submitted for payment in 2017 to approximately 62,103 claims submitted for payment in 2024. By comparison, the overall OPD claims volume decreased by 8.3 percent between 2017 and 2024[221], based on a direct comparison of total OPD claims in 2017 and 2024, and by the 1.1 percent average annualized rate decrease in OPD claims submitted for payment during the same time period. We also examined claims for each of the seven injection procedure codes proposed for addition to the prior authorization list. Between 2017 and 2024, claims containing HCPCS CPT 64611 increased from 2,788 to 5,124, or 83.8 percent. Claims containing CPT 64616 increased from 15,502 to 22,934 (47.9 percent); CPT 64617 from 3,573 to 3,951 (10.6 percent); CPT 64642 from 12,469 to 17,914 (43.7 percent); CPT 64644 from 9,913 to 14,303 (44.3 percent); CPT 64646 from 1,970 to 2,914 (47.9 percent); and CPT 64647 from 322 to 355 (10.2 percent). CPT codes 64616, 64642, and 64644 had the largest increases in the number of claims.

We also recognize that additional FDA-approved indications for botulinum toxin products during this period may have contributed to some increase in utilization. We reviewed new FDA-approved indications from 2017 through 2024 and principal diagnoses on botulinum toxin injection claims. Claims potentially related to expanded indications increased from 1,731 in 2017 to 3,354 in 2024 but remained a small share of the claims analyzed. However, the newly approved indications represent a limited number of additional clinical uses and are not expected to account for the full magnitude of the observed increase in utilization, suggesting that other factors may also be contributing. Accordingly, we do not believe that expanded indications

[220] Using the formula (2024 claims- 2017 claims) ÷ 2017 claims, this results in a 42.8 percent increase. This calculation is separate from the 4.6 percent compound annual growth rate, which reflects the annualized rate of growth during the same period.

[221] Using the formula (2024 claims − 2017 claims) ÷ 2017 claims, this results in an 8.3 percent decrease. This calculation is separate from the 1.1 percent average annualized decrease, which reflects the average year-over-year change during the same period.

alone fully explain the magnitude of the observed growth, which suggests that other factors may also be contributing to increased utilization. Specifically, overall OPD claims decreased from approximately 114 million unique claims in 2017 to approximately 104 million unique claims in 2024. The codes included in our proposal represent approximately $102 million in annual Medicare payments and constitute a subset of overall botulinum toxin utilization selected based on observed utilization volume, growth trends, and program integrity considerations.

When analyzing the data, we took the COVID-19 Public Health Emergency (PHE) into consideration. As a result of the PHE, health care use and spending dropped sharply due to cancellations of elective and non-emergency care to increase hospital capacity and social distancing measures to reduce the community spread of the coronavirus. Consequently, the claims data for CY 2020 showed a notable decrease in volume of services compared to the previous year. This decline in CY 2020 due to the PHE is reflected in the overall trend for the 2017 through 2024 period, including calculations of the 1.1 percent average annualized decrease in OPD claims submitted for payment over the 2017 through 2024 period discussed previously, which is based on year-over-year changes across all years in the period, including CY 2020. Although a decline in utilization was observed in CY 2020, claims volume for these services increased significantly in subsequent years and exceeded levels that would have been reasonably expected based on overall OPD utilization trends. Accordingly, we do not believe any claim decreases resulting from the PHE affect our conclusion that there were "unnecessary increases in the volume of covered" claims for these services. This determination is based on several considerations, including utilization growth for Botulinum Toxin Injection services substantially exceeding overall OPD utilization trends during the same period, despite overall OPD claims volume declining. In addition, the increased utilization persisted over multiple years rather than reflecting a temporary fluctuation. CMS also reviewed potential explanations for the increase in utilization, including changes in clinical need, coding changes, and other factors that could reasonably explain sustained growth in service volume, but did not identify sufficient evidence to

account for the magnitude of the increase observed. CMS further considered broader program integrity concerns, including billing patterns and utilization trends that may indicate a risk of unnecessary utilization.

Our conclusion that increases in volume for Botulinum Toxin Injections are unnecessary is based not only on data specific to these services but also on a comparison of the rate of increase for these procedures to the overall trends for all OPD services. We believe that comparing the utilization rate for specific services to the overall Medicare OPD utilization trends is generally an appropriate method for identifying unnecessary increases in volume, particularly when there are no legitimate clinical or coding reasons for the changes. The Medicare allowed amount analysis discussed above provides additional information regarding broader Medicare spending trends during the same period. As we have stated in the previous OPPS/ASC final rules with comment period, we believe that prior authorization is an effective mechanism to ensure Medicare beneficiaries receive medically necessary care while protecting the Medicare Trust Funds from unnecessary increases in the volume of covered OPD Services without adding onerous new documentation requirements. Therefore, we believe prior authorization for these additional codes will be an effective method for controlling unnecessary increases in the volume of these services and expect that it will reduce the instances in which Medicare pays for services that are determined not to be medically necessary. This will also serve as a tool within CMS' broad program integrity strategy to address potential fraud, waste, and abuse. We requested comments on the addition of these new services, specifically on the potential for unintended clinical consequences that may result from this addition.

We received 122 public comments on this proposal. The following is a summary of the comments we received and our responses.

Comment: Several commenters expressed support for CMS's efforts to improve interoperability, streamline prior authorization, and reduce administrative burden.

Response: We thank the commenters for their support of CMS's efforts to improve

interoperability, streamline prior authorization processes, promote appropriate utilization of Medicare resources, and reduce administrative burden. We remain committed to improving the efficiency of prior authorization processes while supporting appropriate access to care.

Comment: A couple of commenters noted that consumers may be unable to determine whether a service requires prior authorization.

Response: We appreciate the commenters' concern regarding access to information about prior authorization requirements. Regarding Medicare Fee-for-Service, prior authorization requirements apply only to certain items and services. CMS and the Medicare Administrative Contractors (MACs) make information regarding applicable prior authorization requirements publicly available. In addition, MAC websites generally provide tools or searchable resources that allow providers to determine whether a particular service or procedure is subject to prior authorization requirements. Accordingly, providers can consult the applicable MAC's resources to identify whether prior authorization is required for a service before it is furnished.

Comment: A commenter recommended that CMS require or encourage the use of structured, auditable, clinician-owned clinical logic frameworks for prior authorization while preserving licensed clinician oversight of final determinations. The commenter also recommended clinician-owned, auditable governance for SI-assisted prior authorization decisions and cited recent developments involving the WISeR Model as an example of the importance of transparency and clinical accountability in SI-enabled utilization management. The commenter urged CMS to consider these principles as it implements the hospital OPD program.

Response: We appreciate the commenter's recommendations regarding the use of structured, auditable clinical logic frameworks in prior authorization processes while maintaining licensed clinician authority over final determinations. The hospital OPD prior authorization program has been operational since 2020. We will consider the comments regarding transparency, auditability, interoperability, and clinician oversight as we evaluate policies for the

hospital OPD program and future rulemaking. To the extent the comment references the WISeR Model, that model is a separate CMS Innovation Center (CMMI) model and is outside the scope of this rulemaking. Comments specific to the WISeR Model should be directed to WISeR@cms.hhs.gov.

Comment: A commenter recommended that CMS include standards-based, FHIR/mCODE-enabled prior authorization using validated software as a medical service (SaMS) and pilot a structured submission pathway with automated approvals and gold-carding for qualifying providers.

Response: We appreciate the commenter's recommendations regarding the use of standards-based, interoperable technologies and automated processes to streamline prior authorization and reduce provider burden. We also appreciate the commenter's suggestions regarding structured submission pathways and exemptions, sometimes called "gold carding," for qualifying providers. Although it is beyond the scope of our proposal, we note that the hospital OPD prior authorization process currently includes an exemption from prior authorization requirements for qualifying providers that demonstrate a high level of compliance with Medicare requirements. Under 42 CFR 419.83(c), CMS may exempt a provider that demonstrates compliance with Medicare coverage, coding, and payment rules. Under the current annual assessment process, a provider that submits at least 10 prior authorization requests and receives provisional affirmations for at least 90 percent of its initial requests may qualify for an exemption from submitting further requests while the exemption is in effect. CMS continues to assess exempt providers' compliance and may withdraw an exemption.

The commenter's recommendations regarding FHIR/mCODE-enabled prior authorization, validated software as a medical service (SaMS), structured submission pathways, and automated approvals are also beyond the scope of the proposed expansion of the hospital OPD prior authorization process. We note, however, that MACs may accept prior authorization requests submitted using FHIR-based approaches, as applicable. We will consider these

comments as we continue to evaluate opportunities to improve and streamline prior authorization processes.

Comment: Several commenters raised concerns regarding prior authorization for services outside the scope of the proposed expansion. One commenter expressed concerns regarding prior authorization for botulinum toxin injections used to treat certain urologic conditions. Other commenters opposed existing prior authorization requirements for cervical fusion with disc removal, facet joint interventions, and implanted spinal neurostimulator services. Another commenter urged CMS to exercise caution in any future expansion of prior authorization to metabolic and bariatric surgery services, citing potential treatment delays, patient harm, and administrative burden.

Response: We appreciate the commenters' concerns. The proposal addressed in this rule is limited to the eight additional Botulinum Toxin Injection codes identified in the proposed rule. The procedure used for botulinum toxin injection into the bladder is not among the eight additional codes proposed for inclusion in the hospital OPD prior authorization process. In addition, we did not propose changes to the existing prior authorization requirements for cervical fusion with disc removal, facet joint interventions, or implanted spinal neurostimulator services, nor did we propose to expand prior authorization to additional metabolic and bariatric surgery services. Therefore, comments and recommendations concerning prior authorization for these services are outside the scope of this rulemaking.

Comment: A commenter requested that CMS issue implementation guidance sufficiently in advance of July 1, 2027, effective date for the additional botulinum toxin injection codes to allow hospitals adequate time to update prior authorization workflows and avoid disruptions to patient care.

Response: We appreciate the commenter's request. We intend to provide education and implementation guidance well in advance of the July 1, 2027, effective date to support provider preparation and facilitate implementation of the expanded prior authorization

requirements. CMS currently provides guidance, educational resources, and program updates for the hospital OPD prior authorization program on the program's website, including the Operational Guide, Frequently Asked Questions, applicable HCPCS lists, and information regarding changes to program requirements and implementation timelines[222]. We intend to update these resources, as appropriate, and provide additional information through established CMS and MAC communication channels.

Comment: Several commenters expressed concern that expanding prior authorization to additional botulinum toxin injection services could delay medically necessary treatment and adversely affect beneficiary access and outcomes. Commenters emphasized that these services are used to treat chronic neurologic and other disabling conditions and stated that treatment delays could result in worsening symptoms, pain, functional decline, or other complications. Some commenters noted particular concerns for beneficiaries with significant disabilities and those in rural or underserved areas.

Response: We appreciate the commenters' concerns regarding potential delays in access to medically necessary botulinum toxin injection services and the resulting impact on beneficiaries. We recognize the importance of timely treatment, particularly for beneficiaries with significant functional impairments. The Medicare prior authorization process includes established review timeframes designed to support timely access to medically necessary services. Prior authorization requests are generally reviewed within 7 calendar days for standard requests, though the average review time over the past year was 3.6 days, and expedited review within 2 business days is available when a delay could seriously jeopardize the beneficiary's life, health, or ability to regain maximum function. In addition, as noted in response to the previous comment, providers who demonstrated compliance with Medicare coverage requirements through their prior authorization affirmation rate may qualify for an exemption from prior

[222] https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/prior-authorization-pre-claim-review-initiatives/prior-authorization-certain-hospital-outpatient-department-opd-services.

authorization. We believe these safeguards help address concerns regarding timely beneficiary access while supporting appropriate Medicare program oversight.

Comment: Several commenters stated that botulinum toxin injections are recurring, individualized treatments and expressed concern that requiring prior authorization for each treatment cycle could disrupt established treatment plans. Commenters also noted that a beneficiary's clinical condition and treatment needs may change between authorization and the date of service, requiring practitioners to modify the muscles treated or applicable procedure code. Commenters recommended streamlined renewals, longer authorization periods or multi-cycle authorizations for established patients, and flexibility to accommodate clinically necessary changes in treatment.

Response: We appreciate the commenters' concerns regarding the recurring and individualized nature of botulinum toxin treatment, continuity of care, and the need for clinical flexibility. Prior authorization is intended to ensure that Medicare coverage, coding, and payment requirements are met before services are furnished and is not intended to interfere with the treating practitioner's clinical judgment or delay medically necessary care. We recognize that a beneficiary's clinical condition and treatment needs may change between submission of a prior authorization request and the date of service. We considered commenters' recommendations regarding flexibility for clinically necessary changes, streamlined authorization for established patients, and consideration of ongoing treatment in determining whether and how to finalize the proposal. We will continue to evaluate implementation of the prior authorization requirements and consider appropriate operational flexibilities and safeguards to support timely access to medically necessary services while protecting the Medicare Trust Funds.

Comment: Several commenters expressed concern that expanding prior authorization would increase administrative burden on hospitals, physicians, and clinical staff, diverting resources from patient care. Commenters stated that the burden may include preparing and

tracking requests, submitting additional documentation, responding to non-affirmations, resubmitting requests, and pursuing further review. Some commenters questioned whether CMS's burden estimates fully account for the clinical and administrative staff time associated with these activities.

Response: We appreciate the commenters' concerns regarding the administrative burden associated with prior authorization. We recognize the importance of minimizing unnecessary burden on providers and beneficiaries while supporting appropriate utilization of Medicare services. Prior authorization does not establish new Medicare coverage or documentation requirements; rather, it requires documentation supporting applicable Medicare coverage, coding, and payment requirements to be submitted before the service is furnished.

As discussed in the Collection of Information Requirements section of this final rule, we estimate that the average time for office clerical activities associated with preparing and submitting a prior authorization request is 30 minutes, which is equivalent to the time estimated for prepayment or postpayment medical review. We continue to believe that 30 minutes represents a reasonable average estimate of the time needed to prepare and submit a prior authorization request. We acknowledge that the actual time associated with an individual request may vary depending on the circumstances, including whether additional documentation or resubmission is necessary.

We will continue to monitor the program, including its impact on providers and beneficiaries.

Comment: Several commenters questioned whether increased utilization of botulinum toxin injection services demonstrates unnecessary or inappropriate utilization. Commenters stated that utilization growth may reflect factors such as expanded indications, evolving clinical practice, improved access, changes in the Medicare population, or shifts in site of service. Commenters recommended that CMS conduct additional analysis and use more targeted program integrity approaches, such as focused medical review, provider education, Targeted Probe and

Educate, post-payment review, or data-driven review of providers or utilization patterns presenting greater program integrity risk, rather than broadly expanding prior authorization.

Response: We appreciate the commenters' concerns regarding the basis for the proposed expansion. We agree that increased utilization, standing alone, does not establish that services are medically unnecessary or improperly billed. We recognize that utilization trends may be influenced by a variety of factors, including changes in approved indications, clinical practice, beneficiary access, the Medicare population, and site of service. As discussed in the proposed rule, we identified a significant increase in utilization of these services relative to overall hospital OPD utilization during the same period and acknowledged that expanded FDA-approved indications may have contributed to some of this growth. While increased utilization does not, by itself, demonstrate that services are medically unnecessary or improperly billed, the magnitude of the utilization increase supports additional oversight to ensure that applicable Medicare coverage, coding, and payment requirements are met.

We also appreciate the recommendations to use more targeted program integrity approaches. CMS uses a variety of program integrity tools based on the circumstances. Prior authorization allows CMS to review documentation before the service is furnished and the claim is submitted for payment to determine whether applicable Medicare requirements are met. It does not establish new coverage requirements or change existing Medicare coverage criteria. We believe prior authorization is an appropriate program integrity tool in these circumstances.

Comment: Several commenters recommended that, if CMS finalizes the proposed expansion, it adopts safeguards to minimize administrative burden and disruptions in care. Recommendations included expedited review, clear and consistent criteria, streamlined processes for established patients, reduced or standardized documentation, provider exemptions for demonstrated compliance, electronic prior authorization workflows, timely appeals, and monitoring and public reporting of denials, processing times, treatment delays, beneficiary access, and other program outcomes.

Response: We appreciate the commenters' recommendations regarding safeguards to minimize administrative burden and disruptions in care. We recognize the importance of minimizing unnecessary administrative burden and avoiding disruptions in medically necessary care while ensuring that Medicare coverage, coding, and payment requirements are met.

The hospital OPD prior authorization process includes safeguards intended to reduce burden and protect beneficiary access to care. For example, the process provides for expedited review when a delay could seriously jeopardize a beneficiary's life, health, or ability to regain maximum function. This standard is not limited to the situations in which the beneficiary is recovering from an acute event. The process also includes an exemption from prior authorization requirements for qualifying providers that demonstrate a high level of compliance with Medicare requirements.

We will continue to monitor the hospital OPD prior authorization process and consider opportunities to improve transparency, automation, and standardized electronic workflows while maintaining appropriate program integrity safeguards.

Comment: Several commenters asserted that CMS lacks statutory authority to expand prior authorization to the additional hospital OPD botulinum toxin injection services. The commenters argued that section 1833(t)(2)(F) of the Act does not authorize CMS to impose prior authorization requirements for hospital outpatient services.

Response: We appreciate the commenters' concerns. We disagree that we lack authority to establish prior authorization requirements for these hospital OPD services. Section 1833(t)(2)(F) of the Act requires the Secretary to develop a method for controlling unnecessary increases in the volume of covered OPD services. Thus, where, as here, we have determined that there have been unnecessary increases in the volume of covered OPD services, section 1833(t)(2)(F) of the Act gives us authority to utilize prior authorization as a method to control those unnecessary increases. The hospital OPD prior authorization process is an appropriate exercise of this authority because it provides a mechanism to ensure that Medicare payment

requirements are met before services are furnished and claims are submitted. Prior authorization does not prohibit or limit coverage of medically necessary botulinum toxin injection services that meet applicable Medicare coverage, coding, and payment requirements.

After consideration of public comments, we are finalizing our proposal to add eight Botulinum Toxin Injection codes to the hospital OPD prior authorization process.

TABLE 102: 2027 LIST OF ADDITIONAL OUTPATIENT DEPARTMENT SERVICES THAT REQUIRE PRIOR AUTHORIZATION

Beginning for service dates on or after July 1, 2027	
Code	(2) Botulinum Toxin Injections
64611	Chemodenervation of parotid and submandibular salivary glands, bilateral
64616	Chemodenervation of muscle(s); neck muscle(s), excluding muscles of the larynx, unilateral (eg, for cervical dystonia, spasmodic torticollis)
64617	Chemodenervation of muscle(s); larynx, unilateral, percutaneous (eg, for spasmodic dysphonia), includes guidance by needle electromyography, when performed.
64642	Chemodenervation of one extremity; 1-4 muscle(s)
64644	Chemodenervation of one extremity; 5 or more muscles
64646	Chemodenervation of trunk muscle(s); 1-5 muscle(s)
64647	Chemodenervation of trunk muscle(s); 6 or more muscles
J0589	Injection, daxibotulinumtoxina-lanm, 1 unit

TABLE 103: FINAL LIST OF OUTPATIENT DEPARTMENT SERVICES THAT REQUIRE PRIOR AUTHORIZATION

Beginning for service dates on or after July 1, 2020	
Code	(1) Blepharoplasty, Blepharoptosis Repair, and Brow Ptosis Repair[223]
15820	Blepharoplasty, lower eyelid
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad
15822	Blepharoplasty, upper eyelid
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)
67902	Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)
67903	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach
67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach
67906	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)
67908	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (eg, Fasanella-Servat type)

[223] CPT 67911 (Correction of lid retraction) was removed on January 7, 2022.

Code	(2) Botulinum Toxin Injection
64612	Chemodenervation of muscle(s); muscle(s) innervated by facial nerve, unilateral (eg, for blepharospasm, hemifacial spasm)
64615	Chemodenervation of muscle(s); muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (eg, for chronic migraine)
J0585	Injection, onabotulinumtoxina, 1 unit
J0586	Injection, abobotulinumtoxina, 5 units
J0587	Injection, rimabotulinumtoxinb, 100 units
J0588	Injection, incobotulinumtoxin a, 1 unit
Code	(3) Panniculectomy, Excision of Excess Skin and Subcutaneous Tissue (Including Lipectomy), and related services
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication)
15877	Suction assisted lipectomy; trunk
Code	(4) Rhinoplasty, and related services[224]
20912	Cartilage graft; nasal septum
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30420	Rhinoplasty, primary; including major septal repair
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)
30460	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only
30462	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip, septum, osteotomies
30465	Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)
30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft
Code	(5) Vein Ablation, and related services
36473	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated
36474	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; subsequent vein(s) treated in a single extremity, each through separate access sites

[224] CPT 21235 (Obtaining ear cartilage for grafting) was removed on June 10, 2020.

36475	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated
36476	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites
36478	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated
36479	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; subsequent vein(s) treated in a single extremity, each through separate access sites
36482	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; first vein treated
36483	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites
Beginning for service dates on or after July 1, 2021	
Code	(6) Cervical Fusion with Disc Removal
22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2
22552	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace
Code	(7) Implanted Spinal Neurostimulators [225]
63650	Percutaneous implantation of neurostimulator electrode array, epidural
Beginning for service dates on or after July 1, 2023	
Code	(8) Facet Joint Interventions[226]
64490	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level
64491	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level
64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level
64494	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level
64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint

[225] CPT codes 63685 (Insertion or replacement of spinal neurostimulator pulse generator or receiver) and 63688 (Revision or removal of implanted spinal neurostimulator pulse generator or receiver) were temporarily removed from the list of OPD services that require prior authorization, as finalized in the CY 2021 OPPS/ASC final rule with comment period.

[226] CPT codes 64492 (Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; third and any additional level(s)) and 64495 (Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any additional level(s)) will be removed on August 16, 2024.

64634	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint
64636	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint

XX. Codification of Section 6225 of the Consolidated Appropriations Act, 2026 for the Requirements for Provider-Based Status (§§ 413.65 and 419.23)

A. Background

Section 1861(u) of the Act lists the types of facilities that are regarded as providers of services but does not use or define the term "provider-based". Since the beginning of the Medicare program, however, some providers, referred to as *main providers*, have functioned as a single entity while owning and operating multiple subordinate facilities that were treated as part of the main provider for Medicare purposes (as related to, for instance, payment; certification; coverage; and/or billing). With this treatment, compared to being treated as a freestanding facility, provider-based facilities might experience a number of advantages, including most notably, increased payments from Medicare. Therefore, we have maintained that having clear criteria for treating a facility as provider-based, as opposed to operating as a freestanding facility, is important because failure to properly distinguish between the two risks inaccurate program payments, which can result in provider overpayments and increased beneficiary coinsurance liability, with no commensurate benefit to the Medicare program or its beneficiaries. Section 413.65 specifies the criteria for treating a facility as provider-based and the requirements for a CMS determination of provider-based status, including an attestation by the provider that the facility meets the provider-based criteria. Provider compliance with provider-based rules is mandatory, but since the passage of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 (Pub. L. 106-554, App'x F), a provider has needed to submit an attestation only if it wishes to obtain a CMS determination of provider-based status.

B. Requirements at Section 6225 of the Consolidated Appropriations Act, 2026

Section 6225 of the Consolidated Appropriations Act, 2026 (CAA, 2026), Pub. L. 119-75, enacted on February 3, 2026, amends section 1833(t) of the Act by adding new paragraph (23). In brief, section 6225 of the CAA, 2026 will prohibit Medicare payments under the OPPS beginning January 1, 2028, unless off-campus outpatient departments of a provider bill using a

separate National Provider Identifier (NPI) and the main provider has submitted an attestation that the departments meet the provisions at § 413.65. As noted previously, although provider compliance with provider-based rules is mandatory, payment had not been conditioned on verification of such compliance.

Section 1833(t)(23)(A) of the Act, as added by section 6225 of the CAA, 2026, specifies that no payment may be made under that subsection (or under an applicable payment system pursuant to paragraph (21) of section 1833(t) of the Act) for items and services furnished on or after January 1, 2028, by an off-campus outpatient department of a provider unless that department has obtained, and the items and services are billed under, an NPI that is separate from the NPI of the main provider; the main provider has submitted to the Secretary, during the 2-year period ending on the date such items and services are furnished, an initial provider-based status attestation that the off-campus outpatient department is compliant with the requirements described in section § 413.65 (or a successor regulation); and the main provider has submitted a subsequent attestation within the timeframe specified by the Secretary. The initial attestation may include an attestation submitted in accordance with existing § 413.65(b)(3) until the Secretary establishes the new attestation submission process, which is discussed further below.

New section 1833(t)(23)(B)(i) of the Act requires the Secretary, through notice and comment rulemaking, to establish a process for each provider with an off-campus outpatient department to submit an initial and subsequent attestation, for the review of each such attestation and for the determination, through site visits, remote audits, or other means (as determined appropriate by the Secretary), whether each off-campus outpatient department is compliant with the requirements described in subparagraph (A). In addition, new section 1833(t)(23)(C) of the Act defines an "off-campus outpatient department of a provider" for purposes of paragraph (23) as a department of a provider (as defined in § 413.65) that is not located on the campus (also defined in § 413.65) of the main provider or is not within the distance described in such definition of campus from a remote location of a hospital (also defined in § 413.65).

C. Modifications to Implement the Provisions of Section 6225 of the CAA, 2026

1. Modification to the Hospital OPPS Regulations

As discussed previously, section 1833(t)(23)(A) of the Act, as added by section 6225 of the CAA, 2026, specifies that no payment may be made under the OPPS for items and services furnished on or after January 1, 2028, by an off-campus outpatient department of a provider unless that department has obtained, and the items and services are billed under, an NPI that is separate from the NPI of the main provider; the main provider has submitted to the Secretary, during the 2-year period ending on the date such items and services are furnished, an initial provider-based status attestation that the off-campus outpatient department is compliant with the requirements described in section § 413.65; and the main provider has submitted a subsequent attestation within the timeframe specified by the Secretary. In the CY 2027 OPPS/ASC proposed rule (91 FR 41981), we proposed to add new section § 419.23 to codify this requirement. (We note the proposed changes to the provider-based regulations at § 413.65 to implement the attestation requirements are discussed in the next section. We also note, as discussed in greater detail in the next section, we proposed that prior to submitting an attestation, providers must obtain an NPI for each provider-based department.) Public comments on our proposals and our responses are discussed in the subsequent sections.

2. Modifications to the Provider-Based Regulations at § 413.65

In the proposed rule (91 FR 41980 through 41984), we proposed changes to the provider-based regulations at § 413.65 to implement the new requirements in section 6225 of the CAA, 2026. First, we proposed the addition of a new entry in the list of definitions in § 413.65(a)(2) for an "Off-campus outpatient department of a provider". We currently define a "department of a provider" as a facility or organization that is either created by, or acquired by, a main provider for the purpose of furnishing health care services of the same type as those furnished by the main provider under the name, ownership, and financial and administrative control of the main provider. The definition of a department of a provider does not include rural health clinics

(RHCs) or, except as specified in § 413.65(n), Federally Qualified Health Centers (FQHCs). In accordance with the statutory definition provided in section 1833(t)(23)(C) of the Act, we proposed to add a new definition to paragraph (a)(2) describing an off-campus outpatient department of a provider as a department of a provider that is not located on the campus of the main provider or within 250 yards of a remote location of a hospital. Under this proposed definition, facilities or organizations that are not located on the campus of the main provider would be considered off-campus for provider-based purposes. This would include remote locations of a hospital, which are defined in § 413.65 as facilities that provide inpatient services in a location off the campus of a main provider. Remote locations are often referred to as secondary or subordinate "multi-campus" locations of a hospital, and in most cases operate in a substantially similar manner as the main provider. Section 6225 of the CAA, 2026, adding section 1833(t)(23)(C) to the Act, defines an "off-campus outpatient department of a provider" as neither being on the campus of the main provider, nor within the distance specified in the definition of campus of a remote location of a hospital.

Comment: A commenter requested CMS clarify whether the relevant remote location encompasses the broader area surrounding the inpatient facility or is limited to the specific building or buildings providing inpatient services.

Response: As discussed previously, the term "remote location of a hospital" is defined by regulation and it means, in part, a facility that provides inpatient hospital services under the name, ownership, and financial and administrative control of the main provider (see § 413.65(a)(2)). Remote locations are subject to the additional provider-based status requirements applicable to "off-campus" facilities at § 413.65(e). The "campus" definition at § 413.65(a)(2) applies to the physical area encompassing the main buildings of the main provider. We believe the inclusion of the 250-yard limit in section 1833(t)(23)(C) of the Act is intended as an alternative for an on-campus designation for purposes of section 6225 of the CAA, 2026. For this reason, we proposed to amend the regulations to clarify that any outpatient

department that is located within 250 yards of a remote location facility would not be included in the definition of an "off-campus outpatient department of a provider" (and therefore would not be subject to the attestation or separate NPI requirements).

Comment: We received a few comments requesting CMS provide additional clarification on how the measurement from a remote location would be implemented. Specifically, a commenter inquired from what point of the remote location facility would the measurement be taken, and whether certain structures, like awning, walkways, etc., would be acceptable starting points for measurement.

Response: We understand the commenters' interest in this issue. Section 1833(t)(23)(C) of the Act, as added by 6225 of the CAA, 2026, refers to the distance specified in the definition of campus, which is codified at § 413.65(a)(2). In the campus definition, any area or structure within 250 yards of a main building of the hospital is considered on-campus for purposes of applying the provider-based regulations. We proposed that, for purposes of implementing section 6225 of the CAA, 2026, we would add a new definition to paragraph (a)(2) describing which facilities or organizations would be considered off-campus outpatient departments of a provider (91 FR 41981). Under the proposal, any facility on the campus of the main provider or within 250 yards of a remote location of a hospital would *not* meet the regulatory definition of an "off-campus outpatient department of a provider", and would therefore not be subject to the attestation or separate NPI requirements. We did not propose any modification to the definition of a campus in the proposed rule. Based on current practices, the 250-yard measurement could begin at any point of the remote location facility that provides patient care. Typically, when making provider-based on-campus determinations, we have reviewed publicly available satellite mapping software to make these determinations, using straight-line measurements from the main building to the nearest point of the potential provider-based department. In some cases, applicants may supply additional survey material to assist in this measurement process using a submission process designed by CMS. We would expect to follow the same practice in deciding

whether a facility meets the requirements of section 6225 of the CAA, 2026. Regarding the inclusion of certain features, like awnings or walkway overhangs, we believe that non-structural components are not consistent with the definition of a remote location of a hospital and would not be an appropriate measuring point.

After consideration of public comments, we are finalizing the definition of "off-campus outpatient department of a provider" as proposed, without modification.

Section 413.65(e) includes additional requirements applicable to off-campus facilities or organizations. These requirements apply to all off-campus outpatient facilities, including those that are in close proximity to (and often within the same building as) inpatient remote locations. The implementation of section 603 of the Bipartisan Budget Act of 2015 (Pub. L. 114-74) in the CY 2017 OPPS/ASC final rule with comment period (81 FR 79699 through 79719) and interim final rule with comment period (81 FR 79720 through 79729), however, excepted outpatient departments located within 250 yards of a remote location from payment policy implications for off-campus departments. Given the definition of an "off-campus outpatient department of a provider" in section 603 of the Bipartisan Budget Act of 2015 and section 6225 of the CAA, 2026 separates outpatient departments located outside the regulatorily-specified distance of a remote location of a hospital and provider off-campus outpatient departments, we stated in the proposed rule that we believe that it would be appropriate to distinguish off-campus requirements from those for hospital outpatient departments that are within 250 yards of a remote location of the main provider (91 FR 41981). Therefore, we proposed to revise § 413.65(e) to specifically exclude outpatient departments located within 250 yards of a remote location of a hospital, and to revise § 413.65(b)(3)(ii), (g)(1)(i), and (h) to append "or within 250 yards of a remote location of a hospital" to the references of being on the campus of the main provider. We stated we believe these proposed conforming changes would better clarify which facilities are affected by the new legislation and would better align the current provider-based rules with statutory provisions regarding the distinction between on- and off-campus locations and services.

In addition, we proposed to make a technical change to § 413.65(g)(1)(i) and (ii) to revise "treated by Medicare" to "treated by CMS" consistent with the other proposals discussed in this section.

Comment: A commenter urged CMS not to finalize the proposed revisions to § 413.65(e) that would treat outpatient departments located within 250 yards of a hospital's remote location as located on the main provider's campus. The commenter requested that CMS preserve the existing standard to provide stability and avoid imposing any unnecessary burden beyond those required by statute.

Response: We believe the commenter misunderstood the effect of the proposal to revise § 413.65(e) to exclude outpatient departments located within 250 yards of a remote location of a hospital (91 FR 41981). Currently, remote locations of a hospital are considered to be "off-campus", along with any outpatient departments located in close proximity to the inpatient facility that is the remote location of the hospital. Any off-campus facilities are currently subject to the additional applicable off-campus requirements of § 413.65(e), because they are not considered to be located on the main provider's campus. As stated previously, we believe these proposed conforming changes would better align the current provider-based rules with statutory provisions regarding the distinction between on- and off-campus locations and services. Our proposal to revise § 413.65(e) would exclude outpatient departments located within 250 yards of a remote location of a hospital from the additional provider-based status requirements applicable to off-campus facilities, so our proposal would reduce regulatory burden on outpatient departments that are within 250 yards of a remote location of a hospital.

After consideration of public comments, we are finalizing these revisions as proposed.

In the proposed rule (91 FR 41981), we proposed to add new section § 419.23 to codify the separate NPI and attestation requirements for payment under the OPPS for items and services furnished on or after January 1, 2028. In addition, we proposed to add a reference in § 413.65 to the new mandatory attestation requirements required by section 6225 of the CAA, 2026 and

proposed a maximum 5-year timeframe for any subsequent attestation(s) (91 FR 41981). Specifically, we proposed to add § 413.65(b)(6) to state that, as of January 1, 2028, a main provider must submit an initial attestation of provider-based status for each of its off-campus outpatient departments within the 2-year period prior to furnishing services, and subsequent attestation(s) within a period not to exceed 5 years thereafter (91 FR 41981). We stated that we anticipate addressing the subsequent attestation requirement in the 2028 rulemaking cycle; nonetheless, we welcomed comments on the subsequent attestation (91 FR 41982). For all off-campus outpatient departments providing services on or before January 1, 2028, we proposed initial attestations must be submitted between January 1, 2026 and December 31, 2027, and off-campus outpatient departments that begin providing services after January 1, 2028 must submit an attestation within the 2 years prior to when the billed services are delivered. Subsequent attestation(s) would be submitted at an interval to be specified by CMS and not to exceed 5 years thereafter. In addition, we proposed providers that submit initial attestations within the 2-year period prior to January 1, 2028, would meet the attestation requirements of section 6225 of the CAA, 2026, even if they have not received a provider-based status determination from CMS by January 1, 2028. We also sought comments on an initial mandatory attestation for provider departments that received a determination of provider-based status prior to January 1, 2026, and remain in compliance with all applicable provisions of § 413.65. For these departments, we stated that we were considering having the authorized official attest with a letter to CMS with evidence of CMS determination attached affirming its continued compliance with § 413.65.

Comment: Numerous commenters strongly opposed the mandatory NPI and attestation requirements, citing administrative burden and payment disruption concerns and requested CMS consider a longer implementation timeline than what is currently required by law. They additionally recommended establishing a "good-faith" correction period or exercising enforcement discretion due to downstream operational impacts on hospital billing, NPI assignments, and system testing and updates. A commenter stated that the separate NPI required

for an off-campus outpatient department of a provider under the provisions of section 6225 of the CAA, 2026 be consistently reflected on both the hospital's facility claim (paid under the OPPS or applicable payment system under 1833(t)(21)) and the associated physician's professional claim (paid under the Medicare Physician Fee Schedule (PFS)) to allow for a "cross-claim linkage".

Response: We acknowledge the commenters' opposition to the mandated separate NPI and attestation requirements, particularly as related to anticipated administrative burden and payment disruption concerns. The statute establishes January 1, 2028, as the date on which CMS must stop making payments for items and services furnished at an off-campus outpatient department of a provider unless the NPI and attestation requirements are met. Specifically, section 1833(t)(23)(A) of the Act sets forth the requirements for payment for items and services "furnished on or after January 1, 2028, by an off-campus outpatient department of a provider." Failure to meet the separate NPI or attestation requirements would affect payments for the items and services furnished by a specific off-campus outpatient department of a provider, not all OPPS payments to the main provider. As discussed throughout this section, we have sought to minimize the burden on providers in complying with the requirements of section 6225 of the CAA, 2026 while also maintaining appropriate oversight, and will continue to make every effort in doing so. As we implement these provisions, such efforts will include the development of billing, enrollment, and other subregulatory guidance. However, we will monitor implementation progress and may consider these suggestions for future rulemaking. We may consider the commenter's feedback regarding the cross-claim linkage on related professional claims in the development of future billing or other subregulatory guidance.

Comment: Commenters questioned whether multiple hospital services operating at the same physical address require separate NPIs or may be covered by a single NPI, and whether an off-campus location providing multiple hospital services (such as providing both laboratory and radiology services) would need separate NPIs for each service line. Another commenter requested CMS provide clarity on how the location designation in the Provider Enrollment,

Chain, and Ownership System (PECOS) would impact the NPI assignment. For example, whether multiple off-campus provider-based departments located at the same address but with separate identifiers (e.g. room numbers or suite numbers) assigned in PECOS would require a separate NPI for each off-campus provider-based department. Some comments requested clarity on whether hospitals should obtain NPIs by the physical address level, based on how the location is designated in PECOS, or by each individual department.

Response: For purposes of the requirements of section 6225 of the CAA, 2026, and consistent with § 413.65(a)(2), "department of a provider" is identified by the hospital's submission of its physical facility location in the enrollment system— its street address, including suite or floor number, where applicable. A single off-campus location operating at one address is one "department of a provider" and, therefore, needs only one NPI even if multiple types of services are being provided there. For example, a hospital with an off-campus location providing both laboratory and radiology services would obtain one NPI for that location, not separate NPIs per service line.

Comment: Other comments related to the separate NPI requirement included concerns that separate NPIs for off-campus provider-based departments could conflict with CMS requirements to combine same-day outpatient services on a single claim because the Health Insurance Portability and Accountability Act (HIPAA) standard claim format permits only one billing NPI. Some commenters also expressed concern about potential Medicare Advantage (MA) implications of new department-specific NPIs. Commenters stated that new NPIs could trigger new prior authorization requirements for MA patients, disrupt coordination of benefits, and cause supplemental insurance claim denials due to NPI mismatches. Commenters further argued that requiring separate NPIs undermines HIPAA's goal of a single provider identifier and urged CMS to clarify that department-specific NPIs are administrative requirements only and do not indicate new independent provider entities.

Response: The establishment or use of an NPI to satisfy the requirements of section 6225 of the CAA, 2026 does not, by itself, change the nature of the department, which remains a provider-based department of the hospital. To address certain issues mentioned in the comments, we are taking measures to allow the entry of multiple NPIs within a claim – the claim level NPI of the hospital plus the service line NPIs for the various services provided during a given day.

We will continue to consider commenters' feedback—including concerns about burden and operational challenges—as the agency develops policies and subregulatory guidance for implementing the NPI requirement.

Comment: Commenters generally supported our proposals related to timing of the initial attestation, including the proposal to submit initial attestations in the 2-year period prior to January 1, 2028, and the proposal that initial attestations submitted by January 1, 2028 will meet the requirement even if CMS has not issued a provider-based determination by that date. Some commenters recommended that attestation approvals granted prior to January 1, 2026, be "grandfathered" as having met the initial attestation requirement. Other commenters requested that the initial attestation requirement be limited to new off-campus outpatient departments of a provider. Another commenter urged CMS to tie the initial attestation deadline to the existing Form CMS-855A enrollment activation date, such as 60 days following that enrollment activation date. The commenter stated that it is "administratively irrational" to require a provider-based attestation prior to this enrollment activation since the facility does not yet legally exist within the Medicare system. A commenter requested that CMS clarify in the regulation text at § 419.23 that claims for services provided at a department with a complete, timely attestation under review will continue to be paid without interruption.

Response: We appreciate commenters' feedback on our proposals related to the timing of the initial attestation, and are finalizing them, with one modification discussed below. Specifically, we are finalizing our proposal that for departments providing services on or before

January 1, 2028, initial attestations must be submitted between January 1, 2026 and December 31, 2027; for departments beginning services after January 1, 2028, initial attestations must be submitted within the 2 years prior to delivering billed services; and providers submitting initial attestations within the required 2-year period will meet the initial attestation requirement, even if a provider-based status determination has not been received by that date. Based on feedback from commenters, we are adding paragraph (c) to § 419.23 to clarify that a provider satisfies the submission requirement at paragraph (a)(2) of this section even if CMS has not made a determination of provider-based status before the first day on which the outpatient department renders services.

Regarding attestation approvals granted prior to January 1, 2026, section 6225 of the CAA, 2026 specifies the timing for the initial attestation by requiring that payment cannot be made for items or services furnished on or after January 1, 2028 by an off-campus outpatient department of a provider unless such provider has submitted an initial provider-based attestation "during the 2 year period ending on the date such items or services are so furnished." Although attestations submitted before the statutory "2 year period" deadline do not meet the initial attestation requirement, our streamlined attestation process aims to reduce provider burden.

Regarding the request to use the Form CMS-855A enrollment activation date as the deadline for the initial attestation, under current procedures a Form CMS-855A must be submitted, reviewed by the MAC, and assigned an effective date of enrollment activation before an off-campus outpatient department of a provider can be added to a provider's enrollment record. However, as previously discussed, the provisions of section 6225 of the CAA, 2026 specify the timing for the initial attestation, tying it to the date the items or services for which payment is being sought are furnished. We appreciate the commenter's concern and encourage providers to take into account the time needed to add a potential provider-based off-campus outpatient department to their enrollment record when considering when to submit an initial attestation within the statutory 2-year period.

Comment: Several commenters requested CMS modify the proposed maximum 5-year timeframe for the required subsequent attestation to reduce the overall burden on hospitals. Some suggested a timeframe of seven to ten years, and some requested a timeframe of no less than 10 years. Another commenter expressed the importance of maintaining provider-based compliance for equitable payment policy, and suggested CMS implement a shorter timeframe, such as 3 years or upon a change in ownership, for the subsequent attestation. Many commenters recommended requiring only one subsequent attestation after the initial attestation, or only requiring periodic re-attestations in specified circumstances, such as when there is a material change in the relationship between the hospital and its off-campus provider-based department, a change in ownership, or a management contract change. A commenter also requested CMS clarify when the proposed 5-year "countdown" for the subsequent attestation would begin, such as when the initial attestation is submitted or when CMS issues the provider-based status determination.

A commenter stated that CMS should establish the subsequent (post-CY 2028) attestation cadence in the final rule, rather than deferring it to future rulemaking or guidance, to provide adequate lead time for compliance planning.

Response: We appreciate the commenters' feedback. In response to the comment regarding the start of the subsequent attestation timeline, we are clarifying that the time-period for the subsequent attestation would begin on the date the attestation is submitted as we believe this is the most consistent with the statute.

At this time, we continue to believe that a maximum 5-year subsequent attestation period is an appropriate timeframe to balance provider burden while ensuring continued provider-based compliance. As we gain experience with these new requirements, we may revisit this policy, including commenters' suggestions regarding the timing, frequency and/or circumstances of a subsequent attestation.

We appreciate the commenter's request to address the subsequent attestation process in this final rule with comment period. We believe addressing the subsequent attestation requirement, including its timing, frequency, and applicable circumstances, in the 2028 rulemaking cycle will allow CMS to gain experience implementing the initial attestation requirement and to consider additional operational information before establishing the subsequent attestation process.

In response to our request, we also received comments on the subsequent attestation requirement process. We appreciate those suggestions and feedback and will take them into consideration for future rulemaking. As stated in the proposed rule (91 FR 41982), we anticipate addressing the subsequent attestation requirement in the 2028 rulemaking cycle.

In summary, after consideration of public comments, we are finalizing our proposal to codify, at § 419.23, the separate NPI and attestation requirements for payment under the OPPS for items and services furnished on or after January 1, 2028, with one technical edit in paragraph (a)(3) and the modification to address situations where CMS has not issued a provider-based status determination before the first date services are furnished. We are also finalizing our proposal to add § 413.65(b)(6), including a reference to the separate NPI and attestation requirements, with a modification, as discussed below. Specifically, § 413.65(b)(6) provides that, as of January 1, 2028, a main provider must submit an initial attestation of provider-based status for each of its off-campus outpatient departments within the 2-year period prior to furnishing services, and subsequent attestation(s) within a period not to exceed 5 years thereafter. For all off-campus outpatient departments providing services on or before January 1, 2028, initial attestations must be submitted between January 1, 2026 and December 31, 2027, and for off-campus outpatient departments that begin providing services after January 1, 2028, initial attestations must be submitted within the 2 years prior to delivering billed services. For purposes of § 413.65(b)(6), an off-campus outpatient "department" comprises all hospital operations at one physical address as listed in PECOS.

In the proposed rule (91 FR 41982**)**, we discussed that Indian Health Service and Tribal facilities described in § 413.65(m) and certain FQHCs and "look alikes" described in § 413.65(n) are considered to be in compliance with provider-based requirements, and would not be subject to review of provider-based status. We, therefore, proposed to exclude these facilities from the proposed attestation requirements. We stated that other parts of § 413.65 not specifically addressed are outside the scope of this rulemaking.

Comment: We received several comments requesting clarification as to whether certain off-campus facilities for which CMS currently does not make a provider-based determination, such as those listed in § 413.65(a)(1)(ii), would be subject to the requirements of section 6225 of the CAA, 2026. Commenters also inquired whether facilities not paid under the OPPS, such as Critical Access Hospitals (CAHs), Rural Health Clinics (RHCs), and hospitals participating in the Achieving Healthcare Efficiency through Accountable Design (AHEAD) payment model, such as those located in Maryland, would be subject to the requirements of section 6225 of the CAA, 2026.

Response: Section 6225 of the CAA, 2026 specifies that no payment may be made under the OPPS (or under an applicable payment system pursuant to § 1833(t)(21)) of the Act for items and services furnished by an off-campus outpatient department of a provider unless the separate NPI and attestation requirements are met. CAHs are excluded from the OPPS at § 419.20(b)(2), and payment for outpatient CAH services is governed by § 1834(g) of the Act. Therefore, we do not believe that section 6225 of the CAA, 2026 applies to CAHs.

Regarding RHCs, we note that because provider-based RHCs furnish health care services of a *different* type from those of the main provider, an RHC would meet the § 413.65(a)(2) definition of a "provider-based entity", not a "department of a provider". Because § 1833(t)(23)(C), added by Section 6225 of the CAA, 2026, includes the regulatory term "department of a provider" only, "provider-based entities" such as RHCs would not fall within

the scope of section 6225 of the CAA, 2026 applicable to off-campus outpatient departments of a provider.

We also believe that the requirements of section 6225 of the CAA, 2026 do not apply to hospitals, such as those located in Maryland, that are participating in the AHEAD Model since they are not paid under section 1833(t) of the Act. The AHEAD Model is a voluntary state total cost of care model with hospital global budgets that was created under section 1115A of the Social Security Act by CMS's Center for Medicare and Medicaid Innovation (CMS Innovation Center) that specifies participating hospitals payments; participating hospitals are not paid under the OPPS.

Initially, we determined we would not make a provider-based determination for facilities listed at § 413.65(a)(1)(ii) because we believe obtaining provider-based status typically would have no direct payment impact. Facility types mentioned in § 413.65(a)(1)(ii) may be paid under a separate payment system from OPPS. In the case of therapy services described in § 413.65(a)(1)(ii)(H), we make no provider-based status determination when there is no annual financial cap amount on payments for provider-based and freestanding facilities.[227] Section 6225 requirements apply to any facility that meets the definition of an "off-campus outpatient department of a provider" and section 6225 does not distinguish between facilities that receive different payments. However, we will take into consideration the concerns expressed regarding those facilities for which we historically have not made provider-based status determinations and may consider appropriate ways to minimize burden as we develop subregulatory guidance implementing the requirements of section 6225 of the CAA, 2026.

Comment: A commenter requested clarification as to whether a remote location of a hospital must obtain and maintain its own organizational (Type 2) NPI.

[227] Currently, the financial cap is applicable to both freestanding and provider-based facilities described in § 413.65(a)(1)(ii)(H).

Response: As discussed previously, a "remote location of a hospital" refers only to a facility that furnishes inpatient services, and is not, itself, an “off-campus outpatient department of a provider” and therefore is not subject to the provisions of Section 6225 of the CAA, 2026.

Comment: A commenter requested CMS to confirm that an off-campus outpatient department of a provider that does not submit Medicare claims for OPPS payments is not required to obtain a separate NPI or submit an attestation unless and until it intends to bill Medicare. Other commenters specifically asked about outpatient departments of Children’s Hospitals, requesting an exclusion for facilities with a de minimis number of Medicare claims.

Response: As stated previously, section 6225 of the CAA specifies that no payment may be made under the OPPS (or under an applicable payment system pursuant to section 1833(t)(21)) for items and services furnished by an off-campus outpatient department of a provider unless the separate NPI and attestation requirements are met. It contains no de minimis exception. However, a facility that is not seeking payment under the referenced payment systems would not be compelled to comply with the requirements of section 6225 of the CAA, 2026.

After consideration of public comments, we are finalizing our proposal to exclude Indian Health Service and Tribal facilities described in § 413.65(m) and certain FQHCs and “look alikes” described in § 413.65(n) from the attestation requirements. In addition, we are adding language to § 413.65(b)(6) to specify that an off-campus department operating as part of CAH is excluded from the attestation requirements.

In the proposed rule (91 FR 41982**)**, to implement section 6225 of the CAA, 2026, we proposed to establish a standardized attestation form for provider-based determinations, which would replace the current Medicare Administrative Contractor (MAC)-specific templates and ensure consistency across MACs. Through this standardization, CMS proposed that main providers would submit the attestation through a centralized electronic system, which we stated we believed would result in a reduction in administrative burden for providers and a more efficient review process for MACs and CMS. Further, we stated that we anticipated that

standardization and centralized submission processes may reduce unnecessary duplicative documentation burden while continuing to support appropriate compliance review and program integrity oversight. Until the standardized form and centralized electronic system are finalized, we stated that providers may continue to submit attestations in accordance with existing § 413.65(b)(3)(ii) in satisfaction of section 6225 of the CAA, 2026 to their servicing MAC. (91 FR 41982)

Comment: Commenters generally supported CMS's proposal to establish a centralized electronic system for submitting provider-based attestations, noting that such a system could promote greater consistency and efficiency. Commenters requested that the system support streamlined or bulk submissions for providers with multiple off-campus departments.

Response: We thank commenters for their support of a centralized electronic submission system. We intend for the centralized system to provide a standardized mechanism for submitting and maintaining provider-based attestations and to eliminate variations with the existing MAC processes. We also intend for the system to eliminate duplication in documentation submission for multiple attestations, where practicable. We will ensure that the system provides the necessary information for providers to attest to the provider-based requirements and will provide additional operational instructions regarding use of the system through subregulatory guidance.

After consideration of public comments, we are finalizing our proposal to adopt the centralized electronic system for attestations as proposed.

To ensure providers have clarity on how to satisfy the mandatory attestation requirement under section 6225 of the CAA, 2026, we proposed to require that providers submit attestations using the referenced CMS-standardized attestation form. The attestation would be a list of identifying information of the main provider and provider-based department such as name, address, and NPI that includes a list of the requirements at § 413.65(d)(e), (g), and (h) with a certifying statement affirming compliance to be signed by an authorized official of the main

provider. A draft was made available at the following link for comment: *https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1850-p*. Under the current attestation process, providers submit their attestations and supporting documentation to their MAC, which performs a preliminary review and forwards its recommendation to CMS for the initial determination. We proposed to modify this process so that CMS' contractors, including MACs, conduct standardized review and validation activities in support of initial determination regarding compliance with § 413.65, rather than requiring separate CMS review of each attestation recommendation. To reflect this proposal, we proposed to revise § 413.65(b)(3)(iii) to specify that CMS "or its agents" will send the provider written acknowledgment of receipt of the attestation, review the attestation for completeness and consistency with information in the possession of CMS "or its agents" at the time the attestation is received, and make a determination as to whether the facility or organization is provider-based (91 FR 41982). We also proposed that the determinations issued through this process would constitute CMS initial determinations for purposes of § 498.3(b)(2). In conducting review and validation activities, we proposed that CMS and its contractors, including MACs, would employ standardized review, validation, and risk-based screening processes to assess attestations for completeness, consistency with the provider's enrollment records, and compliance with the applicable requirements of § 413.65. We stated these processes may include automated validation activities, data analysis, targeted documentation review, and contractor review procedures designed to support consistent national implementation and program integrity oversight. We proposed to establish, through operational guidance, specific review criteria, validation protocols, and documentation standards that CMS and its contractors, including MACs, must apply in conducting review and validation activities and supporting initial determinations, in order to promote consistent assessment of provider-based requirements across all CMS contactors including MAC jurisdictions. We stated that CMS would conduct ongoing quality

review and oversight of attestation determinations and related review activities (91 FR 41982). (For additional discussion of our proposed documentation requirements for provider-based attestations and proposed verification and oversight activities, refer to sections XX.D, and XX.E, respectively, of this preamble.)

Comment: We received a number of comments on the attestation process, including the initial attestation pathway and form design. Commenters generally supported a streamlined attestation process and form but requested clarification or modification of several data elements. For example, commenters noted that the proposed form does not provide a means to identify a designated contact acting on behalf of the provider. Several commenters also recommended that CMS allow delegated submission authority so that an authorized submitter can complete and submit attestations and supporting documents on behalf of the organization without requiring the direct involvement of the authorized official. A commenter requested CMS avoid open-ended review timelines and establish a specific review and determination timeframe, such as 60 or 90 days.

Response: We thank commenters for their recommendations and will make every effort to include appropriate changes to the attestation process and form, including the ability to designate a provider contact and delegation authority. We note that section 6225 of the CAA, 2026 does not establish a deadline by which CMS must complete the review of attestations or make provider-based determinations. We understand the commenter's concern regarding extended review periods and, as we gain experience with the implementation of the mandatory attestation, review and determination requirements, we will continue to refine or revise our policies and procedures to minimize unnecessary delays.

In the proposed rule (91 FR 41982), we proposed an additional modification to § 413.65(b)(3)(ii) to revise the timing and modernize submission of supporting documentation for off-campus provider-based facilities and organizations. We proposed CMS and its contractors, including MACs, employ standardized review and validation processes, including

automated validation activities, data analysis, risk-based screening methodologies, targeted documented review, and other program integrity activities, to evaluate attestations and identify submissions requiring additional review of compliance verification. Providers would continue to be required to maintain documentation demonstrating compliance with applicable provider-based requirements and to furnish such information to CMS or its contractors, including MACs, upon request as part of review, validation, audit, or oversight activities. We stated that we believe these proposals would afford providers greater flexibility in meeting the statutory deadlines imposed by section 6225 of the CAA, 2026, while continuing to allow CMS oversight and access to information necessary to evaluate compliance and make a determination. We also proposed a modification to § 413.65(k) to remove references to what constitutes a "complete" attestation, with supporting documentation and additional information to be requested from the provider, as necessary, after the standardized attestation form has been submitted (91 FR 41982).

Comment: Commenters generally supported our proposed centralized electronic system and streamlined attestation process and offered recommendations to reduce administrative burden, particularly for health systems with multiple off-campus departments. These commenters urged CMS to minimize duplicative documentation for departments that already received an affirmative provider-based determination from CMS. Commenters also asked us to clarify whether providers must submit supporting documentation along with their attestation.

Response: We thank commenters for their support of a streamlined attestation process and for their detailed operational recommendations. We clarify at the outset that an attestation serves as a provider's certification of compliance with the applicable provider-based requirements at § 413.65. We do not intend to require the submission of documentation supporting the basis for the claims made in the attestation at the time the attestation is submitted. Providers will be expected, however, to furnish documentation demonstrating compliance with the provider-based requirements upon our request.

Departments that received an affirmative provider-based determination before January 1, 2026, are required to submit a new attestation under the streamlined process described. The streamlined process is intended to reduce burden for all attestations, including for departments that previously received an affirmative provider-based determination. We expect to address this process further in future rulemaking or subregulatory guidance.

We received general support from commenters regarding the proposals to streamline and reduce the administrative burden of the provider-based attestation process. After consideration of public comments, we are finalizing as proposed our proposal to revise the timing and modernize the manner in which supporting documentation is submitted for off-campus provider-based facilities and organizations at § 413.65(b)(3)(ii). We are also finalizing our proposal to modify § 413.65(k) to remove references to what constitutes a 'complete' attestation as proposed.

We proposed that main providers, prior to submitting an attestation, must obtain an NPI for each provider-based department and update PECOS. As discussed previously, to implement section 6225 of the CAA, 2026, we proposed to establish a standardized attestation form for provider-based determinations that would replace the current MAC-specific templates; the attestation would then be submitted through a centralized electronic system. We stated we believe this standardized approach would ensure consistency across MACs and would result in a reduction in administrative burden for providers and a more efficient review process for MACs and CMS. For providers that submit attestations for more than one off-campus outpatient department, we stated that we were considering streamlined supporting documentation requirements and sought input on how best to minimize burden while ensuring robust oversight. Further, we stated we anticipated a reduction in the documentation supporting the attestation. For instance, we anticipated leveraging system capabilities to reduce duplicative documentation submissions by allowing supporting documentation applicable to multiple locations to be submitted a single time, where appropriate (91 FR 41983).

Comment: Commenters expressed concern about the administrative burden associated with repeatedly submitting the same information and supporting documentation for multiple off-campus departments within the same hospital or health system. Commenters recommended that CMS allow information and documentation applicable to multiple departments to be submitted once and applied across the relevant departments, rather than requiring duplicative submissions.

Response: We thank commenters for these recommendations. As discussed, providers will not be required to submit supporting documentation with the initial attestation. When we request supporting documentation, we intend to use the centralized electronic system to minimize duplicative submissions, including by allowing providers to submit documentation once when the same information applies to multiple off-campus departments or demonstrates compliance with multiple provider-based requirements.

After consideration of public comments, we are finalizing these provisions concerning the use of a centralized electronic system, standardized attestation, and supporting documentation as proposed. We are also finalizing that, prior to submitting an attestation, main providers must obtain an NPI for each provider-based department and update their enrollment record in CMS's system of record — currently PECOS — or any successor system accordingly.

In the proposed rule (91 FR 41983), we stated that the future standard attestation format would request identifying information for both the main provider and the provider-based entity, including applicable NPIs. We stated that once all attestations are submitted, providers would indicate their submission is complete. We stated CMS and its contractors, including MACs, may employ automated validation, screening, targeted review and risk-based methodologies to identify attestations requiring additional review, supporting documentation, or follow-up activities. We stated that we anticipate giving providers a reasonable period, generally not to exceed 60 days, to furnish requested supporting documentation.

If CMS or its contractors, including MACs, determine that an attestation demonstrates compliance with the provider-based requirements at § 413.65, we proposed that an approval

notice would be issued. We proposed CMS and its contractor, including MACs, would request supporting documentation at any stage of the review, validation, audit or oversight process to evaluate compliance with applicable provider-based requirements. If CMS or its contractor determines that an attestation fails to demonstrate compliance with the provider-based requirements, or if the provider fails to furnish all requested information or attest to all applicable requirements, we proposed that a denial would be issued, including applicable appeal rights. Until the standardized form and centralized electronic system are finalized, we proposed providers may continue to submit attestations in accordance with § 413.65(b)(3), in satisfaction of section 6225 of the CAA, 2026 (91 FR 41983). As noted previously, an off-campus outpatient department of a provider will also need to obtain an NPI by January 1, 2028 to be paid under the OPPS (or under an applicable payment system in accordance with section 1833(t)(21)) of the Act, consistent with section 1833(t)(23)(A)(i) of the Act as added by section 6225 of the CAA, 2026.

In addition in the proposed rule (91 FR 41983), we proposed to use program integrity mechanisms currently available to CMS, or that may become available in the future, whether through improved technology, contracting, data analysis or other means, to evaluate compliance with provider-based requirements and identify attestations requiring additional review or oversight activities. In § 413.65(k), we proposed to specify that these activities may include site visits, remote audits, investigations, or require submission of additional documentation as may be necessary to make a determination of compliance with the provider-based requirement, and the use of current or future Medicare program integrity contractors. We stated that we believe this proposal would continue to address CMS' longstanding concerns, regarding potential increased costs to the Medicare program and its beneficiaries by ensuring compliance with provider-based regulations. (For additional discussion of our proposed documentation requirements for provider-based attestations, refer to section XX.D of this preamble. For

additional discussion of the proposed CMS verification and oversight activities, refer to section XX.E of this preamble.)

Comment: Commenters requested that CMS establish clear procedures for communicating the outcome of provider-based attestation reviews, including written notice of findings, opportunities to correct deficiencies before a denial, and information regarding applicable appeal rights.

Response: We thank commenters for these recommendations. We will provide written notification of the outcome of an attestation review, including a determination as to whether the department satisfies the applicable provider-based requirements. If we determine that a department does not satisfy the requirements, the notification will identify the basis for the adverse determination and provide information with applicable appeal rights. As appropriate, providers that CMS determines would otherwise satisfy the provider-based requirements, but have minor attestation-based deficiencies may also be afforded an informal opportunity to correct those deficiencies before we issue a determination.

After consideration of public comments, we intend to provide written notice of the review outcome with applicable appeal rights. We are also finalizing without modification the proposed changes to § 413.65(k) regarding program integrity mechanisms for compliance with the provider-based requirements.

D. Documentation Requirements for Provider-Based Attestations

To support meaningful CMS oversight of provider compliance with the provider-based requirements of § 413.65, and consistent with the mandatory attestation requirement established by section 6225 of the CAA, 2026, in the proposed rule (91 FR 41983), we proposed that attestations submitted through the proposed standardized attestation process would include, or be supported by, documentation sufficient to demonstrate compliance with the applicable provisions of § 413.65(d), (e), (g), and (h). We described, as discussed later in this section, the categories of documentation that providers may be required to submit or retain in connection with their

attestations. As discussed further, we stated that CMS anticipated that not all documentation described herein would be required at the time of initial attestation submission; rather, CMS and its contractors, including MACs, will employ risk-based screening and targeted documentation review processes to identify those attestations for which additional documentation is warranted. We stated the rationale behind using targeted documentation review is that any main provider typically manages its departments in a consistent manner. By drawing a sample from each main provider's universe of provider-based departments, we would be able to gain a reliable understanding of their universe. This approach would not only ensure adequate representation across all providers, regardless of their volume—it would also provide meaningful insight into whether compliance standards are being upheld across all departments. We invited public comment on the appropriate scope of documentation requirements, including whether any of the categories described should be modified, consolidated, or eliminated in order to reduce provider burden while preserving CMS' ability to evaluate compliance and protect the Medicare program. Specifically, in the proposed rule (91 FR 41983 through 41984) we proposed the following documentation framework:

- *Attestation Form Completeness and Authorization:*

++ We proposed that providers must submit a completed attestation using the CMS-standardized attestation form, signed and dated by an authorized official of the main provider as identified in PECOS. The attestation would be required to identify both the main provider and each off-campus outpatient department of the provider for which provider-based status is sought, including the applicable NPIs, provider numbers, addresses, and the date on which provider-based conditions were met or the date the department was acquired, as applicable. Where a provider designates a consultant or outside representative as the primary contact for the attestation, we proposed the provider must authorize the representative in writing.

- *Location:*

++ We stated we anticipate the attestation system would have the ability to measure the distance requirement. However, if the distance is not systematically verified or exceeds 35-miles, we proposed providers would be required to submit supporting documentation in support of § 413.65(e)(3).

- *Licensure:*

++ We proposed providers must be prepared to demonstrate that the off-campus outpatient department is operated under the same licensure as the main provider, consistent with § 413.65(d)(1), or to provide documentation that the applicable State does not require a separate license for the department.

- *Clinical Services Integration:*

++ We proposed providers must be prepared to demonstrate that the off-campus outpatient department meets the clinical integration requirements of § 413.65(d)(2), including that professional staff at the department hold privileges at the main provider; that appropriate monitoring and oversight of the department by the main provider is in place; that inpatient and outpatient services of the department and the main provider are integrated; and that patients treated at the department who require further care have full access to all services of the main provider.

- *Financial Integration:*

++ We proposed providers must be prepared to demonstrate that the revenues and expenses of the off-campus outpatient department are integrated with those of the main provider, consistent with § 413.65(d)(3), such that the department does not maintain a separate general ledger or trial balance independent of the main provider.

- *Public Awareness:*

++ We proposed that providers must be prepared to demonstrate that the off-campus outpatient department is clearly identified to the public as part of the main provider, consistent

with § 413.65(d)(4), and that patients entering the department are aware they are receiving services from the main provider.

- *Obligations of Hospital Outpatient Departments:*

++ For off-campus outpatient departments that are departments of hospitals, we proposed that providers must be prepared to demonstrate compliance with the applicable obligations of hospital outpatient departments under § 413.65(g), including compliance with Emergency Medical Treatment and Labor Act (EMTALA) requirements, antidumping rules, site-of-service billing requirements, and the requirement to provide written notice to Medicare beneficiaries of their potential financial liability prior to the delivery of services at an off-campus location.

- *Ownership, Control, Administration, and Supervision (Off-Campus Departments):*

++ We proposed providers must be prepared to demonstrate that the department operates under the ownership and control of the main provider consistent with § 413.65(e)(1), including that the department is 100 percent owned by the main provider and that the main provider retains final approval over administrative decisions, personnel policies, and medical staff appointments. We also proposed providers must also be prepared to demonstrate that the administrative functions of the department are integrated with those of the main provider consistent with § 413.65(e)(2), including through submission of an organizational chart reflecting the reporting relationship between the department and the main provider.

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: Commenters requested greater clarity and consistency regarding the documentation CMS may require demonstrating compliance with the provider-based requirements. A commenter recommended a uniform national documentation checklist identifying the evidence necessary to demonstrate compliance with § 413.65.

Response: We thank commenters for their recommendations on the documentation

requirements for the provider-based requirements. We plan to provide specific guidance on the required documentation for each provider-based requirement in future rulemaking or subregulatory guidance.

E. CMS Verification and Oversight Activities

Section 1833(t)(23)(B)(i) of the Act directs the Secretary to establish a process for determining, through site visits, remote audits, or other means as determined appropriate by the Secretary, whether each off-campus outpatient department of a provider is compliant with the applicable requirements. Consistent with this statutory direction, in the proposed rule (91 FR 41984), we proposed that CMS and its contractors, including MACs, employ a layered, risk-based approach to verification and oversight that would be designed to promote efficient processing of the significantly increased volume of attestations expected under the mandatory attestation requirement while preserving meaningful CMS oversight of provider compliance with § 413.65.

We proposed that, at the initial review stage, CMS and its contractors, including MACs, would conduct automated validation and screening of all submitted attestations to verify completeness, consistency with PECOS enrollment records, and the presence of required attestation elements. Attestations that pass automated validation would be processed for initial determination. Attestations that present indicators of incompleteness, inconsistency, or elevated compliance risk would be flagged for targeted documentation review, during which CMS or its contractors may request that the provider furnish supporting documentation from any or all of the categories described.

At the extended review stage, we proposed that CMS and its contractors, including MACs, would employ risk-based methodologies to select a subset of attestations for more extensive compliance review. Such methodologies may include remote audits of provider records and documentation, site visits conducted by CMS or its contractors to verify that the attested department meets the physical, financial, clinical, and administrative integration

requirements of § 413.65, or investigations of potential non-compliance identified through data analysis, referral, or other sources. We stated the criteria and methodologies CMS would use to select attestations for extended review would be established through operational guidance and would be designed to focus oversight resources on providers and departments that present the highest risk of non-compliance with the provider-based requirements. We proposed that failure to submit requested documentation within the timeframe specified by CMS may result in a determination of non-compliance and recovery of payments as described in § 413.65(k).

We invited public comment on the appropriate scope and sequencing of documentation requirements, including whether the categories described should be further prioritized, consolidated, or phased in over time to facilitate provider compliance with the January 1, 2028 statutory deadline.

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: Commenters generally supported CMS's use of risk-based verification and oversight but requested greater clarity regarding the criteria and procedures for targeted reviews, documentation requests, remote audits, and site visits.

Response: We thank commenters for their support regarding our proposed verification and oversight activities. Following our reviews of submitted attestations, we anticipate we will prioritize resources to perform extended reviews for hospitals with only a single off-campus outpatient department and targeted extended reviews for hospitals with multiple off-campus departments by selecting a random sample of submissions. Providers will be asked to submit specific documentation to demonstrate compliance with each provider-based requirement at § 413.65. If a provider is found to be out of compliance for a specific requirement, we may extend the review of that requirement to departments not included in the sample. We will continue to develop policies and procedures, such as remote audits, data analysis, alternative data sourcing approaches and site visits, as we gain experience with the oversight of these off-campus

provider-based requirements.

After consideration of public comments, we are finalizing these provisions as proposed.

XXI. Payment for Direct and Indirect Graduate Medical Education (GME) Costs -- Notice of Closure of Teaching Hospitals and Opportunity to Apply for Available Slots

a. Background

Section 5506 of the Patient Protection and Affordable Care Act (Pub. L. 111–148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152) (collectively, "Affordable Care Act"), authorizes the Secretary to redistribute residency slots after a hospital that trained residents in an approved medical residency program closes. Section 5506 of the Affordable Care Act instructs the Secretary to establish a process by regulation that redistributes slots from teaching hospitals that close to hospitals that meet certain criteria, with priority given to certain hospitals including those located in the same Core Based Statistical Area (CBSA), in a contiguous CBSA or in the same state as the closed hospital.

Specifically, section 5506 of the Affordable Care Act amended the Act by adding subsection (vi) to section 1886(h)(4)(H) of the Act and modifying language at section 1886(d)(5)(B)(v) of the Act. These changes instruct the Secretary to establish a process to increase the FTE resident caps at other hospitals based upon the FTE resident caps at teaching hospitals that closed on or after March 23, 2008. In the CY 2011 Outpatient Prospective Payment System (OPPS) final rule with comment period (75 FR 72264), we established regulations at 42 CFR 413.79(o) and an application process for qualifying hospitals to apply to CMS to receive direct GME and IME FTE resident cap slots from the hospital that closed. We made certain additional modifications to § 413.79 in the FY 2013 IPPS/LTCH PPS final rule (77 FR 53434), and we made changes to the section 5506 application process in the FY 2015 IPPS/LTCH PPS final rule (79 FR 50122-50134). The procedures we established apply to teaching hospitals that closed between March 23, 2008, and August 3, 2010, and to teaching hospitals that close after August 3, 2010 (75 FR 72215).

b. Notice of Closure of St. Luke's Des Peres Hospital Located in Des Peres, MO, and the Application Process—Round 32

CMS learned of the closure of St. Luke's Des Peres Hospital, located in Des Peres, MO (CCN 260176). Accordingly, we are providing notice of the closure of this teaching hospital and initiating another round of the application and selection process to redistribute the closed hospital's FTE resident caps. This round will be the 32nd round ("Round 32") of the application and selection process. Table 104 contains the identifying information for the closed teaching hospital and its IME and direct GME FTE resident caps, which are part of the Round 32 application process under section 5506 of the Affordable Care Act.

TABLE 104: ST. LUKE'S DES PERES HOSPITAL FTE RESIDENT CAPS

CCN	Provider Name	City and State	CBSA Code	Terminating Date	IME FTE Resident Cap	Direct GME FTE Resident Cap
260176	St. Luke's Des Peres Hospital	Des Peres, MO	41180	July 31, 2025	25.16[1]	26.06[2]

1 St. Luke Des Peres Hospital's 1996 IME FTE resident cap is 25.16.
2 St. Luke Des Peres Hospital's 1996 Direct GME FTE resident cap is 26.06.

c. Notice of Closure of Franciscan Health Hammond Located in Hammond, IN, and the Application Process—Round 33

CMS learned of the closure of Franciscan Health Hammond, located in Hammond, IN (CCN 150004). Accordingly, we are providing notice of the closure of this teaching hospital and initiating another round of the application and selection process to redistribute the closed hospital's FTE resident slots. This round will be the 33rd round ("Round 33") of the application and selection process. Table 105 contains the identifying information for the closed teaching hospital and its IME and direct GME FTE resident caps, which are part of the Round 33 application process under section 5506 of the Affordable Care Act.

TABLE 105: FRANCISCAN HEALTH HAMMOND FTE RESIDENT CAPS

CCN	Provider Name	City and State	CBSA Code	Terminating Date	IME FTE Resident Cap (including +/- MMA Sec. 422[1] adjustments)	Direct GME FTE Resident Cap (including +/- MMA Sec. 422 adjustments)
150004	Franciscan Health Hammond	Hammond, IN	29414	December 31, 2022	6.11 – 1.72 sec. 422 reduction = 4.39[2]	6.11 – 1.75 sec. 422 reduction = 4.36[3]

1 Section 422 of the MMA, Public Law 108–173, redistributed unused IME and direct GME residency slots effective July 1, 2005.
2 Franciscan Health Hammond's 1996 IME FTE resident cap is 6.11. Under section 422 of the MMA, the hospital received a reduction of 1.72 to its IME FTE cap = 6.11 – 1.72 = 4.39.
3 Franciscan Health Hammond's 1996 Direct GME FTE resident cap is 6.11. Under section 422 of the MMA, the hospital received a reduction of 1.75 to its Direct GME FTE cap = 6.11 – 1.75 = 4.36.

d. Application Process for Available Resident Slots

The application period for hospitals to apply for slots under section 5506 of the Affordable Care Act is 90 days following notice to the public of a hospital closure (77 FR 53436). Therefore, hospitals that wish to apply for and receive slots from the previously noted hospitals' FTE resident caps must submit Round 32 and 33 applications using the electronic application intake system, Medicare Electronic Application Request Information System™ (MEARIS™) no later than **February 2, 2027**. The Section 5506 application can be accessed at *https://mearis.cms.gov/public/home.*

CMS will only accept Round 32 and 33 applications submitted via MEARIS™. Applications submitted through any other method will not be considered. Within MEARIS™, we have built in several resources to support applicants:

- Please refer to the "Resources" section for guidance regarding the application submission process at *https://mearis.cms.gov/public/resources.*
- Technical support is available under "Useful Links" at the bottom of the MEARIS™ webpage.
- Application related questions can be submitted to CMS using the form available under "Contact" at *https://mearis.cms.gov/public/resources*.

Application submission through MEARIS™ will not only help CMS track applications and streamline the review process, but it will also create efficiencies for applicants when compared to a paper submission process.

We have not established a deadline for when CMS will issue the final determinations to hospitals that receive slots under section 5506 of the Affordable Care Act. However, we review all applications received through MEARIS™ by the application deadline and notify applicants of our determinations as soon as possible.

We refer readers to the CMS Direct Graduate Medical Education (DGME) website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/direct-graduate-medical-education-dgme.* Hospitals should access this website for a list of additional section 5506 guidelines for applying for slots, and the redistribution of the slots under sections 1886(h)(4)(H)(vi) and 1886(d)(5)(B)(v) of the Act.

XXII. Consideration of Potential Approaches for Separate IPPS Payment for Domestic Procurement of Personal Protective Equipment and Essential Medicines

In the CY 2027 OPPS/ASC proposed rule (91 FR 41985 through 41996), we sought public comment on potential options we could consider for Medicare participating hospitals to help foster a more resilient supply chain for American-made PPE and essential medicines to secure our nation's health and safety, and to reflect the additional resource costs incurred when procuring these domestically manufactured items. Specifically, we solicited public comment on potentially eligible PPE and essential medicines, the applicable definitions of "domestic" for PPE and essential medicines, respectively, the use of standardized cost differentials for eligible domestic PPE and essential medicines, a potential manufacturer attestation of domestic origin, potential approaches under the IPPS to separately pay for the additional resource costs that hospitals face when purchasing eligible domestic PPE and essential medicines, and an appropriate maximum annual amount of aggregate separate payment under this potential policy. We also solicited general input on additional options from the public.

We thank commenters for the many thoughtful comments we received on this topic and will consider them for future rulemaking as appropriate.

XXIII. Request for Information on Strengthening the Standardization and Comparability of Hospital Price Transparency Data

In the CY 2027 OPPS/ASC proposed rule (91 FR 41996 through 41999), we included a RFI on strengthening the standardization and comparability of the hospital price transparency data. Specifically, we asked questions on how to strengthen the transparency and utility of the machine-readable files and on how to enhance the comparability of the consumer-friendly display. We received 185 timely pieces of correspondence that were submitted in response to the hospital price transparency RFI questions. The public comments received reflected input from a diverse range of interested parties, including academic researchers, consumers and consumer advocacy organizations, employer organizations, hospitals and hospital associations, health technology organizations, and users of the hospital price transparency machine-readable files. We thank all interested parties for their comments and will take them into consideration for future rulemaking.

XXIV. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), 44 U.S.C. 3501–3520, we are required to provide notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. To fairly evaluate whether an information collection should be approved by OMB, 44 U.S.C. 3506(c)(2)(A) requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We solicited public comment on each of these issues for the following sections of this document that contain information collection requirements (ICRs):

A. ICRs for the Hospital Outpatient Quality Reporting (OQR) Program

1. Background

In sections XIV. and XV. of this final rule with comment period, we discuss the finalized requirements for the Hospital Outpatient Quality Reporting Program. The Hospital Outpatient Quality Reporting Program is generally aligned with the CMS quality reporting program for hospital inpatient services known as the Hospital Inpatient Quality Reporting Program. We refer readers to the CY 2026 OPPS/ASC final rule with comment period (90 FR 54029 through 54037) for detailed discussions of the previously finalized Hospital Outpatient Quality Reporting Program ICRs which are currently approved under OMB control number 0938-1109 (expiration date July 31, 2029).

In this final rule with comment period, we are: (1) removing the Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients measure beginning with the CY 2027

reporting period/CY 2029 payment determination; (2) including electronic clinical quality measures (eCQMs) into the existing validation process for chart-abstracted measures beginning with eCQM data from the CY 2027 reporting period affecting the CY 2030 payment determination; (3) reducing the validation selection pool from 500 to up to 400 HOPDs beginning with validation affecting the CY 2030 payment determination; and (4) removing the requirement for hospitals to resubmit medical documentation as part of their request for reconsideration of validation noncompliance, beginning with data from the CY 2026 reporting period affecting the CY 2028 payment determination.

As part of including eCQMs into the existing validation process for chart-abstracted measures beginning with CY 2027 eCQM data affecting the CY 2030 payment determination, we are: (1) modifying the number of chart-abstracted cases required for validation from 12 per quarter to a maximum of 7 per quarter per measure beginning with validation affecting the CY 2030 payment determination; (2) replacing the previously finalized 2-year validation cycle with a 3-year validation cycle, where hospitals selected for validation based on CY 2027 data affecting the CY 2029 payment determination will not be selected again for validation of the same data affecting the CY 2030 payment determination; (3) determining eCQM validation scores using the same methodology currently used to score chart-abstracted measure validation; (4) revising the policy to allow the results of educational reviews for all four quarters of chart-abstracted measure validation to be reflected in the final validation score prior to the calculation of the confidence interval; and (5) extending the educational review process established for chart-abstracted measure validation to eCQM validation.

In the CY 2026 OPPS/ASC final rule with comment period, we calculated reporting burden estimates for the Hospital Outpatient Quality Reporting Program by utilizing the Bureau of Labor Statistics (BLS) median hourly wage rate for Medical Records Specialists (90 FR 54029). Specifically, we used the industry-specific wage for Medical Records Specialists working in “general medical and surgical hospitals”, as this categorization aligns the closest with

the Hospital Outpatient Quality Reporting Program care setting. The most recent data from BLS' May 2025 National Occupational Employment and Wage Estimates reflects a median hourly wage of $28.59 per hour for Medical Records Specialists working in "general medical and surgical hospitals" (SOC 29-2072).[228] We calculated the cost of overhead, including fringe benefits, at 100 percent of the median hourly wage, consistent with previous years. This is a rough adjustment, both because fringe benefits and overhead costs vary significantly by employer and methods of estimating these costs vary widely in the literature. Nonetheless, we believe that doubling the hourly wage rate ($28.59 × 2 = $57.18) to estimate total cost burden is reasonably accurate. Accordingly, unless otherwise specified, we calculate cost burden to hospitals using a wage plus benefits estimate of $57.18 per hour throughout the discussion in this section of this final rule with comment period for the Hospital Outpatient Quality Reporting Program.

In the CY 2026 OPPS/ASC final rule with comment period, our burden estimates assumed that approximately 3,200 hospital outpatient departments (HOPDs) will report data to the Hospital Outpatient Quality Reporting Program (90 FR 54029). For this final rule with comment period, based on the most recent available data from the CY 2026 Hospital Outpatient Quality Reporting Program payment determination, we estimate that 3,000 HOPDs will report data to the Hospital Outpatient Quality Reporting Program for the CY 2027 reporting period/CY 2029 payment determination and future years.

2. Information Collection Burden Estimate for the Removal of the Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients Measure Beginning with the CY 2027 Reporting Period/CY 2029 Payment Determination

As discussed in section XIV.B. of this final rule with comment period, we are removing the Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients measure

[228] U.S. Bureau of Labor Statistics. (2026). Occupational Outlook Handbook, Medical Records Specialists. Available at *https://data.bls.gov/oes/#/industry/622100/2025.* Accessed May 18, 2026.

beginning with the CY 2027 reporting period/CY 2029 payment determination. For this measure, HOPDs are required to abstract data from patient charts as well as report the measure electronically via CMS' Hospital Quality Reporting (HQR) system. According to the current Hospital Outpatient Quality Reporting Program Specifications Manual, the sample size requirement for HOPDs with populations of 900 patients or less is 63 cases annually, and the requirement for HOPDs with populations of greater than 900 patients is 96 cases annually.[229] To be conservative, we base our burden estimates on an estimate of 96 cases per HOPD annually. Under OMB control number 0938-1109, the currently approved burden is 2.92 minutes (0.049 hours) per case for chart-abstraction and 10 minutes (0.167 hours) per HOPD to report the measure via the HQR. Therefore, we estimate that this measure removal will result in a decrease in burden for all 3,000 HOPDs of 14,612 hours [(0.049 hours x 96 cases x 3,000 HOPDs) + (0.167 hours x 3,000 HOPDs)] at a savings of $835,514 (14,612 hours x $57.18) beginning with the CY 2027 reporting period.

We did not receive public comments on this information collection burden estimate.

3. Information Collection Burden Estimate for the Validation of eCQMs Beginning with Validation of CY 2027 Data Affecting the CY 2030 Payment Determination

As discussed in section XV.D. of this final rule with comment period, we are including eCQMs in the Hospital Outpatient Quality Reporting Program's existing validation process for chart-abstracted measures. We assume HOPDs will upload only one PDF file per case to CMS' HQR system with an estimated burden of 1 minute (0.0167 hours) per case per HOPD. In the CY 2027 OPPS/ASC proposed rule, we proposed to validate up to 32 eCQM cases annually from four calendar quarters of eCQM data (91 FR 41963). In this final rule with comment period, we are finalizing to validate up to 28 eCQM cases annually from four calendar quarters of eCQM data (up to 7 cases × 4 quarters) for each eCQM with mandatory reporting, starting with

[229] CMS. (2025). Hospital OQR Program Specifications Manual Release Notes version 19.0. Available at *https://qualitynet.cms.gov/files/69274c02ec892eacec2209b5?filename=OQR_SpecManual_v19.0a.pdf.*

validation of CY 2027 eCQM data affecting the CY 2030 payment determination. As discussed in section XXIV.A.4. of this final rule with comment period, we are finalizing a reduction of the validation selection pool from 500 to up to 400 HOPDs; therefore validation burden is estimated for up to 400 HOPDs. We note submission of medical documentation will occur in the CY immediately following the CY of the data being submitted (for example, CY 2027 data will be submitted in CY 2028 affecting the CY 2030 payment determination, and CY 2028 data will be submitted in CY 2029 affecting the CY 2031 payment determination). For the CY 2030 payment determination, in which HOPDs will be selected for validation of the ST-Segment Elevation Myocardial Infarction (STEMI) eCQM, we estimate an increase in burden of 187 hours across the 400 HOPDs selected for eCQM validation (0.0167 hours × 4 quarters × 7 cases × 400 HOPDs) at a cost of $10,674 (187 hours × $57.18). For the CY 2031 payment determination and subsequent years, HOPDs will be selected for validation of both the STEMI and Emergency Care Access & Timeliness eCQMs; thus, we estimated an increase in burden of 373 hours across the 400 HOPDs selected for eCQM validation (0.0167 hours × 4 quarters × 14 cases × 400 HOPDs) at a cost of $21,347 (373 hours x $57.18).

As discussed in section XV.D. of this final rule with comment period, we are finalizing policies which will align the inclusion of eCQMs into the existing validation process for chart-abstracted measures beginning with CY 2027 eCQM data. However, we are finalizing that impacts to payment for validation of eCQM data will not begin until the CY 2030 payment determination, which will be based off CY 2028 eCQM data. In the CY 2027 OPPS/ASC proposed rule, we proposed to validate up to 32 randomly selected patient cases annually for each chart-abstracted measure (91 FR 41963). In this final rule with comment period, we are finalizing a change to the number of cases selected for chart-abstracted measure validation under the Hospital Outpatient Quality Reporting Program to align with the number of cases selected for eCQM validation. Specifically, we will validate up to 28 randomly selected patient cases annually for each chart-abstracted measure. Under these policies, we will validate up to 28

randomly selected patient cases for chart-abstracted clinical process of care measures (up to 7 cases per quarter), starting with validation of CY 2027 data affecting the CY 2030 payment determination. Submission of medical documentation will occur in the CY immediately following the CY of the data being submitted (for example, CY 2027 data will be submitted in CY 2028 affecting the CY 2030 payment determination). As currently approved under OMB control number 0938-1109, selected HOPDs are required to submit medical documentation for validation for 48 cases (12 cases per quarter), for which we estimate an information collection burden of 15 minutes (0.25 hours) per case, or 12 hours per HOPD (0.25 hours/case x 48 cases). For the CY 2030 payment determination, in which HOPDs will be selected for validation of both the Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients and the Head Computed Tomography (CT) or Magnetic Resonance Imaging (MRI) Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients Who Received Head CT or MRI Scan Interpretation Within 45 Minutes of Arrival measures, we estimate the burden associated with these policies for the 400 HOPDs selected for validation to be 5,600 hours (0.25 hours x 56 cases x 400 HOPDs) at a cost of $320,208 (5,600 hours x $57.18). For the CY 2031 payment determination and subsequent years, in which HOPDs will be selected for validation of only the Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients Who Received Head CT or MRI Scan Interpretation Within 45 Minutes of Arrival measures, we estimate the burden associated with these policies for the 400 HOPDs selected for validation to be 2,800 hours (0.25 hours x 28 cases x 400 HOPDs) at a cost of $160,104 (2,800 hours x $57.18). We discuss the revised information collection burden for all HOPDs selected for chart-abstracted measure validation in section XXIV.A.4. of this final rule with comment period where we discuss modifying the validation selection pool from 500 HOPDs to 400 HOPDs.

Additionally, we are replacing the previously finalized 2-year validation cycle with a 3-year validation cycle beginning with CY 2027 data affecting the CY 2030 payment

determination, under which validation results for a single year of data will be applied to the applicable payment determination 3 years later. Under this policy, HOPDs selected for chart-abstracted measure validation based on CY 2027 data, affecting the CY 2029 payment determination, will not be selected again for validation of the same data affecting the CY 2030 payment determination. We will also determine eCQM validation scores using the methodology currently used to score chart-abstracted measure validation; revise our policy to allow the results of educational reviews for all four quarters of chart-abstracted measure validation to be reflected in the final validation score prior to the calculation of the confidence interval; and extend the educational review process established for chart-abstracted measure validation to eCQM validation. These changes to the HOPD validation cycles, scoring methodology, validation scoring, and the educational review process do not affect information collection burden as neither the amount of data nor frequency of data submission is impacted.

We did not receive public comments on this information collection burden estimate.

4. Information Collection Burden Estimate for the Modification of the Validation Selection Pool from 500 to up to 400 HOPDs Beginning with Validation of CY 2027 Data Affecting the CY 2030 Payment Determination

As discussed in section XV.D.2.a. of this final rule with comment period, we are reducing the number of hospitals selected at random for validation from 450 HOPDs to up to 200 HOPDs and increasing the number of hospitals selected by targeting criteria from 50 HOPDs to up to 200 HOPDs, for a total of up to 400 HOPDs selected each year beginning with validation of CY 2027 data affecting the CY 2030 payment determination. As discussed in section XXIV.A.3. of this final rule with comment period, HOPDs will be required to submit medical record documentation for 28 cases. As discussed in section XXIV.A.3. of this final rule with comment period, for the CY 2030 payment determination, we estimate these two policies will result in a revised total burden of 5,600 hours (0.25 hours x 4 quarters x 14 cases x 400 HOPDs) at a cost of $320,208 (5,600 hours x $57.18); a decrease of -400 hours and $22,872 from our

currently approved burden of 6,000 hours and $343,080. For the CY 2031 payment determination and subsequent years, we estimate these two policies will result in a revised total burden of 2,800 hours (0.25 hours x 4 quarters x 7 cases x 400 HOPDs) at a cost of $160,104 (2,800 hours x $57.18); a decrease of -3,200 hours and $182,976 from our currently approved burden estimate.

We did not receive public comments on this information collection burden estimate.

5. Information Collection Burden Estimate for the Removal of the Requirement for Hospitals to Resubmit Medical Documentation as Part of a Validation Reconsideration Request, Beginning with Data from the CY 2026 Reporting Period Affecting the CY 2028 Payment Determination

As discussed in section XV.E. of this final rule with comment period, we are removing the requirement for HOPDs to resubmit medical documentation as part of their request for reconsideration of validation noncompliance, beginning with data from the CY 2026 reporting period affecting the CY 2028 payment determination. Instead, we will re-use the medical documentation previously submitted by the HOPD during the validation process. The removal of this requirement will not affect burden related to validation requirements, as reconsideration is an optional administrative activity, and HOPDs will still be required to submit the same number of requested medical records to validate the accuracy of eCQM data (the extent to which data abstracted from the submitted medical record matches the data submitted in the QRDA I file). Additionally, as currently approved under OMB control number 0938-1109, consistent with regulations under the Paperwork Reduction Act of 1995, 5 CFR 1320.4, the burden associated with filing a Reconsideration Request is excluded from our calculation of information collection burden because this collection occurs during the conduct of an administrative action.

We did not receive public comments on this information collection burden estimate.

6. Summary of Information Collection Burden Estimates for the Hospital OQR Program

Tables 106 through 108 summarize the information collection burden changes under OMB control number 0938-1109. We estimate that the finalized measure removal and

modifications to the validation process in this final rule with comment period will result in a net decrease in information collection burden of 17,439 hours at a savings of $997,143 annually for all 3,000 program-eligible HOPDs beginning with the CY 2029 reporting period/CY 2031 payment determination. We will submit the revised information collection estimates to OMB for approval under OMB control number 0938-1109. With respect to any costs/burdens unrelated to data submission, we refer readers to the regulatory impact analysis in section XXVII. of this final rule with comment period.

TABLE 106: SUMMARY OF FINALIZED HOSPITAL OUTPATIENT QUALITY REPORTING PROGRAM INFORMATION COLLECTION BURDEN CHANGE FOR THE CY 2027 REPORTING PERIOD/CY 2029 PAYMENT DETERMINATION

	Annual Recordkeeping and Reporting Requirements Under OMB Control Number 0938-1109 for the CY 2027 Reporting Period							
Activity	**Estimated time per record (minutes)**	**Number of reporting quarters per year**	**Number of HOPDs reporting**	**Average number records per HOPDs per quarter**	**Annual burden (hours) per HOPD**	**Finalized annual burden (hours) across HOPDs**	**Previously finalized annual burden (hours) across HOPDs**	**Net difference in annual burden hours**
Remove Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients Measure (Chart Abstraction)	2.92	1	3,000	96	4.7	0	14,112	-14,112
Remove Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients Measure (Measure Reporting)	10	1	3,000	1	0.167	0	500	-500
	Total Change in Information Collection Burden Hours: -14,612							
	Total Cost Estimate: Updated Hourly Wage ($57.18) x Change in Burden Hours (-14,612) = **-$835,514**							

TABLE 107: SUMMARY OF FINALIZED HOSPITAL OUTPATIENT QUALITY REPORTING PROGRAM INFORMATION COLLECTION BURDEN CHANGE FOR THE CY 2028 REPORTING PERIOD/CY 2030 PAYMENT DETERMINATION

	Annual Recordkeeping and Reporting Requirements Under OMB Control Number 0938-1109 for the CY 2028 Reporting Period							
Activity	**Estimated time per record (minutes)**	**Number of reporting quarters per year**	**Number of HOPDs reporting**	**Average number records per HOPDs per quarter**	**Annual burden (hours) per HOPD**	**Finalized annual burden (hours) across HOPDs**	**Previously finalized annual burden (hours) across HOPDs**	**Net difference in annual burden hours**
Remove Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients Measure (Chart Abstraction)	2.92	1	3,000	96	4.7	0	14,112	-14,112
Remove Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients Measure (Measure Reporting)	10	1	3,000	1	0.167	0	500	-500
Implement Updates to Chart-Abstracted Measure Validation	15	4	400	14	14	5,600	6,000	-400
Implement eCQM Validation	1	4	400	7	0.467	187	0	187
	Total Change in Information Collection Burden Hours: -14,825							
	Total Cost Estimate: Updated Hourly Wage ($57.18) x Change in Burden Hours (-14,825) = **-$847,712**							

TABLE 108: SUMMARY OF FINALIZED HOSPITAL OUTPATIENT QUALITY REPORTING PROGRAM INFORMATION COLLECTION BURDEN CHANGE FOR THE CY 2029 REPORTING PERIOD/CY 2031 PAYMENT DETERMINATION

	Annual Recordkeeping and Reporting Requirements Under OMB Control Number 0938-1109 for the CY 2029 Reporting Period							
Activity	**Estimated time per record (minutes)**	**Number of reporting quarters per year**	**Number of HOPDs reporting**	**Average number records per HOPDs per quarter**	**Annual burden (hours) per HOPD**	**Finalized annual burden (hours) across HOPDs**	**Previously finalized annual burden (hours) across HOPDs**	**Net difference in annual burden hours**
Remove Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients Measure (Chart Abstraction)	2.92	1	3,000	96	4.7	0	14,112	-14,112
Remove Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients Measure (Measure Reporting)	10	1	3,000	1	0.167	0	500	-500
Implement Updates to Chart-Abstracted Measure Validation	15	4	400	7	7	2,800	6,000	-3,200
Implement eCQM Validation	1	4	400	14	0.933	373	0	373
	Total Change in Information Collection Burden Hours: -17,439							
	Total Cost Estimate: Updated Hourly Wage ($57.18) x Change in Burden Hours (-17,439) = **-$997,143**							

B. ICRs for the Rural Emergency Hospital (REH) Quality Reporting Program

1. Background

In section XVI. of this final rule with comment period, we summarize the previously approved requirements for the REH Quality Reporting Program. We are not finalizing any

changes to the previously finalized REH Quality Reporting Program policies in this final rule with comment period. The REH Quality Reporting Program is generally aligned with the CMS quality reporting program for HOPDs, known as the Hospital Outpatient Quality Reporting Program. We refer readers to the CY 2026 OPPS/ASC final rule with comment period (90 FR 54037 through 54041) for detailed discussions of the previously finalized REH Quality Reporting Program ICRs, which have been approved under OMB control number 0938-1454 (expiration date July 31, 2029).

In the CY 2026 OPPS/ASC final rule with comment period, we calculated reporting burden estimates for the REH Quality Reporting Program by utilizing the BLS median hourly wage rate for Medical Records Specialists (90 FR 54037). Specifically, we used the industry-specific wage for Medical Records Specialists working in the "general medical and surgical hospitals" industry, as this categorization aligns the closest with the REH Quality Reporting Program care setting. The most recent data from BLS' May 2025 National Occupational Employment and Wage Estimates reflects a median hourly wage of $28.59 per hour for Medical Records Specialists working in "general medical and surgical hospitals" (SOC 29-2072).[230] We calculated the cost of overhead, including fringe benefits, at 100 percent of the median hourly wage, consistent with previous years. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly by employer and methods of estimating these costs vary widely in the literature. Nonetheless, doubling the hourly wage rate ($28.59 × 2 = $57.18) to estimate total cost is a reasonably accurate estimation method. Accordingly, unless otherwise specified, we will calculate cost burden to REHs using a wage plus benefits estimate of $57.18 per hour throughout the discussion in this section of this rule for the REH Quality Reporting Program.

[230] U.S. Bureau of Labor Statistics. (2026). Occupational Outlook Handbook, Medical Records Specialists. Available at *https://data.bls.gov/oes/#/industry/622100/2025.* Accessed May 18, 2026.

In the CY 2026 OPPS/ASC final rule with comment period, our burden estimates were based on the 38 acute care and critical access hospital conversions to REH status as of April 11, 2025 (90 FR 54037). For this final rule with comment period, based on the actual number of acute care and critical access hospital conversions to REH status as of April 6, 2026, we estimate that 48 REHs will report data to the REH Quality Reporting Program during the CY 2027 reporting period unless otherwise noted. While the exact number of REHs required to submit data may vary due to status changes to and from an REH, as reiterated in section XVI. of this final rule with comment period, REHs are required by statute to submit quality data. Therefore, we assume that all 48 REHs will submit data under the REH Quality Reporting Program for the CY 2027 reporting period and subsequent years. We will submit the revised information collection estimates to OMB for approval under OMB control number 0938-1454.

2. Revised Information Collection Burden Estimates for Currently Approved Measures

Our currently approved information collection burden estimates of 464 hours at a cost of $26,532 (using revised wage rates) are based on an estimate of 38 REHs reporting data for the REH Quality Reporting Program. This burden is entirely associated with the reporting of chart-abstracted measures as REHs have the option to report either the Median Time for Discharged Emergency Department (ED) Patients measure or the Emergency Care Access & Timeliness eCQM to meet program requirements, and the estimated burden for the Median Time for Discharged ED Patients is greater than the estimated burden for the Emergency Care Access & Timeliness eCQM. As discussed in section XXIV.B.1. of this final rule with comment period, we are updating our assumption of the number of REHs that will submit data under the REH Quality Reporting Program from 38 REHs to 48 REHs, an increase of 10 REHs. Our currently approved burden estimates assume that for chart-abstracted measures where patient-level data are submitted directly to CMS, REHs require 2.9 minutes, or 0.049 hours per case per measure to collect and submit the data for each submitted case. We further assume that each REH will abstract and submit data from 63 cases per quarter, for a total of 252 cases per year. Therefore,

we estimate each REH requires 12.2 hours (0.049 hours x 252 cases) at a cost of approximately $698 (12.2 hours x $57.18) to collect and report data for the Median Time for Discharged ED Patients measure. For the increase of 10 REHs, we estimate an increase in annual chart-abstraction burden of 122 hours (12.2 hours x 10 REHs) at a cost of $6,976 (122 hours x $57.18).

C. ICRs for the Ambulatory Surgical Center (ASC) Quality Reporting Program

1. Background

In sections XIV. and XVII. of this final rule with comment period, we discussed the finalized requirements for the ASC Quality Reporting Program. We refer readers to the CY 2026 OPPS/ASC final rule with comment period (90 FR 54041 through 54045) for detail regarding the previously finalized ASC Quality Reporting Program ICRs which are currently approved under OMB control number 0938-1270 (expiration date July 31, 2029). We are removing the Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients measure beginning with the CY 2027 reporting period/CY 2029 payment determination.

In the CY 2026 OPPS/ASC final rule with comment period, we calculated reporting burden estimates for the ASC Quality Reporting Program by utilizing the BLS median hourly wage rate for Medical Records Specialists (90 FR 54042). Specifically, we used the industry-specific wage for Medical Records Specialists working in the "general medical and surgical hospitals" industry, as this categorization aligns the closest with the ASC Quality Reporting Program care setting. The most recent data from BLS' May 2025 National Occupational Employment and Wage Estimates reflects a median hourly wage of $28.59 per hour for Medical Records Specialists working in "general medical and surgical hospitals" (SOC 29-2072).[231] We calculated the cost of overhead, including fringe benefits, at 100 percent of the median hourly wage, consistent with previous years. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly by employer and methods of estimating

[231] U.S. Bureau of Labor Statistics. (2026). Occupational Outlook Handbook, Medical Records Specialists. Available at *https://data.bls.gov/oes/#/industry/622100/2025.* Accessed May 18, 2026.

these costs vary widely in the literature. Nonetheless, doubling the hourly wage rate ($28.59 × 2 = $57.18) to estimate total cost is a reasonably accurate estimation method. Accordingly, unless otherwise specified, we will calculate cost burden to ASCs using a wage plus benefits estimate of $57.18 per hour throughout the discussion in this section of this rule for the ASC Quality Reporting Program.

Based on the most recent analysis of the CY 2026 payment determination data, we found that of the 6,930 ASCs that were actively billing Medicare, 4,399 were required to participate in the ASC Quality Reporting Program. Of the 2,531 ASCs not required to participate in the program, 650 ASCs did so and met full requirements. On this basis, we estimate that 5,149 ASCs (4,399 + 650) will submit data for the ASC Quality Reporting Program for the CY 2027 reporting period/CY 2029 payment determination and future years.

2. Information Collection Burden Estimate for the Removal of the Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients Measure Beginning with the CY 2027 Reporting Period/CY 2029 Payment Determination

As discussed in section XIV.B. of this final rule with comment period, we are removing the Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients measure beginning with the CY 2027 reporting period/CY 2029 payment determination. For this measure, ASCs are required to both abstract data from patient charts as well as report the measure electronically via the HQR system. Regarding the number of cases required for chart-abstraction, based on the current ASC Quality Reporting Program Specifications Manual, we estimate that each participating ASC will abstract and submit data for the minimum yearly sample size of 63 annually.[232] Under OMB control number 0938-1270, the currently approved burden is 2.92 minutes (0.049 hours) per case for chart-abstraction and 10 minutes (0.167 hours) per ASC to report the measure via the HQR. Therefore, we estimate that this measure removal

[232] *https://qualitynet.cms.gov/files/692dbe71ec892eacec22890b?filename=ASC_v15.0a_FullSpecMan.pdf.*

will result in a decrease in burden for all 5,149 ASCs of 16,753 hours [(0.049 hours x 63 cases x 5,149 ASCs) + (0.167 hours x 5,149 ASCs)] at a savings of $957,937 (16,753 hours x $57.18).

We did not receive public comments on this information collection burden estimate.

3. Summary of Information Collection Burden Estimates for the ASC Quality Reporting Program

Table 109 summarizes the information collection burden changes for OMB control number 0938-1270. We estimated the finalized measure removal in this final rule with comment period will result in a decrease in information collection burden of 16,753 hours at a savings of $957,937 annually for all 5,149 program-eligible ASCs beginning with the CY 2027 reporting period/CY 2029 payment determination. We will submit the revised information collection estimates to OMB for approval under OMB control number 0938-1270. With respect to any costs/burdens unrelated to data submission, we refer readers to the regulatory impact analysis in section XXVII. of this final rule with comment period.

We received a public comment on the information collection burden for the ASC Quality Reporting Program. The following is a summary of the comment we received and our response.

Comment: A commenter expressed support for the continued use of the ASC Quality Reporting Program as an important mechanism for quality improvement due to its belief that quality reporting promotes accountability, supports performance measurement, and encourages facilities to continually evaluate patient outcomes and care processes. However, the commenter stated that participation in these programs requires significant administrative resources for data collection, reporting, compliance monitoring, staff education, and performance improvement activities, all while maintaining daily patient care and surgical operations. The commenter therefore encouraged CMS to continue supporting meaningful quality reporting while ensuring that reporting requirements remain practical and achievable for ASCs of varying sizes and resources; provide timely performance feedback; and provide reasonable opportunities to correct reporting deficiencies before payment penalties are imposed to strengthen compliance efforts and

continued beneficiary access to high-quality outpatient care.

Response: We thank the commenter for their support and acknowledge challenges related to the varied size and resource availability across ASCs. We seek to support ASCs in meeting program requirements and will consider their concerns and recommendations in future rulemaking.

TABLE 109: SUMMARY OF ASCQR PROGRAM INFORMATION COLLECTION BURDEN CHANGE FOR THE CY 2027 REPORTING PERIOD/CY 2029 PAYMENT DETERMINATION

	Annual Recordkeeping and Reporting Requirements Under OMB Control Number 0938-1270 for the CY 2027 Reporting Period							
Activity	**Estimated time per record (minutes)**	**Number of reporting quarters per year**	**Number of ASCs reporting**	**Average number records per ASC per quarter**	**Annual burden (hours) per ASC**	**Finalized annual burden (hours) across ASCs**	**Previously finalized annual burden (hours) across ASCs**	**Net difference in annual burden hours**
Remove Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients Measure (Chart Abstraction)	2.92	1	5,149	63	3.1	0	15,895	-15,895
Remove Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients Measure (Reporting)	10	1	5,149	1	0.167	0	858	-858
	Total Change in Information Collection Burden Hours: -16,753							
	Total Cost Estimate: Updated Hourly Wage ($57.18) x Change in Burden Hours (-16,753) = **-$957,937**							

D. ICRs for the Implementation of Section 6225 of the Consolidated Appropriations Act, 2026 for the Requirements for Provider-Based Status (§ 413.65)

The requirements for a determination that a facility or an organization has provider-based status are in the regulations at § 413.65. Section 6225 of the CAA, 2026 added paragraph (23) to section 1833(t) of the Act, and prohibits Medicare payments for items and services furnished on

or after January 1, 2028, unless off-campus outpatient departments of a provider meet certain conditions. New section 1833(t)(23)(A) of the Act requires, as a condition of receiving payment, that off-campus outpatient departments of a provider obtain and bill under separate NPIs and that main providers submit provider-based attestations in accordance with provisions at § 413.65. New section 1833(t)(23)(B)(i) of the Act requires the Secretary, through notice and comment rulemaking, to establish a process for each provider with an off-campus outpatient department to submit an initial and subsequent attestation, for the review of each such attestation and for the determination, through site visits, remote audits, or other means (as determined appropriate by the Secretary), whether each off-campus outpatient department is compliant with the requirements described in subparagraph (A). In addition, new section 1833(t)(23)(C) of the Act defines an "off-campus outpatient department of a provider" for purposes of paragraph (23) as a department of a provider (as defined in § 413.65) that is not located on the campus (also defined in § 413.65) of the main provider or is not within the distance described in such definition of campus from a remote location of a hospital (also defined in § 413.65).

As discussed in greater detail section XX. of this final rule with comment period, we finalized with certain modifications proposed changes to the provider-based regulations at § 413.65 to implement the new requirements of section 6225 of the CAA, 2026. Among those changes, we are revising § 413.65(b) to add a reference to the new mandatory attestation requirement for an off-campus outpatient department of a provider required by section 6225 of the CAA, 2026 and a maximum 5-year timeframe for any subsequent attestation(s), as proposed. In addition, as we proposed, we are establishing a standardized attestation form for provider-based determinations, in connection with the provisions of section 6225 of the CAA, 2026, that providers will submit through a centralized electronic system. The standardized form will replace the current MAC-specific templates. We are also finalizing our proposal to eliminate the mandatory requirement for off-campus provider-based facilities or organizations to supply supporting documentation at the time of attestation. Under our final policy, until the

standardized form and centralized electronic system are finalized, providers may continue to submit attestations using the current process in satisfaction of section 6225 of the CAA, 2026.

The collection of information requirements for the existing regulations at § 413.65 that govern the requirements for a determination that a facility or an organization has provider-based status is associated with OMB control number 0938-0798 (expiration date December 31, 2027). For the existing attestation requirement in § 413.65(b)(3), OMB has currently approved 2,500 hours of burden at a cost of approximately $327,150 based on accounting for information collection burden experienced by approximately 250 main providers. This estimated burden is based on the expectation that it would take a main provider 10 hours per attestation and each main provider would submit 1 attestation. Later in this section, we describe the burden changes regarding collection of information, under OMB control number 0938–0798.

The burden associated with this new attestation requirement continues to be the time for the main provider to report the facility's status to CMS and furnish the necessary documentation to support a provider-based determination. We believe this is reasonable as the information submitted by the provider is typically information that the provider already has regarding their business. However, as discussed in greater detail in section XX.3. of this final rule with comment period, under the finalized policy to establish a standardized attestation form for provider-based determinations that providers will submit through a centralized electronic system, we expect there will be a reduction in administrative burden for providers, and a more efficient review process for MACs and CMS. We anticipate that this reduction in administrative burden for providers will decrease the time required to submit each attestation by 25 to 75 percent.

As discussed in section XX.C. of this final rule with comment period, under existing regulations the attestation process was required only if the main provider sought a CMS determination of provider-based status. However, under the provisions of section 6225 of the CAA, 2026, Medicare payments will be prohibited unless off-campus outpatient departments of a provider meet certain conditions, including that the main provider has submitted an initial

provider-based status attestation that the off-campus outpatient department is compliant with the requirements described in section § 413.65 (or a successor regulation); and the main provider has submitted a subsequent attestation within the timeframe specified by the Secretary. As a result of this new mandatory attestation requirement, as discussed in the proposed rule, we expect there to be an increase in both the number of main providers submitting attestations and the number of attestations submitted by each main provider. In the proposed rule (91 FR 42007), we stated that under these new provider-based status attestation requirements, it is estimated that 1,832 main providers would take 5 hours per attestation, and, on average, each main provider would submit 9 attestations for provider-based departments. Therefore, we calculated the burden as follows: 16,488 responses times 5 hours per response = 82,440 burden hours. We stated that we believe that an executive officer will be making the attestation because an executive officer is in the best position to have access to the business information required to make the attestation. Based on the most recent Bureau of Labor and Statistics Occupational and Employment Data (May 2024) at *http://www.bls.gov/oes/current/oes_nat.htm#* for Category 11-0000 for the position of Top Executives, the mean hourly wage for a top executive is $67.24. We added 100 percent for fringe and overhead benefits, which calculates to $134.48 per hour. We estimated the total cost is $11,086,531 (82,440 hours x $134.48 per hour). The estimated number of attestations increased due to section 6225 of the CAA, 2026 requiring providers submit attestations for all off-campus provider-based departments. As such, the estimated number of attestations increased from 250 to 16,488 and the estimated total cost increased from $327,150 to $11,086,531. (See 91 FR 42007.)

We received public comments on these estimates included in the proposed rule. The following is a summary of the comments we received and our responses.

Comment: Some commenters stated that CMS' estimate understates the actual burden and fails to account for certain costs associated with the new requirements. Some commenters indicated that attestation process costs include coordinating and maintaining documentation for

distance and location, clinical and financial integration, ownership and control, and public awareness, which would require substantial staff time across multiple organizational components. Commenters requested that CMS revise its estimate to include administrative, operational, and systems costs as well as the costs of obtaining separate NPIs. These commenters stated that the documentation required for attestations may be spread out across multiple organizational components. Some commenters suggested that the size or location of the main provider may affect the number of hours required for each attestation. Some commenters provided alternate estimates for the number of hours required for the attestation process, some of which separated the burden associated with submitting the initial attestation (which some estimated to be shorter than CMS' estimate) and gathering and submitting additional information that may be requested after the initial submission (which some estimated to be longer than CMS' estimate). A commenter stated that while CMS' estimate is based on an attestation completed by a top executive, in practice an executive signs a package that takes a team more than five hours to prepare.

Response: We appreciate the additional information provided by commenters related to the time and costs associated with the attestation requirement. We believe that the best way to calculate the burden is to use an estimate of the number of hours associated with a typical provider's typical attestation. Although we recognize that the time taken to complete individual attestations may be shorter or longer than our estimate, and unique circumstances may contribute to this variation, it would not be feasible to include every possible situation into our estimate.

However, in response to the commenters' feedback that the burden estimate should account for additional factors and costs, including the need for multiple departments to be involved in the attestation process, and that the estimated time per attestation is not adequate, we are revising our estimate of the burden in this final rule with comment period. Specifically, we are revising the estimate of the total amount of time for submitting an attestation from 5 hours to 8 hours (representing a 25 percent reduction of the currently-approved estimate of 10 hours to

account for the streamlined process). Therefore, under this revised estimate, we calculated the burden as follows: 16,488 responses times 8 hours per response = 131,904 burden hours. Rather than estimating that the 8 hours will be done solely by a chief executive, we are estimating the following staffing mix for each attestation: Compliance Officers account for 3.5 hours, Lawyers for 1 hour, Medical and Health Service Managers for 2 hours, Secretaries and Administrative Assistants for 1 hour, and Top Executives for 0.5 hours. Based on the most recent Bureau of Labor and Statistics Occupational and Employment Data (May 2025) at *http://www.bls.gov/oes/current/oes_nat.htm#* (although the proposed rule used the May 2024 data, we are using the most recent data available for this final rule) we estimate the cost as follows:

For Category 13-1041 for the position of Compliance Officers, we estimate that each attestation would require 3.5 hours. Therefore, the total hour burden for Compliance Officers is 57,708 (16,488 responses x 3.5 hours per response). The mean hourly wage for a compliance officer is $42.50. We add 100 percent for fringe and overhead benefits, which calculates to $85.00 per hour. We estimate the total cost is $4,905,180.00 (57,708 hours x $85.00 per hour).

For Category 23-1101 for the position of Lawyers, we estimate that each attestation would require 1 hour. Therefore, the total hour burden for Lawyers is 16,488 (16,488 responses x 1 hour per response). The mean hourly wage for a lawyer is $89.35. We add 100 percent for fringe and overhead benefits, which calculates to $179.70 per hour. We estimate the total cost is $2,946,405.60 (16,488 hours x $179.70 per hour).

For Category 11-9111 for the position of Medical and Health Service Managers, we estimate that each attestation would require 2 hours. Therefore, the total hour burden for Medical and Health Service Managers is 32,976 (16,488 responses x 2 hours per response). The mean hourly wage for a medical and health service manager is $67.77. We add 100 percent for fringe and overhead benefits, which calculates to $135.54 per hour. We estimate the total cost is $4,469,567.04 (32,976 hours x $135.54 per hour).

For the Category 43-6010 for the position of Secretaries and Administrative Assistants, we estimate that each attestation would require 1 hour. Therefore, the total hour burden for Secretaries and Administrative Assistants is 16,488 (16,488 responses x 1 hour per response). The mean hourly wage for secretaries and administrative assistants is $25.63. We add 100 percent for fringe and overhead benefits, which calculates to $51.26 per hour. We estimate the total cost is $845,174.88 (16,488 hours x $51.26 per hour).

For Category 11-0000 for the position of Top Executives, we estimate that each attestation would require 0.5 hours. Therefore, the total hour burden for Top Executives is 8,224 (16,488 responses x 0.5 hours per response). The mean hourly wage for a top executive is $68.33. We add 100 percent for fringe and overhead benefits, which calculates to $136.66 per hour. We estimate the total cost is $1,126,625.04 (8,224 hours x $136.66 per hour).

Therefore, under our revised estimate, the total cost of the burden is $14,292,952.56 ($4,905,180 for Compliance Officers + $2,946,405.60 for Lawyers + $4,469,567.04 for Medical and Health Service Managers + $845,174.88 for Secretaries and Administrative Assistants + $1,126,625.04 for Top Executives).

We plan to submit an update to the currently approved PRA package (OMB number 0938-0798) for the attestation requirements once the revised estimates have been finalized.

With respect to the comments about the burden associated with the separate NPI requirement, we note that the PRA package for NPIs is currently approved under OMB control number 0938-0931.

E. ICRs for Expansion of Botulinum Toxin Injection Codes for Hospital Outpatient Department (OPD) Prior Authorization Process

In the CY 2020 OPPS/ASC final rule with comment period, we established a prior authorization process for certain hospital OPD services using our authority under section 1833(t)(2)(F) of the Act, which requires the Secretary to develop a method for controlling unnecessary increases in the volume of covered OPD services (84 FR 61142, 61446

through 61456).[233] As part of the CY 2021 OPPS/ASC final rule with comment period, we added additional service categories to the prior authorization process (85 FR 85866, 86236 through 86248). Through the CY 2023 OPPS/ASC final rule with comment period, we added an eighth service category to the list of OPD services requiring prior authorization (87 FR 71748, 72224 through 72233.) The regulations governing the prior authorization process are located in subpart I of 42 CFR part 419, specifically at §§ 419.80 through 419.89.

In accordance with § 419.83(b), we proposed to expand the Botulinum Toxin Injection service category to include additional codes requiring prior authorization. To improve readability and brevity, as we indicated earlier in the preamble, effective dates were removed and the section numbering in the regulatory text was updated. The former paragraphs (a)(1)(i) through (v), (a)(2)(i) and (ii), and (a)(3) have been renumbered as (a)(1) through (8). The additional Botulinum Toxin Injection codes would be added to existing codes located at proposed revised § 419.83 (a)(2) and would require prior authorization beginning for service dates on or after July 1, 2027.

The ICR associated with prior authorization requests for these covered outpatient department services is the required documentation submitted by providers. The prior authorization request must include all relevant documentation necessary to show that the service meets applicable Medicare coverage, coding, and payment rules. The request must be submitted before the service is provided to the beneficiary and before the claim is submitted for processing.

The burden associated with the prior authorization process for the additional Botulinum Toxin Injection codes will be the time and effort necessary for the submitter to locate and obtain the relevant supporting documentation to show that the service meets applicable coverage, coding, and payment rules, and to forward the information to CMS or its contractor (Medicare Administrative Contractor) for review and determination of a provisional affirmation. We expect that this information will generally be maintained by providers within the normal course of

[233] See also Correction Notice issued January 3, 2020 (85 FR 224).

business and that this information will be readily available. We estimate that the average time for office clerical activities associated with this task would be 30 minutes, which is equivalent to that for normal prepayment or postpayment medical review. We anticipate that most prior authorization requests will be sent by means other than mail. However, we estimate a cost of $5 per request for mailing medical records. Based on CY 2024 data for the new services, we estimate that annually, there would be 17,699 initial requests mailed during a year. In addition, we estimate there would be 5,808 resubmissions of a request mailed following a non-affirmed decision. Therefore, the total annual mailing cost is estimated at $117,537 (23,507 mailed requests x $5). We also estimate that an additional 3 hours per provider would be required to attend educational meetings, train staff on what services require prior authorization, and review training documents.

The average labor costs (including 100 percent fringe benefits) used to estimate the costs were calculated using data available from the Bureau of Labor Statistics (BLS). Based on the BLS 2024 rate for Healthcare Support Workers, All Other[234], we estimate an average median clerical hourly rate of $22.14 with a loaded rate of $44.28. The prior authorization program for the new services will not create any new documentation requirements. Instead, it will only require the same documents needed to support claim payments to be submitted earlier in the claim process. The estimate uses the clerical rate since we do not believe that clinical staff will need to spend more time completing the documentation that will be needed in the absence of the prior authorization policy. The hourly rate reflects the time required for the additional clerical work of submitting the prior authorization request. We believe providers will need to educate their staff on what services are included in the prior authorization process. Following this education, the staff will know which services need prior authorization and will not need additional time or resources to determine whether a service requires prior authorization. We estimate that the total annual number of submissions would be 78,358 (54,851 submissions via

[234] *https://www.bls.gov/oes/current/oes_nat.htm.*

fax or electronic means + 23,507 mailed submissions). The annual burden hours for the new services, allotted across all providers, would be 41,555 hours (0.5 hours x 78,358 submissions plus 3 hours x 792 providers for education). The annual burden cost would be $1,957,592 (41,555 hours x $44.28 plus $117,537 for mailing costs). The ICR approved under OMB control number 0938-1368 will be revised and submitted to OMB for approval.

Table 110 is a chart reflecting the total burden and associated costs for the provisions included in this final rule with comment period.

TABLE 110: TOTAL BURDEN FOR NEW SERVICES

Information Collection Requests	Burden Hours Increase/Decrease (+/-)*	Cost (+/-)*
Addition of Additional Services for Hospital OPD Prior Authorization Process	+41,555	+$1.96 M

* Numbers rounded.

XXV. Files Available to the Public via the Internet

The Addenda to the OPPS/ASC proposed rules and final rules with comment period are published and available via the Internet on the CMS website. In the CY 2019 OPPS/ASC final rule with comment period (83 FR 59154), for CY 2019, we changed the format of the OPPS Addenda A, B, and C by adding a column titled "Copayment Capped at the Inpatient Deductible of $1,364.00" where we flag, through use of an asterisk, those items and services with a copayment that is equal to or greater than the inpatient hospital deductible amount for any given year (the copayment amount for a procedure performed in a year cannot exceed the amount of the inpatient hospital deductible established under section 1813(b) of the Act for that year). In the CY 2021 OPPS/ASC final rule with comment period (85 FR 86266), we updated the format of the OPPS Addenda A, B, and C by adding a column titled "Drug Pass-Through Expiration during Calendar Year" where we flag, through the use of an asterisk, each drug for which pass-through payment is expiring during the calendar year on a date other than December 31. In the CY 2026 final rule with comment period (90 FR 54058), we retained these columns that are updated to reflect the drug codes for which pass-through payment is expiring in the applicable

year.

In the CY 2023 OPPS/ASC final rule with comment period (87 FR 72250) for CY 2023, we changed the format of the OPPS Addenda A, B, and C by adding a column titled "Drug Pass-Through Expiration during Calendar Year" to include devices, so that the column reads: "Drug and Device Pass-Through Expiration during Calendar Year" where we flagged, through the use of an asterisk, each drug and device for which pass-through payment was expiring during the calendar year on a date other than December 31.

In the CY 2024 OPPS/ASC final rule with comment period (88 FR 82131), we deleted the column titled "Copayment Capped at the Inpatient Deductible" and instead added a new column for "Adjusted Beneficiary Copayment" to identify any copayment adjustment due to either the inpatient deductible amount copayment cap or the inflation-adjusted copayment of a Part B rebatable drug per sections 1833(t)(8)(F) and 1833(i)(9) of the Act, as added by section 11101 of the Inflation Reduction Act (IRA). We also added another column for notes. The "Note" column contains multiple messages including, but not limited to, inflation-adjusted copayment of a Part B rebatable drug, the copayment for a code capped at the inpatient deductible, or 8 percent of the reference product add-on applied for a biosimilar.

In addition, for CY 2024, we updated the format of the OPPS Addenda A, B, and C by adding another column for "IRA Coinsurance Percentage" to identify the percentage for the inflation-adjusted copayment of a Part B rebatable drug per sections 1833(t)(8)(F) and 1833(i)(9) of the Act, as added by section 11101 of the IRA.

In the CY 2026 OPPS/ASC proposed rule, we proposed that for CY 2026 and subsequent years to keep the same format for the addenda A, B, and C, and we did not propose any additional changes for CY 2026 (90 FR 33837). In the CY 2026 OPPS/ASC final rule with comment period, we finalized our policy as proposed (90 FR 54058).

For CY 2027, we did not propose any changes relating to the format for the addenda A, B, and C and therefore, we are finalizing the addenda, A, B, and C format as proposed.

To view the Addenda to this final rule with comment period pertaining to CY 2027 payment rates under the OPPS, we refer readers to the CMS website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices* select "CMS-1850-FC" from the list of regulations. All OPPS Addenda to this final rule with comment period are contained in the zipped folder titled "2027 NFRM OPPS Addenda" in the related links section at the bottom of the page. To view the Addenda to this final rule with comment period pertaining to CY 2027 payment rates under the ASC payment system, we refer readers to the CMS website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-regulations-and-notices*; select "CMS-1850-FC" from the list of regulations. The ASC Addenda to this final rule with comment period are contained in a zipped folder titled "2027 NFRM Addendum AA, BB, DD1, DD2, EE, and FF" in the related links section at the bottom of the page.

XXVI. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the "DATES" section of this preamble; and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

XXVII. Economic Analyses

A. Statement of Need

This final rule with comment period is necessary to make updates to the Medicare hospital OPPS rates. It is also necessary to make changes to the payment policies and rates for outpatient services furnished by hospitals and CMHCs in CY 2027. We are required under section 1833(t)(3)(C)(ii) of the Act to update annually the OPPS conversion factor used to determine the payment rates for APCs. We also are required under section 1833(t)(9)(A) of the Act to review, not less often than annually, and revise the groups, the relative payment weights, and the wage and other adjustments described in section 1833(t)(2) of the Act. We must review the clinical integrity of payment groups and relative payment weights at least annually. We are revising the APC relative payment weights using claims data for services furnished on and after January 1, 2025 through and including December 31, 2025, and processed through June 30, 2026, and updated HCRIS cost report information.

This final rule with comment period is also necessary to make updates to the ASC payment rates for CY 2027, enabling CMS to make changes to payment policies and payment rates for covered surgical procedures and covered ancillary services that are performed in ASCs in CY 2027. Because ASC payment rates are based on the OPPS relative payment weights for most of the procedures performed in ASCs, the ASC payment rates are updated annually to reflect annual changes to the OPPS relative payment weights. In addition, we are required under section 1833(i)(1) of the Act to review and update the list of surgical procedures that can be performed in an ASC, not less frequently than every 2 years.

In the CY 2019 OPPS/ASC final rule with comment period (83 FR 59075 through 59079), we finalized a policy to update the ASC payment system rates using the hospital market basket update instead of the CPI-U for CY 2019 through 2023. In the CY 2024 OPPS/ASC final rule with comment period, we finalized a policy to extend the 5-year interim period by an additional 2 years, through CY 2024 and CY 2025, to enable us to more accurately analyze

whether the application of the hospital market basket update to the ASC payment system resulted in a migration of services from the hospital setting to the ASC setting (88 FR 81960). In the CY 2026 OPPS/ASC final rule with comment period, we finalized a policy to extend our utilization of the hospital market basket update as the update factor for the ASC payment system for one additional year, through CY 2026 (90 FR 54058). As discussed in section XIII. of this final rule with comment period, we are finalizing our proposal to extend our utilization of the hospital market basket update as the update factor for the ASC payment system for one additional year (through CY 2027). The ASC impacts discussed below reflect our application of the hospital market basket update for CY 2027.

In addition, this final rule with comment period is necessary to make policy changes for facilities reporting data under the Hospital Outpatient Quality Reporting and ASC Quality Reporting Programs. The primary objective of these quality reporting programs is to promote higher quality, more efficient health care for Medicare beneficiaries by collecting and reporting on quality-of-care metrics. This information is made available to consumers, both to empower Medicare beneficiaries and inform decision making, as well as to incentivize healthcare facilities to make continued improvements.

B. Overall Impact of Provisions of this Final Rule with Comment Period

We have examined the impacts of this rule as required by Executive Order 12866, "Regulatory Planning and Review"; Executive Order 13132, "Federalism"; Executive Order 13563, "Improving Regulation and Regulatory Review"; Executive Order 14192, "Unleashing Prosperity Through Deregulation"; the Regulatory Flexibility Act (RFA) (Pub. L. 96-354); section 1102(b) of the Social Security Act; and section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4); and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select those regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety, and other advantages; distributive impacts; and equity). Section 3(f) of Executive Order 12866 defines a "significant regulatory action" as any regulatory action that is

likely to result in a rule that may: (1) have an annual effect on the economy of $100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities; (2) create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raise novel legal or policy issues arising out of legal mandates, or the President's priorities.

A regulatory impact analysis (RIA) must be prepared for a regulatory action that is significant under section 3(f)(1) of E.O. 12866. Based on our estimates, the Office of Management and Budget's (OMB) Office of Information and Regulatory Affairs (OIRA) has determined this rulemaking is significant per section 3(f)(1). Accordingly, we have prepared a Regulatory Impact Analysis that to the best of our ability presents the costs and benefits of the rulemaking.

We estimate that the total increase in Federal Government expenditures under the OPPS for CY 2027, compared to CY 2026, due to the changes to the OPPS in this final rule with comment period, will be approximately $1.78 billion. Taking into account our estimated changes in enrollment, utilization, and case-mix for CY 2027, we estimate that the OPPS expenditures, including beneficiary cost-sharing, for CY 2027 will be approximately $114.4 billion, which is approximately $10.7 billion higher than estimated OPPS expenditures in CY 2026. We also estimate that the final 2.0 percentage point adjustment for the 340B Remedy Offset is expected to reduce overall OPPS payments by $1.6 billion in CY 2027. Table 112 of this final rule with comment period displays the distributional impact of the CY 2027 changes in OPPS payment to various groups of hospitals and for CMHCs.

We note that under our final CY 2027 policy, drugs and biologicals are generally paid at ASP plus 6 percent, WAC plus 6 percent, or 95 percent of AWP, as applicable. However, under

the final 340B drug payment policy for CY 2027, we would pay for drugs acquired through the 340B Drug program at ASP minus 28.0 percent.

We estimate that the final update to the conversion factor will increase total OPPS payments by 2.3 percent in CY 2027. The final changes to the APC relative payment weights, the final changes to the wage indexes, the continuation of a payment adjustment for rural SCHs, including EACHs, the final cost-of-living adjustment for hospitals in Alaska and Hawaii, the final 340B-Drug payment adjustment, and the final payment adjustment for cancer hospitals would not increase total OPPS payments because these changes to the OPPS are budget neutral. However, these updates would change the distribution of payments within the budget neutral system. We estimate that the total change in payments between CY 2026 and CY 2027, considering all budget-neutral payment adjustments, final changes in estimated total outlier payments, the application of the frontier State wage adjustment, the final payment adjustment for imaging without contrast services furnished at excepted off campus PBDs, in addition to the application of the OPD fee schedule increase factor after all adjustments required by sections 1833(t)(3)(F), 1833(t)(3)(G), and 1833(t)(17) of the Act will increase total estimated OPPS payments by 1.7 percent. We note that, as previously discussed in section V.B.7 of this final rule with comment period, we finalized to reduce payments for non-drug items and services for hospitals for whom the annual reduction to payment amounts under § 419.32(b)(1)(iv)(B)(12) applies by 2.0 percentage points in CY 2027. We estimate that this reduction would reduce OPPS spending by approximately $1.6 billion in CY 2027.

We estimate the total increase (from changes to the ASC provisions in this final rule with comment period, as well as from enrollment, utilization, and case-mix changes) in Medicare expenditures (not including beneficiary cost-sharing) under the ASC payment system for CY 2027 compared to CY 2026, to be approximately $560 million. Tables 112 and 113 of this final rule with comment period display the redistributive impact of the CY 2027 changes

regarding ASC payments, grouped by specialty area and then grouped by procedures with the greatest ASC expenditures, respectively.

C. Detailed Economic Analyses

1. Estimated Effects of OPPS Changes in this Final Rule with Comment Period

a. Limitations of Our Analysis

The distributional impacts presented here are the projected effects of the final CY 2027 policy changes on various hospital groups. We post our hospital-specific estimated payments for CY 2027 on the CMS website with the other supporting documentation for this final rule with comment period. To view the hospital-specific estimates, we refer readers to the CMS website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient.* On the website, select "Regulations and Notices" from the left side of the page and then select "CMS-1850-FC" from the list of regulations and notices. The hospital-specific file layout and the hospital-specific file are listed with the other supporting documentation for this final rule with comment period. We show hospital-specific data only for hospitals whose claims were used for modeling the impacts shown in Table 112 of this final rule with comment period. We do not show hospital-specific impacts for hospitals whose claims we were unable to use. We refer readers to section II.A. of this final rule with comment period for a discussion of the hospitals whose claims we do not use for ratesetting or impact purposes.

We estimate the effects of the individual policy changes by estimating payments per service, while holding all other payment policies constant. We use the best data available but do not attempt to predict behavioral responses to our policy changes in order to isolate the effects associated with specific policies or updates, but any policy that changes payment could have a behavioral response. In addition, we have not made any adjustments for future changes in variables, such as service volume, service-mix, or number of encounters.

b. Estimated Effects of the Proposal to Control Unnecessary Increases in the Volume of Outpatient Services Furnished in Excepted Off-Campus Provider Based Departments (PBDs)

In section X.A. of this final rule with comment period, we discuss our CY 2027 policy to control for unnecessary increases in the volume of outpatient services by paying for imaging without contrast services furnished at an off-campus PBD at an amount equal to the site-specific PFS payment rate for nonexcepted items and services furnished by a nonexcepted off-campus PBD (the PFS payment rate). Specifically, we will pay for HCPCS codes billed with modifier ''PO'' and assigned to and paid through imaging without contrast APCs 5521 through 5524 and composite imaging without contrast APCs 8004, 8005, and 8007 at an amount equal to the site-specific PFS payment rate for nonexcepted items and services furnished by a nonexcepted off-campus PBD (the PFS payment rate).

To develop an estimated impact of this policy, we began with CY 2025 outpatient claims data used, for claim lines with HCPCS codes assigned for payment through imaging without contrast APCs 5521 through 5524 and composite imaging without contrast APCs 8004, 8005, and 8007 that contained modifier ''PO'' because the presence of this modifier indicates that such claims were billed for services furnished by an off-campus department of a hospital paid under the OPPS. We then simulated payment for the remaining claim lines as if they were paid at the PFS-equivalent rate, removing a portion of the payment associated with rural sole community hospitals based on our finalized exception for those hospitals. An estimate of the final policy that includes the effects of estimated changes in enrollment, utilization, and case-mix based on the FY 2027 Mid-Session review budget approximates the estimated decrease in total payments at $260 million, with Medicare OPPS payments decreasing by $190 million and beneficiary copayments decreasing by $70 million in CY 2027.

This estimate is utilized for the accounting statement displayed in Table 111 of this final rule with comment period because the impact of this final CY 2027 policy, which is not budget neutral, is combined with the impact of the OPD update, which is also not budget neutral, to estimate changes in Medicare spending under the OPPS as a result of the changes in this final rule with comment period.

We note our estimates may differ from the actual effect of the final policy due to offsetting factors, such as changes in provider behavior. We note that by removing this payment differential that may influence site-of-service decision-making, we anticipate an associated decrease in the volume of imaging without contrast services provided in the excepted off-campus PBD setting.

TABLE 111: ESTIMATED EFFECT OF CHANGES TO IMAGING WITHOUT CONTRAST SERVICES WHEN FURNISHED AT EXCEPTED OFF-CAMPUS PROVIDERS (IN $ MILLIONS)

CY	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2027 – 2036
Part B Trust Fund benefits	(260)	(680)	(750)	(820)	(900)	(980)	(1,070)	(1,180)	(1,290)	(1,400)	(9,330)
Premium offset	70	170	190	210	230	250	260	290	320	350	2,340
Net Part B Trust Fund impact	(190)	(510)	(560)	(610)	(670)	(730)	(810)	(890)	(970)	(1,050)	(6,990)
Beneficiary cost-sharing	(70)	(170)	(190)	(210)	(230)	(250)	(270)	(300)	(330)	(360)	(2,380)

c. Estimated Effects of OPPS Changes to Part B Drug Payment on 340B Eligible Hospitals Paid Under the OPPS

In section V.B.7. of this final rule with comment period, we discuss our finalized policies to reduce the payment for nonpass-through, separately payable drugs purchased by certain 340B-participating hospitals through the 340B Program. Rural SCHs, children's hospitals, and PPS-exempt cancer hospitals are excepted from this payment policy in CY 2027. Specifically, in this final rule with comment period, for CY 2027, for hospitals paid under the OPPS (other than those that are excepted for CY 2027), we are paying for separately payable drugs and biologicals that are obtained with a 340B discount, excluding those on pass-through payment status and vaccines, at ASP minus 28 percent instead of ASP+6 percent. For context, based on CY 2025 claims data, the total OPPS Part B drug payment is approximately $27.7 billion.

We note that in the CY 2025 claims available for OPPS ratesetting purposes that the modifier "TB" continued to be active, and identifies drugs and biologicals acquired through the 340B Drug Pricing program. Therefore, we used separately payable drug lines with prospective

status indicator “K,” which would be subject to the 340B Payment policy, that also were billed with status indicator “TB” to identify lines that would be included for purposes of determining the budget neutrality adjustment. Under our final CY 2027 policy, rural SCHs, children’s hospitals, and PPS-exempt cancer hospitals would be excepted from this payment policy and so they were similarly excepted from these calculations for budget neutrality and impact analysis purposes.

Using that claims data, we estimate that OPPS payments for separately payable drugs, including beneficiary copayments, will decrease by approximately $4.65 billion under this finalized policy, which reflects a $200 million decrease in the estimated reduction relative to the proposed rule estimate of $4.85 billion. This change is largely attributable to the changes made in the final CY 2027 340B Payment Policy and additional claims data available in the final rule. Because we are implementing this payment reduction in a budget neutral manner within the OPPS, the reduced payments for separately payable drugs purchased through the 340B Program will increase payment rates for other non-drug items and services paid under the OPPS by an offsetting aggregate amount.

In this final rule, we project that reducing payment for 340B drugs to ASP minus 28.0 percent will increase OPPS payment rates for non-drug items and services by approximately 7.5 percent in CY 2027. The estimated impacts of this policy are displayed in Table 112. We note that the payment rates included in Addendum A and Addendum B of this final rule with comment period do not reflect the reduced payments for drugs purchased under the 340B Program; however, they do include the increase to payments rates for non-drug items and services due to the corresponding increase in the conversion factor.

In summary, to maintain budget neutrality within the OPPS, the estimated $4.65 billion in reduced drug payments from adoption of this final 340B payment methodology will be redistributed in an equal offsetting amount to all hospitals paid under the OPPS through

increasing the payment rates by 7.5 percent for nondrug items and services furnished by all hospitals paid under the OPPS for CY 2027.

d. Estimated Effects of OPPS Changes on Hospitals

Table 112 shows the estimated impact of the final rule on hospitals. Historically, the first line of the impact table, which estimates the change in payments to all facilities, has always included cancer and children's hospitals, which are held harmless to their pre-Balanced Budget Act (BBA) amount. We also include CMHCs in the first line that includes all providers. We include a second line for all hospitals, excluding permanently held harmless hospitals and CMHCs.

We present separate impacts for CMHCs in Table 112, and we discuss them separately below, because CMHCs are paid only for partial hospitalization and intensive outpatient program services under the OPPS and are a different provider type from hospitals. In the CY 2025 OPPS/ASC final rule with comment period (89 FR 94269 through 94270), we finalized paying CMHCs for partial hospitalization services and intensive outpatient services under APCs 5851 through 5854. For CY 2027, we are maintaining the same APC structure and are continuing our CY 2026 methodology for calculating rates by applying the 40 percent Medicare Physician Fee Schedule (MPFS) Relativity Adjuster to calculate PHP and IOP payment rates for CMHCs.

The estimated increase in the total payments made under the OPPS is determined largely by the increase to the conversion factor under the statutory methodology. The distributional impacts presented do not include assumptions about changes in volume and service-mix. The conversion factor is updated annually by the OPD fee schedule increase factor, as discussed in detail in section II.B. of this final rule with comment period.

Section 1833(t)(3)(C)(iv) of the Act provides that the OPD fee schedule increase factor is equal to the market basket percentage increase applicable under section 1886(b)(3)(B)(iii) of the Act, which we refer to as the IPPS market basket percentage increase. The final IPPS market basket percentage increase applicable to the OPD fee schedule for CY 2027 is 3.2 percent.

Section 1833(t)(3)(F)(i) of the Act reduces that 3.2 percent by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act, which is a final 0.9 percentage point for CY 2027 (which is also the productivity adjustment for FY 2027 in the FY 2027 IPPS/LTCH PPS final rule (91 FR 50459) resulting in the final CY 2027 OPD fee schedule increase factor of 2.3 percent. We are using the OPD fee schedule increase factor of 2.3 percent in the calculation of the final CY 2027 OPPS conversion factor. Section 10324 of the Affordable Care Act, as amended by HCERA, further authorized additional expenditures outside budget neutrality for hospitals in certain frontier States that have a wage index less than 1.0000. The amounts attributable to this frontier State wage index adjustment are incorporated in the estimates in Table 112 of this final rule with comment period.

To illustrate the impact of the CY 2027 changes, our analysis begins with a baseline simulation model that uses the CY 2026 relative payment weights, the CY 2026 final OPPS wage indexes that include reclassifications, and the final CY 2026 conversion factor. Table 112 shows the estimated redistribution of the increase or decrease in payments for CY 2027 over CY 2026 payments to hospitals and CMHCs as a result of the following factors: the impact of the APC reconfiguration and recalibration changes between CY 2026 and CY 2027 (Column 2); the wage indexes and the provider adjustments (Column 3); the effect of the final payment adjustment for drugs acquired through the 340B Program (Column 4); the combined impact of all of the changes described in the preceding columns plus the 2.3 percent OPD fee schedule increase factor update to the conversion factor (Column 5); the additional estimated impact for the final payment adjustment for imaging without contrast services furnished at excepted off campus PBDs (Column 6); the estimated impact taking into account all payments for CY 2027 relative to all payments for CY 2026, including the impact of changes in estimated outlier payments and changes to the pass-through payment estimate (Column 7).

We did not model an explicit budget neutrality adjustment for the rural adjustment for SCHs because we are maintaining the current adjustment percentage for CY 2027. Because the

final updates to the conversion factor (including the update of the OPD fee schedule increase factor), the estimated cost of the rural adjustment, and the estimated cost of projected pass-through payment for CY 2027 are applied uniformly across services, observed redistributions of payments in the impact table for hospitals largely depend on the mix of services furnished by a hospital (for example, how the APCs for the hospital's most frequently furnished services would change, or what proportion of OPPS payments to the hospital are for services compared to drugs), and the impact of the wage index changes on the hospital. However, total payments made under this system and the extent to which this final rule with comment period redistribute money during implementation will also depend on changes in volume, practice patterns, and the mix of services billed between CY 2026 and CY 2027 by various groups of hospitals, which CMS cannot forecast.

Overall, we estimate that the proposed rates for CY 2027 would increase Medicare OPPS payments by an estimated 1.7 percent. Removing payments to cancer and children's hospitals because their payments are held harmless to the pre-OPPS ratio between payment and cost and removing payments to CMHCs results in an estimated 1.7 percent increase in Medicare payments to all other hospitals. These estimated payments would not significantly impact other providers. We note that providers not considered "new providers" for purposes of the 340B remedy offset would receive an adjustment to their OPPS payment rates of minus 2.0 percent, which we estimate reduces overall provider payment by 2.0 percent.

Column 1: Total Number of Hospitals

The first line in Column 1 in Table 112 shows the total number of facilities (3,620), including designated cancer and children's hospitals and CMHCs, for which we were able to use CY 2025 hospital outpatient and CMHC claims data to model CY 2026 and CY 2027 payments, by classes of hospitals, for CMHCs and for dedicated cancer hospitals. We excluded all hospitals and CMHCs for which we could not plausibly estimate CY 2026 or CY 2027 payment and entities that are not paid under the OPPS. The latter entities include CAHs, IHS and tribal

hospitals, and hospitals located in Guam, the U.S. Virgin Islands, Northern Mariana Islands, American Samoa, and the State of Maryland. This process is discussed in greater detail in section II.A. of this final rule with comment period. At this time, we are unable to calculate a DSH variable for hospitals that are not also paid under the IPPS because DSH payments are only made to hospitals paid under the IPPS. Hospitals for which we do not have a DSH variable are grouped separately and generally include freestanding psychiatric hospitals, rehabilitation hospitals, and long-term care hospitals. We show the total number of OPPS hospitals (3,502), excluding the hold harmless cancer and children's hospitals and CMHCs, on the second line of the table. We excluded cancer and children's hospitals because section 1833(t)(7)(D) of the Act permanently holds harmless cancer hospitals and children's hospitals to their "pre-BBA amount" as specified under the terms of the statute, and therefore, we removed them from our impact analyses. We show the isolated impact on the 42 CMHCs at the bottom of the impact table (Table 112) and discuss that impact separately below.

Column 2: APC Recalibration – All Changes

Column 2 shows the estimated effect of APC recalibration. Column 2 also reflects any changes in multiple procedure discount patterns or conditional packaging that occur as a result of the changes in the relative magnitude of payment weights. As a result of APC recalibration, we estimate that urban hospitals would experience an increase of 0.1, with the impact ranging from a decrease of 0.3 to an increase of 0.7, depending on the number of beds. Rural hospitals would experience a decrease of 0.3 percent overall. Major teaching hospitals would experience a decrease of 0.3 percent.

Column 3: Wage Indexes and the Effect of the Provider Adjustments

Column 3 demonstrates the combined budget neutral impact of the APC recalibration, the updates for the wage indexes with the FY 2027 IPPS post-reclassification wage indexes, the rural adjustment, the frontier adjustment, and the cancer hospital payment adjustment. We modeled the independent effect of the budget neutrality adjustments and the OPD fee schedule increase

factor by using the relative payment weights and wage indexes for each year and using a CY 2026 conversion factor that included the OPD fee schedule increase and a budget neutrality adjustment for differences in wage indexes.

We modeled the independent effect of updating the wage indexes by varying only the wage indexes, holding APC relative payment weights, service-mix, and the rural adjustment constant and using the CY 2027 scaled weights and a CY 2026 conversion factor that included a budget neutrality adjustment for the effect of the changes to the wage indexes between CY 2026 and CY 2027.

Column 3 reflects the independent effects of the updated wage indexes, including the application of budget neutrality for the rural floor policy on a nationwide basis, as well as the final CY 2027 changes in wage index policy, discussed in section II.C. of this final rule with comment period. We did not model a budget neutrality adjustment for the rural adjustment for SCHs because we are continuing the rural payment adjustment of 7.1 percent to rural SCHs for CY 2027, as described in section II.E. of this final rule with comment period. We modeled a budget neutrality adjustment for the final cancer hospital payment adjustment because the final payment-to-cost ratio target for the cancer hospital payment adjustment in CY 2027 is 0.88, which is higher than the PCR target adopted in the CY 2026 OPPS/ASC final rule with comment period (90 FR 53501). We note that, in accordance with section 16002 of the 21st Century Cures Act, we apply a budget neutrality factor calculated as if the cancer hospital adjustment target payment-to-cost ratio was 0.89, not the 0.88 target payment-to-cost ratio we discuss in section II.F. of this final rule with comment period.

Column 3 also includes the effects of the final COLA factors for hospitals located in Hawaii and Alaska, which would apply to the non-labor portion of OPPS payments. This policy is discussed in detail in section X.C of this final rule with comment period.

Column 4: Effect of the Final Payment Adjustment for 340B Drugs

Column 4 demonstrates the total payment effect of the final payment adjustment for drugs acquired under the 340B Program from ASP plus 6 percent to ASP minus 28.0 percent. This column includes both the reduced payment for 340B acquired drugs and the increase to the conversion factor for budget neutrality purposes, which increases payment for all non-drug OPPS services. For rural sole community hospitals, this column shows a 5.3 percent increase, reflecting no payment adjustment for drugs (because these providers are exempt from these reductions) and a 7.5 percent increase for non-drug services.

We also note that the proposed 340B drug payment policy described in this column can significantly affect an OPPS provider's estimated CY 2027 payment depending on the proportion of a provider's payment represented by drugs purchased through the 340B Drug Program. For providers that are excepted from the 340B drug payment proposal and for non-340B hospitals, we would generally expect an increase in these providers' estimated 2027 OPPS payments under this column, as they would receive an increase to their non-drug service payments through the budget neutral adjustment to the OPPS conversion factor due to this policy but no change to their drug payments. However, for 340B hospitals, estimated payment changes due to this policy would depend on the volume of 340B drugs the provider furnishes and how that compares to the volume of non-drug services provided by the provider. For most 340B providers, the decreased 340B drug payments will outweigh the increased payments for non-drug services.

Column 5: All Budget Neutrality Changes Combined with the Market Basket Update

Column 5 demonstrates the combined impact of all the final changes previously described and the final update to the conversion factor of 2.3 percent. Overall, these changes would increase payments to urban hospitals by 2.0 percent and to rural hospitals by 5.6 percent. Rural sole community hospitals would receive an estimated increase of 7.9 percent while other rural hospitals would receive an estimated increase of 1.9 percent.

Column 6: Final Off-Campus PBD Imaging Without Contrast Payment Policy

Column 6 displays the estimated effect of our final CY 2027 policy to pay for imaging without contrast services assigned to APCs 5521 through 5524 and composite imaging without contrast APCs 8004, 8005, and 8007 when billed with modifier ‘‘PO’’ at a PFS-equivalent rate. We note that the numbers provided in this column isolate the estimated effect of this final policy adjustment relative to the numerator of Column 5. Therefore, the numbers reported in Column 6 show how much of the difference between the estimates in Column 5 and the estimates in Column 7 are a result of the off-campus PBD imaging without contrast policy.

Column 7: All Changes with Outlier – Final CY 2027 Update

Column 7 depicts the full impact of the final CY 2027 policies on each hospital group by including the effect of all changes for CY 2027 and comparing them to all estimated payments in CY 2026. Column 7 shows the combined budget neutral effects of Columns 2 and 3 and 4; the effect of the off-campus provider-based department drug administration policy; the OPD fee schedule increase; the impact of estimated OPPS outlier payments, as discussed in section II.G. of this final rule with comment period; the Hospital OQR Program payment reduction for the small number of hospitals in our impact model that failed to meet the reporting requirements (discussed in section XV. of this final rule with comment period); and other rule adjustments to the CY 2027 OPPS payments.

Of those hospitals that failed to meet the Hospital OQR Program reporting requirements for the full CY 2026 update (and assumed, for modeling purposes, to be the same number for CY 2027), we included 66 hospitals in our model because they had both CY 2025 claims data and recent cost report data. We estimate that the cumulative effect of all changes for CY 2027 would increase payments to all facilities by 1.7 percent for CY 2027. We modeled the independent effect of all changes in Column 7 using the final relative payment weights for CY 2026 and the final relative payment weights for CY 2027. We used the final conversion factor for CY 2026 of $91.415 and a CY 2027 conversion factor of $99.970 discussed in section II.B. of this final rule with comment period.

Column 7 contains simulated outlier payments for each year. We used the 1-year charge inflation factor used in the FY 2027 IPPS/LTCH PPS final rule (91 FR 50383) of 7.3 percent (1.07268) to increase charges on the CY 2025 claims, and we used the overall CCR in the July 2026 Outpatient Provider-Specific File (OPSF) to estimate outlier payments for CY 2026. Using the CY 2025 claims and a 7.3 percent charge inflation factor, we currently estimate that outlier payments for CY 2026, using a multiple threshold of 1.75 and a fixed-dollar threshold of $6,225, would be approximately 1.21 percent of total payments. The estimated current outlier payments of 1.21 percent are incorporated in the comparison in Column 7. We used the same set of claims and a charge inflation factor of 15.1 percent (1.15064) and the CCRs in the July 2026 OPSF, with an adjustment of 0.971037 (91 FR 50383), to reflect relative changes in cost and charge inflation between CY 2026 and CY 2027, to model the proposed CY 2027 outliers at 1.0 percent of estimated total payments using a multiple threshold of 1.75 and a fixed dollar threshold of $7,150. The charge inflation and CCR inflation factors are discussed in detail in the FY 2027 IPPS/LTCH PPS final rule with comment period (91 FR 50380 through 50385).

Overall, we estimate that facilities would experience an increase of 1.7 percent under this final rule with comment period in CY 2027 relative to total spending in CY 2026. This projected increase (shown in Column 7) of Table 112 of this final rule with comment period reflects the final 2.3 percent OPD fee schedule increase factor, removing the 0.21 difference in estimated outlier payments between CY 2026 (1.21 percent) and CY 2027 (1.0 percent), including the 0.4 percent decrease due to the payment adjusted for imaging without contrast services at off campus PBDs, plus 0.07 percent for the change in the pass-through payment estimate between CY 2026 and CY 2027. We estimate that the combined effect of all changes for CY 2027 would increase payments to urban hospitals by 1.3 percent. Overall, we estimate that rural hospitals would experience a 5.3 percent increase as a result of the combined effects of all the changes for CY 2027.Among hospitals, by teaching status, we estimate that the impacts resulting from the combined effects of all changes include a decrease of 2.7 percent for major

teaching hospitals and an increase of 6.0 percent for nonteaching hospitals. Minor teaching hospitals would experience an estimated increase of 2.8 percent.

In our analysis, we also have categorized hospitals by type of ownership. Based on this analysis, we estimate that voluntary hospitals would experience an increase of 1.4 percent, proprietary hospitals would experience an increase of 10.1 percent, and governmental hospitals would experience a decrease of 1.7 percent.

Reduction for Providers Subject to the 340B Remedy Offset

In column 8 we have included additional information to account for estimated payment changes in the CY 2027 OPPS for providers subject to the 340B Remedy Offset which will be a 2.0 percentage point decrease in CY 2027.

TABLE 112: ESTIMATED IMPACT OF FINAL CY 2027 CHANGES FOR SERVICES PROVIDED IN THE HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
		Number of Hospitals	**APC Recalibration (all changes)**	**New Wage Index and Provider Adjustments**	**340B Adjustment**	**All Budget Neutral Changes (combined cols 2-4) with Market Basket Update**	**Payment Adjustment for Imaging w/o Contrast at Off Campus Providers**	**All CY 2027 Changes**	*Impact of Adjustment only for Providers Subject to 340B Remedy Offset*
ALL PROVIDERS *		3,620	0.0	0.1	0.0	2.4	-0.4	**1.7**	-2.0
ALL HOSPITALS		3,502	0.1	0.1	-0.1	2.3	-0.4	**1.7**	-2.0
	(excludes hospitals held harmless and CMHCs)								
URBAN HOSPITALS		2,837	0.1	0.0	-0.5	2.0	-0.4	**1.3**	-2.0
	LARGE URBAN (>1 M)	1,342	0.2	-0.2	-0.8	1.4	-0.4	**0.8**	-2.0
	OTHER URBAN (<=1 M)	1,495	0.1	0.3	-0.2	2.4	-0.4	**1.7**	-2.0
RURAL HOSPITALS		665	-0.3	0.3	3.3	5.6	-0.1	**5.3**	-2.0
	SOLE COMMUNITY	324	-0.3	0.6	5.3	7.9	0.0	**7.7**	-2.0
	OTHER RURAL	341	-0.3	-0.1	0.0	1.9	-0.3	**1.4**	-2.0
BEDS (URBAN)									
	0 - 99 BEDS	1004	0.7	-0.1	4.5	7.6	-0.2	**7.1**	-1.8
	100-199 BEDS	787	0.3	0.4	2.7	5.8	-0.3	**5.2**	-2.0
	200-299 BEDS	425	0.4	0.0	1.8	4.5	-0.5	**3.9**	-2.0
	300-499 BEDS	387	0.3	-0.1	0.5	3.0	-0.4	**2.3**	-2.0
	500 + BEDS	234	-0.3	0.0	-4.8	-2.9	-0.5	**-3.7**	-2.0
BEDS (RURAL)									
	0 - 49 BEDS	309	-0.1	0.7	4.3	7.3	0.0	**6.9**	-2.0

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
		Number of Hospitals	**APC Recalibration (all changes)**	**New Wage Index and Provider Adjustments**	**340B Adjustment**	**All Budget Neutral Changes (combined cols 2-4) with Market Basket Update**	**Payment Adjustment for Imaging w/o Contrast at Off Campus Providers**	**All CY 2027 Changes**	*Impact of Adjustment only for Providers Subject to 340B Remedy Offset*
	50- 100 BEDS	203	-0.2	0.3	3.8	6.3	0.0	**6.0**	-2.0
	101- 149 BEDS	87	-0.4	-0.3	1.6	3.2	-0.2	**3.0**	-2.0
	150- 199 BEDS	36	-0.4	0.6	3.5	6.2	-0.2	**5.3**	-2.0
	200 + BEDS	30	-0.5	0.1	2.6	4.6	-0.2	**4.4**	-2.0
REGION (URBAN)									
	NEW ENGLAND	122	-0.1	0.1	-0.8	1.5	-0.6	**0.7**	-2.0
	MIDDLE ATLANTIC	300	0.0	0.4	-1.1	1.6	-0.8	**0.7**	-2.0
	SOUTH ATLANTIC	474	0.2	0.4	-0.1	2.8	-0.4	**2.3**	-1.9
	EAST NORTH CENTRAL	426	0.0	0.3	-0.7	1.9	-0.6	**1.2**	-2.0
	EAST SOUTH CENTRAL	177	0.0	-1.0	-2.6	-1.4	-0.4	**-1.8**	-2.0
	WEST NORTH CENTRAL	182	0.0	0.0	-1.6	0.7	-0.2	**-0.6**	-2.0
	WEST SOUTH CENTRAL	478	0.7	-0.5	1.4	4.0	-0.4	**3.6**	-2.0
	MOUNTAIN	239	0.3	-0.1	1.0	3.5	-0.2	**2.6**	-1.9
	PACIFIC	387	0.2	-0.3	-0.6	1.6	-0.3	**1.1**	-2.0
	PUERTO RICO	52	0.9	-2.3	4.5	5.4	0.0	**5.4**	0.0
REGION (RURAL)									
	NEW ENGLAND	20	-0.6	0.8	3.8	6.3	0.0	**6.2**	-2.0
	MIDDLE ATLANTIC	45	-0.4	0.0	1.4	3.3	-0.2	**3.2**	-2.0
	SOUTH ATLANTIC	109	-0.3	0.8	2.8	5.6	-0.4	**5.3**	-2.0
	EAST NORTH CENTRAL	110	-0.2	0.3	3.1	5.6	-0.2	**5.4**	-2.0
	EAST SOUTH CENTRAL	124	-0.2	-1.1	1.0	1.9	-0.1	**2.0**	-2.0
	WEST NORTH CENTRAL	72	-0.4	-0.2	5.1	6.9	0.0	**6.1**	-2.0
	WEST SOUTH CENTRAL	121	0.3	-0.5	4.7	6.9	-0.2	**6.9**	-2.0
	MOUNTAIN	39	-0.4	1.3	5.2	8.5	0.0	**6.7**	-1.9
	PACIFIC	24	-0.6	2.8	2.9	7.6	0.0	**7.6**	-2.0
	PUERTO RICO	1	0.8	3.6	9.3	16.9	0.0	**9.8**	0.0
TEACHING STATUS									
	NON-TEACHING	2,081	0.4	0.2	3.5	6.5	-0.3	**6.0**	-1.9
	MINOR	955	0.3	0.1	0.8	3.5	-0.4	**2.8**	-2.0
	MAJOR	466	-0.3	0.0	-3.9	-2.0	-0.5	**-2.7**	-2.0

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
		Number of Hospitals	**APC Recalibration (all changes)**	**New Wage Index and Provider Adjustments**	**340B Adjustment**	**All Budget Neutral Changes (combined cols 2-4) with Market Basket Update**	**Payment Adjustment for Imaging w/o Contrast at Off Campus Providers**	**All CY 2027 Changes**	*Impact of Adjustment only for Providers Subject to 340B Remedy Offset*
DSH PATIENT PERCENT									
	0	11	1.4	-0.8	7.4	10.5	0.0	**10.5**	-0.7
	> 0 - 0.10	254	0.8	0.2	6.5	10.1	-0.4	**9.5**	-1.9
	>= 0.10 - 0.16	263	0.6	0.5	6.3	9.9	-0.5	**9.2**	-1.9
	>= 0.16 - 0.23	546	0.6	0.2	5.6	8.9	-0.5	**8.3**	-2.0
	>= 0.23 - 0.35	1,135	-0.1	0.2	-0.8	1.6	-0.4	**0.9**	-2.0
	>= 0.35	743	-0.3	-0.3	-5.2	-3.6	-0.3	**-4.2**	-2.0
	DSH NOT AVAILABLE **	550	4.5	-0.8	6.4	12.9	-0.3	**12.7**	-1.9
URBAN TEACHING/DSH									
	TEACHING & DSH	1,234	0.0	0.0	-1.8	0.5	-0.5	**-0.2**	-2.0
	NO TEACHING/DSH	1,067	0.5	0.1	3.4	6.4	-0.4	**5.8**	-1.9
	NO TEACHING/NO DSH	9	1.6	-0.2	7.3	11.3	0.0	**11.4**	-1.0
	DSH NOT AVAILABLE**	526	4.5	-0.7	6.4	13.0	-0.4	**12.7**	-1.9
TYPE OF OWNERSHIP									
	VOLUNTARY	1,989	0.0	0.1	-0.4	2.1	-0.4	**1.4**	-2.0
	PROPRIETARY	1,106	1.3	-0.2	6.8	10.5	-0.2	**10.1**	-1.9
	GOVERNMENT	407	-0.3	-0.2	-2.9	-1.1	-0.3	**-1.7**	-2.0
CMHCs		42	17.2	-0.4	7.4	28.3	0.0	**29.0**	-0.1

Column (1) shows total hospitals and/or CMHCs.

Column (2) includes all CY 2027 OPPS policies and compares those to the CY 2026 OPPS.

Column (3) shows the budget neutral impact of updating the wage index by applying the FY 2027 hospital inpatient wage index. The rural SCH adjustment continues our current policy of 7.1 percent so the budget neutrality factor is 1. The budget neutrality adjustment for the cancer hospital adjustment is 0.9996 because the CY 2027 target payment-to-cost ratio is higher than the CY 2026 PCR target.

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
		Number of Hospitals	**APC Recalibration (all changes)**	**New Wage Index and Provider Adjustments**	**340B Adjustment**	**All Budget Neutral Changes (combined cols 2-4) with Market Basket Update**	**Payment Adjustment for Imaging w/o Contrast at Off Campus Providers**	**All CY 2027 Changes**	*Impact of Adjustment only for Providers Subject to 340B Remedy Offset*
Column (4) shows the impact of the final 340B drug payment adjustment and the corresponding increase in non-drug payment.									
Column (5) shows the impact of all budget neutrality adjustments and the addition of the 2.3 percent OPD rate update factor (3.2 percent reduced by 0.9 percentage points for the productivity adjustment).									
Column (6) shows the separate impact of the payment adjustment for imaging without contrast APC services furnished at excepted off campus providers.									
Column (7) shows the combined impact of columns 5 and 6, plus additional adjustments to the conversion factor resulting from a change in the pass-through estimate and adding estimated outlier payments. Note that previous years included the frontier adjustment in this column, but we have included the frontier adjustment to Column 3 in this table.									
The column for providers subject to the 340B Remedy Offset shows the separate impact of applying the final 2.0 percentage point reduction to the OPPS conversion factor update as part of the 340B Remedy Offset.									
We estimate that 3,322 providers would be subject to the reduction to payments that result from the 340B remedy offset.									
*These 3,620 providers include children and cancer hospitals, which are held harmless to pre-BBA amounts, and CMHCs.									
** Complete DSH numbers are not available for providers that are not paid under IPPS, including rehabilitation, psychiatric, and long-term care hospitals.									

d. Estimated Effects of OPPS Changes on CMHCs

The last line of Table 112 demonstrates the isolated impact on CMHCs, which furnished only partial hospitalization and intensive outpatient program services under the OPPS during CY 2025. As discussed in section VIII.C. of this final rule with comment period, we proposed for CY 2027 to continue paying CMHCs using APCs 5851 through 5854. We modeled the impact of this APC policy, assuming CMHCs will continue to provide the same PHP and IOP care as seen in the CY 2025 claims used for ratesetting in this final rule with comment period. We did not exclude days with one or two services from our modeling for CY 2027, because our final policy would pay the per diem rate for APC 5853 for such days in CY 2027. As a result of the

final PHP APC changes for CMHCs, we estimate that CMHCs would experience a 17.2 percent increase in CY 2027 payments relative to their CY 2026 payments (shown in Column 2). For a detailed discussion of our final PHP and IOP policies, please see section VIII. of this final rule with comment period.

Column 3 shows the estimated impact of adopting the final FY 2027 wage index values, which result in an estimated decrease of 0.4 percent to CMHCs.

Column 5 shows that combining the OPD fee schedule increase factor, along with the final changes in APC policy for CY 2027 and the final FY 2027 wage index updates, and final 340B payment policy, would result in an estimated increase of 28.3 percent.

f. Estimated Effect of OPPS Changes on Beneficiaries

For services for which the beneficiary pays a copayment of 20 percent of the payment rate, the beneficiary's payment would increase for services for which the OPPS payments would rise and decrease for services for which the OPPS payments would fall. For further discussion of the calculation of the national unadjusted copayments and minimum unadjusted copayments, we refer readers to section II.H. of this final rule with comment period. In all cases, section 1833(t)(8)(C)(i) of the Act limits beneficiary liability for copayment for a procedure performed in a year to the hospital inpatient deductible for the applicable year.

We estimate that the aggregate beneficiary coinsurance percentage would be approximately 18 percent for all services paid under the OPPS in CY 2027. The estimated aggregate beneficiary coinsurance reflects general system adjustments. We note that the individual payments, and therefore copayments, associated with services may differ based on the setting in which they are furnished.

g. Estimated Effects of OPPS Changes on Other Providers

The relative payment weights and payment amounts established under the OPPS affect the payments made to ASCs, as discussed in section XIII. of this final rule with comment period. Hospitals, CMHCs, and ASCs will be affected by the changes in this final rule with comment

period. Additionally, the payment policies we established for IOP services affect RHCs and FQHCs. These providers of IOP are not paid under the OPPS and are not included in the impact analysis shown in Table 112. However, the final payment amount for OPPS APC 5861 will affect payments to RHCs and FQHCs since under sections 1834(o)(5)(A) and 1834(y)(3)(A) of the Act payment for IOP services in these settings is required to be equal to the payment determined for IOP services in the hospital outpatient department.

h. Estimated Effects of OPPS Changes on the Medicare and Medicaid Programs

The effect of the update on the Medicare program is expected to be an increase of $1.78 billion in program payments for OPPS services furnished in CY 2027. The effect on the Medicaid program is expected to be limited to copayments that Medicaid may make on behalf of Medicaid recipients who are also Medicare beneficiaries. We estimate that the changes in this final rule would increase these Medicaid beneficiary payments by approximately $40 million in CY 2027. Currently, there are approximately 11.8 million dual-eligible beneficiaries, which represent approximately 40 percent of Medicare Part B fee-for-service beneficiaries. The impact on Medicaid was determined by taking 12 percent of the beneficiary cost-sharing impact. The national average split of Medicaid payments is 58 percent Federal payments and 42 percent State payments. Therefore, for the estimated $40 million Medicaid increase, approximately $25 million would be from the Federal Government and $15 million would be from State governments.

i. Alternative OPPS Policies Considered

Alternatives to the OPPS changes we finalized and the reasons we finalized the selected policies are discussed throughout this final rule with comment period. We received public comments on our impact analysis. The following is a summary of the comments we received and our responses.

Comment: A commenter requested that we incorporate site-of-service substitution effects into the impact analysis.

Response: As noted earlier in this section, we do not attempt to predict behavioral responses to our policy changes to isolate the effects associated with specific policies or updates, but any policy that changes payment could have a behavioral response. In addition, we have not made any adjustments for future changes in variables, such as service volume, service-mix, or number of encounters.

Comment: A commenter requested that we develop a case-mix like variable for the OPPS impact files, similar to that included in the inpatient PPS impact files, that would help represent year-over-year changes to service weighting.

Response: We appreciate the commenter's recommendation and will take it into consideration in the future.

After consideration of the comments, we are finalizing our impact methodology as proposed.

2. Estimated Effects of CY 2027 ASC Payment System Changes

Most ASC payment rates are calculated by multiplying the ASC conversion factor by the ASC relative payment weight. As discussed fully in section XIII. of this final rule with comment period, we are setting the CY 2027 ASC relative payment weights by scaling the final CY 2027 OPPS relative payment weights by the final CY 2027 ASC scalar of 0.814. The estimated effects of the updated relative payment weights on payment rates are varied and are reflected in the estimated payments displayed in Tables 113 and 114.

Beginning in CY 2011, section 3401 of the Affordable Care Act requires that the annual update to the ASC payment system after application of any quality reporting reduction be reduced by a productivity adjustment. In CY 2019, we adopted a policy for the annual update to the ASC payment system to be the hospital market basket update for CY 2019 through CY 2023. In the CY 2024 OPPS/ASC final rule with comment period, we extended this 5-year interim period an additional 2 years through CYs 2024 and 2025. In the CY 2026 OPPS/ASC final rule with comment period, we extended the interim period an additional year through 2026. As

discussed in further detail in section XIII. of this final rule with comment period, we proposed and are finalizing an extension of our utilization of the hospital market basket update as the update factor to the ASC payment system for 1 additional year (through CY 2027). Section 1886(b)(3)(B)(xi)(II) of the Act defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economywide private nonfarm business multifactor productivity (as projected by the Secretary for the 10-year period, ending with the applicable fiscal year, year, cost reporting period, or other annual period). For ASCs that fail to meet their quality reporting requirements, the CY 2027 payment determinations would be based on the application of a 2.0 percentage point reduction to the hospital market basket update for CY 2027. We calculated the final CY 2027 ASC conversion factor by adjusting the CY 2026 ASC conversion factor ($56.322) by 1.0018 to account for changes in the pre-floor and pre-reclassified hospital wage indexes between CY 2026 and CY 2027, which includes our policy to limit wage index declines of greater than 5 percent, and by applying the CY 2027 hospital market basket update factor of 2.3 percent (which is equal to the final inpatient hospital market basket percentage increase of 3.2 percent reduced by a productivity adjustment of 0.9 percentage point). The final CY 2027 ASC conversion factor is $57.721 for ASCs that successfully meet the quality reporting requirements.

a. Limitations of Our Analysis

Presented here are the projected effects of the final changes for CY 2027 on Medicare payment to ASCs. A key limitation of our analysis is our inability to predict changes in ASC service-mix between CY 2026 and CY 2027 with precision. We believe the net effect on Medicare expenditures resulting from the final CY 2027 changes would be small in the aggregate for all ASCs. However, such changes may have differential effects across surgical specialty groups, as ASCs continue to adjust to the payment rates based on the policies of the revised ASC payment system. We are unable to accurately project such changes at a disaggregated level.

Individual ASCs will experience changes in payment that differ from the aggregated estimated impacts presented below.

b. Estimated Effects of ASC Payment System Policies on ASCs

Some ASCs are multispecialty facilities that perform a wide range of surgical procedures from excision of lesions to hernia repair to cataract extraction; others focus on a single specialty and perform only a limited range of surgical procedures, such as ophthalmology, digestive system, or orthopedic procedures. The combined effect of the final update to the payments on an individual ASC would depend on a number of factors, including, but not limited to, the mix of services the ASC provides, the volume of specific services provided by the ASC, the percentage of its patients who are Medicare beneficiaries, and the extent to which an ASC provides different services in the coming year. The following discussion includes tables that display estimates of the impact of the final CY 2027 updates to the ASC payment system on Medicare payments to ASCs, assuming the same mix of services, as reflected in our CY 2025 claims data. Table 113 depicts the estimated aggregate percent change in payment by surgical specialty by comparing estimated CY 2026 payments to estimated CY 2027 payments, and Table 114 shows a comparison of estimated CY 2026 payments to estimated CY 2027 payments for items and procedures that we estimate would receive the most Medicare payment in CY 2026.

In Table 113, we have aggregated the surgical HCPCS codes by specialty group and then estimated the effect on aggregated payment for surgical specialty. The groups are sorted for display in descending order by estimated Medicare program payment to ASCs. The following is an explanation of the information presented in Table 113.

- Column 1—Surgical Specialty Group indicates the surgical specialty into which ASC procedures are grouped. To group surgical procedures by surgical specialty, we used the CPT code range definitions and Level II HCPCS codes and Category III CPT codes, as appropriate, to account for all surgical procedures to which the Medicare program payments are attributed.

- Column 2—Estimated CY 2026 ASC Payments were calculated using CY 2025 ASC utilization data (the most recent full year of ASC utilization) and CY 2026 ASC payment rates. The surgical specialty groups are displayed in descending order based on estimated CY 2026 ASC payments.

- Column 3—Estimated CY 2027 Percent Change is the aggregate percentage increase or decrease in Medicare program payment to ASCs for each surgical specialty that is attributable to the final update to ASC payment rates for CY 2027 compared to CY 2026.

As shown in Table 113, for the six specialty groups that account for the most ASC utilization and spending, we estimate that the final update to ASC payment rates for CY 2027 would result in a 1 percent decrease in aggregate payment amounts for eye and ocular adnexa procedures, a 6 percent increase in aggregate payment amounts for musculoskeletal system procedures, a 6 percent increase in aggregate payment amounts for nervous system procedures, a 1 percent decrease in aggregate payment amounts for digestive system procedures, a 5 percent increase in aggregate payment amounts for cardiovascular system procedures, and a 1 percent increase in aggregate payment amounts for genitourinary system procedures. We note that these changes can be a result of different factors, including updated data, payment weight changes, and changes in policy. After the payment rate update is accounted for, aggregate payment increases or decreases for a category of services can be higher or lower than the final 2.3 percent increase, depending on if payment weights in the OPPS APCs after application of the ASC weight scaler that correspond to the applicable services increased or decreased, if the most recent data show an increase or a decrease in the volume of services performed in an ASC for a category. For example, we estimate a 1 percent decrease in eye surgical procedure payments and a 1 percent decrease in gastrointestinal surgical procedure payments. The decrease in expenditures for these surgical specialties is attributable to the 2.3 percent hospital market basket update being offset by the reduction in the ASC weight scaler. The reduction in the ASC weight scaler from 0.872 in CY 2026 to our final 0.814 for CY 2027 is attributable to the increase in device portions under

the ASC payment system as a result of the increase in OPPS payment rates for clinical services for CY 2027 and our policy to treat device portions of device-intensive procedures as constant between the OPPS and ASC payment system. The increase in final CY 2027 OPPS payment rates for clinical services is a result of the OPPS budget neutrality adjustment from the final 340B drug payment policy. Therefore, surgical specialties that predominantly consist of procedures designated as device-intensive under the ASC payment system will see an increase in expenditures greater than the 2.3 percent hospital market basket update whereas surgical procedures that are not device-intensive will see a relatively smaller increase or decrease in CY 2027 expenditures. The increases in expenditures for musculoskeletal, nervous system, and cardiovascular surgical specialties groups is a result of the higher share of device-intensive procedures that are assigned to these surgical specialty groups. For estimated changes for selected procedures, we refer readers to Table 113.

TABLE 113: ESTIMATED IMPACT OF THE FINAL CY 2027 UPDATE TO THE ASC PAYMENT SYSTEM ON AGGREGATE CY 2026 MEDICARE PROGRAM PAYMENTS BY SURGICAL SPECIALTY OR ANCILLARY ITEMS AND SERVICES GROUP

Surgical Specialty Group (1)	Estimated CY 2026 ASC Payments (in Millions) (2)	Estimated CY 2027 Percent Change (3)
Total	$8,349	2
Eye	$2,120	-1
Musculoskeletal	$2,019	6
Nervous System	$1,580	6
Gastrointestinal	$1,059	-1
Cardiovascular	$635	5
Genitourinary	$365	1

Table 114 shows the estimated impact of the updates to the revised ASC payment system on aggregate ASC payments for selected surgical procedures during CY 2027. The table displays 30 of the procedures receiving the greatest estimated CY 2026 aggregate Medicare payments to ASCs. The HCPCS codes are sorted in descending order by estimated CY 2026 program payment.

- Column 1–CPT/HCPCS code.
- Column 2–Short Descriptor of the HCPCS code.
- Column 3–Estimated CY 2026 ASC Payments were calculated using CY 2025 ASC utilization (the most recent full year of ASC utilization) and the CY 2026 ASC payment rates. The estimated CY 2026 payments are expressed in millions of dollars.
- Column 4–Estimated CY 2027 Percent Change reflects the percent differences between the estimated ASC payment for CY 2026 and the estimated payment for CY 2027 based on the final update.

TABLE 114: ESTIMATED IMPACT OF THE FINAL CY 2027 UPDATE TO THE ASC PAYMENT SYSTEM ON AGGREGATE PAYMENTS FOR SELECTED PROCEDURES

CPT/HCPCS Code (1)	Short Descriptor (2)	Estimated CY 2026 ASC Payment (in millions) (3)	Estimated CY 2027 Percent Change (4)
66984	Xcapsl ctrc rmvl w/o ecp	$1,383	-2
27447	Total knee arthroplasty	$529	4
63685	Ins/rplc spi npg/rcvr pocket	$421	13
27130	Total hip arthroplasty	$284	5
45385	Colonoscopy w/lesion removal	$273	-1
45380	Colonoscopy and biopsy	$253	-1
23472	Reconstruct shoulder joint	$215	7
43239	Egd biopsy single/multiple	$174	-1
63650	Implant neuroelectrodes	$161	5
64590	Ins/rpl prph sac/gstr npg/r	$131	8
66991	Xcapsl ctrc rmvl insj 1+	$125	9
64483	Njx aa&/strd tfrm epi l/s 1	$108	-3
66982	Xcapsl ctrc rmvl cplx wo ecp	$103	-2
64635	Destroy lumb/sac facet jnt	$103	-3
29827	Sho arthrs srg rt8tr cuf rpr	$97	35
36902	Intro cath dialysis circuit	$90	0
64628	Trml dstrj ios bvn 1st 2 l/s	$75	6
64493	Inj paravert f jnt l/s 1 lev	$74	-3
0627T	Perq njx algc fluor lmbr 1st	$73	7
66821	After cataract laser surgery	$67	-3
G0105	Colorectal scrn; hi risk ind	$64	-1
65820	Relieve inner eye pressure	$57	-1
64561	Implant neuroelectrodes	$56	7
64555	Implant neuroelectrodes	$54	8
15823	Revision of upper eyelid	$51	-5
G0121	Colon ca scrn not hi rsk ind	$47	-1
62323	Njx interlaminar lmbr/sac	$44	-2
64721	Carpal tunnel surgery	$42	-3
33285	Insj subsq car rhythm mntr	$41	3
27279	Arthrd si jt perq/min nvas	$40	7

c. Estimated Effects of ASC Payment System Policies on Beneficiaries

We estimate that the CY 2027 update to the ASC payment system will be generally positive (that is, result in lower cost-sharing) for beneficiaries with respect to the procedures we are finalizing to add to the ASC CPL for CY 2027. First, other than certain preventive services where coinsurance and the Part B deductible are waived to comply with sections 1833(a)(1) and (b) of the Act, the ASC coinsurance rate for all procedures is 20 percent. This contrasts with procedures performed in HOPDs under the OPPS, where the beneficiary is responsible for copayments that range from 20 percent to 40 percent of the procedure payment (other than for certain preventive services), although the majority of HOPD procedures have a 20-percent copayment. Second, in almost all cases, the ASC payment rates under the ASC payment system are lower than payment rates for the same procedures under the OPPS. Therefore, the beneficiary coinsurance amount under the ASC payment system will usually be less than the OPPS copayment amount for the same services. (The only exceptions will be if the ASC coinsurance amount exceeds the hospital inpatient deductible since the statute requires that OPPS copayment amounts not exceed the hospital inpatient deductible. Therefore, in limited circumstances, the ASC coinsurance amount may exceed the hospital inpatient deductible and, therefore, the OPPS copayment amount for similar services.) Beneficiary coinsurance for services migrating from physicians' offices to ASCs may decrease or increase under the ASC payment system, depending on the particular service and the relative payment amounts under the MPFS compared to the ASC. While the ASC payment system bases most of its payment rates on hospital cost data used to set OPPS relative payment weights, services that are performed a majority of the time in a physician office are generally paid the lesser of the ASC amount according to the standard ASC ratesetting methodology or at the nonfacility practice expense-based amount payable under the PFS. For those additional procedures that we finalized to designate as office-based in CY 2027, the beneficiary coinsurance amount under the ASC payment system generally will be no greater than the beneficiary coinsurance under the PFS

because the coinsurance under both payment systems generally is 20 percent (except for certain preventive services where the coinsurance is waived under both payment systems).

Accounting Statements and Tables for OPPS and ASC Payment System

As required by OMB Circular A-4 (available on the Office of Management and Budget website at *https://www.whitehouse.gov/wp-content/uploads/2025/08/CircularA-4.pdf*, we have prepared accounting statements to illustrate the impacts of the OPPS and ASC changes in this final rule with comment period. The first accounting statement, Table 115, illustrates the classification of expenditures for the CY 2027 estimated hospital OPPS incurred benefit impacts associated with the final CY 2027 OPD fee schedule increase and the final policy for imaging without contrast services furnished at excepted off-campus PBDs. The second accounting statement, Table 116, illustrates the classification of expenditures associated with the 2.3 percent CY 2027 update to the ASC payment system, based on the provisions of this final rule with comment period and the baseline spending estimates for ASCs. Both tables classify most estimated impacts as transfers.

TABLE 115: ACCOUNTING STATEMENT: CY 2027 ESTIMATED HOSPITAL OPPS TRANSFERS FROM CY 2026 TO CY 2027 ASSOCIATED WITH THE CY 2027 HOSPITAL OUTPATIENT OPD FEE SCHEDULE INCREASE

Category	Transfers
Annualized Monetized Transfers	$1.78 billion
From Whom to Whom	Federal Government to outpatient hospitals and other providers who receive payment under the hospital OPPS

TABLE 116: ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED TRANSFERS FROM CY 2026 TO CY 2027 AS A RESULT OF THE CY 2027 UPDATE TO THE ASC PAYMENT SYSTEM

Category	Transfers
Annualized Monetized Transfers	$170 million
From Whom to Whom	Federal Government to Medicare Providers and Suppliers
Total	$170 million

3. Effects of Changes in Requirements for the Hospital Outpatient Quality Reporting Program

a. Background

We refer readers to the CY 2026 OPPS/ASC final rule with comment period (90 FR 54071 and 54072) for the previously estimated effects of changes to the Hospital Outpatient Quality Reporting Program for the CY 2026 reporting period and subsequent years. Of the 2,984 hospital outpatient departments (HOPDs) that met eligibility requirements for the CY 2026 payment determination for the Hospital Outpatient Quality Reporting Program, we determined that 35 HOPDs did not meet the program requirements to receive the full annual Outpatient Department (OPD) fee schedule increase factor while an additional 47 HOPDs elected not to participate.

b. Impact of CY 2027 OPPS/ASC Final Rule Policies

We finalized to: (1) remove the Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients measure beginning with the CY 2027 reporting period/CY 2029 payment determination; (2) incorporate electronic clinical quality measures (eCQMs) into the existing validation process for chart-abstracted measures beginning with eCQM data from the CY 2027 reporting period affecting the CY 2030 payment determination; (3) reduce the validation selection pool from 500 to up to 400 HOPDs beginning with validation affecting the CY 2030 payment determination; and (4) remove the requirement for hospitals to resubmit medical documentation as part of their request for reconsideration of validation, beginning with data from the CY 2026 reporting period affecting the CY 2028 payment determination.

As part of the incorporation of eCQMs into the existing validation process for chart-abstracted measures, we will also update our data validation policies for chart-abstracted measures, including modifying the number of chart-abstracted measure cases required for validation from 12 per quarter to up to 7 per quarter per measure beginning with validation affecting the CY 2030 payment determination.

We refer readers to section “XXIV. Collection of Information” of this final rule with comment period for a detailed discussion of the calculations estimating the changes to the

information collection and reporting burden for data requirements under the Hospital Outpatient Quality Reporting Program for the estimated 3,000 program-eligible HOPDs. As shown in summary Table 108 in section XXIV.A.6. of this final rule with comment period, we estimate a total information collection and reporting burden net decrease of 17,439 hours at a savings of $997,143 annually associated with our policies beginning with the CY 2029 reporting period/CY 2031 payment determination compared to our information collection burden estimates which are currently approved under OMB control number 0938-1109 (expiration date July 31, 2029).

In addition to the reduced information collection burden associated with the policies in this final rule with comment period, we believe there will be administrative cost savings associated with the removal of the requirement for HOPDs to resubmit medical documentation as part of their request for reconsideration of validation noncompliance. Regarding the incorporation of eCQMs into the existing validation process for chart-abstracted measures, with more than 98 percent of HOPDs eligible to participate in the Hospital Outpatient Quality Reporting Program affiliated with hospital systems that are already familiar with the eCQM validation process under the Hospital Inpatient Quality Reporting Program, we anticipate their experience with eCQM validation for the Hospital Inpatient Quality Reporting Program will minimize the additional costs beyond the information collection burden discussed in section XXIV.A. of this final rule with comment period associated with eCQM validation by leveraging existing or similar personnel and processes.

We do not believe the remaining policies will result in any additional economic impact beyond that discussed in section "XXIV. Collection of Information" of this final rule with comment period.

We did not receive public comments on the estimated impacts of these policies.

4. Effects of Requirements for the Rural Emergency Hospital (REH) Quality Reporting Program

We refer readers to the CY 2026 OPPS/ASC final rule with comment period (90 FR 54072 and 54073) for the previously discussed effects of changes to the REH Quality Reporting

Program for the CY 2026 reporting period and subsequent years. For the CY 2027 reporting period, we have estimated there will be 48 REHs required to report under the REH Quality Reporting Program based on acute care and critical access hospital conversions to REH status as of April 6, 2026. We note that this estimate is an increase of 10 REHs from our estimate of 38 provided in the CY 2026 OPPS/ASC final rule with comment period, resulting in an increase in total information collection burden for the REH Quality Reporting Program of 122 hours and $6,976 (90 FR 54072). We are not finalizing any changes to our previously finalized REH Quality Reporting Program policies in this final rule with comment period.

5. Effects of Changes in Requirements for the Ambulatory Surgical Center (ASC) Quality Reporting Program

a. Background

We refer readers to the CY 2026 OPPS/ASC final rule with comment period (90 FR 54073) for the previously estimated effects of changes to the ASC Quality Reporting Program for the CY 2026 reporting period and subsequent years. Based on the most recent analysis of the CY 2026 payment determination data, we found that, of the 6,930 ASCs that were actively billing Medicare, 4,399 were required to participate in the ASC Quality Reporting Program. Of the 2,531 ASCs not required to participate in the program, 650 ASCs did so and met full requirements. On this basis, we estimate that 5,149 ASCs (4,399 + 650) will submit data for the ASC Quality Reporting Program for the CY 2027 reporting period and subsequent years unless otherwise noted. We note that this estimate is an increase of 559 ASCs from our estimate of 4,590 provided in the CY 2026 OPPS/ASC final rule with comment period (90 FR 54073) due to more recent data analysis regarding numbers of eligible ASCs.

b. Impact of CY 2027 OPPS/ASC Final Rule Policies

We finalized to remove the Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients measure beginning with the CY 2027 reporting period/CY 2029 payment determination. We refer readers to section “XXIV. Collection of Information” of this final rule

with comment period for a detailed discussion of the calculations estimating the changes to the information collection and reporting burden for data requirements under the ASC Quality Reporting Program for the estimated 5,149 program-eligible ASCs. As shown in summary Table 109 in section XXIV.C.3. of this final rule with comment period, we estimate a total information collection and reporting burden decrease of 16,753 hours at a savings of $957,937 annually associated with our policy for the CY 2027 reporting period/CY 2029 payment determination and subsequent years compared to our information collection burden estimates which are currently approved under OMB control number 0938-1270 (expiration date July 31, 2029). We do not believe this policy will result in any additional economic impact beyond those discussed in section "XXIV. Collection of Information" of this final rule with comment period.

We did not receive public comments on the estimated impacts of these policies.

6. Effects of Addition of New Codes for Hospital Outpatient Department (OPD) Prior Authorization Process

a. Overall Impact

In the CY 2020 OPPS/ASC final rule with comment period, we established a prior authorization process for certain hospital OPD services using our authority under section 1833(t)(2)(F) of the Act, which requires the Secretary to develop "a method for controlling unnecessary increases in the volume of covered OPD services" (84 FR 61142, November 12, 2019).[235] As part of the CY 2021 OPPS/ASC final rule with comment period, we added additional service categories to the prior authorization process (85 FR 85866, December 29, 2020). Through the CY 2023 OPPS/ASC final rule with comment period, we added an eighth service category to the list of OPD services requiring prior authorization (87 FR 71748, 72224 through 72233, November 23, 2022). The regulations governing the prior authorization process are located in subpart I of 42 CFR part 419, specifically at §§ 419.80 through 419.89.

[235] See also Correction Notice issued January 3, 2020 (85 FR 224).

In accordance with § 419.83(b), we proposed to expand the Botulinum Toxin Injection service category to include additional codes requiring prior authorization. To improve readability and brevity, as we indicated earlier in section XVIII. of this final rule with comment period, effective dates were removed and the section numbering in the regulatory text was updated. The former paragraphs (a)(1)(i) through (v), (a)(2)(i) and (ii), and (a)(3) have been renumbered as (a)(1) through (8). The additional Botulinum Toxin Injection codes would be added to the existing codes located at proposed revised § 419.83(a)(2) and would require prior authorization beginning for service dates on or after July 1, 2027.

The addition of these services is consistent with our authority under section 1833(t)(2)(F) of the Act and is based upon our determination that there has been an unnecessary increase in the volume of these services.

The overall economic impact on the healthcare sector to require prior authorization for these additional codes is dependent on the number of claims affected. Table 118, Overall Economic Impact on the Health Sector, lists an estimate of the overall economic impact on the health sector for the new services. The values populating Table 117 were obtained from the cost reflected in Table 118, Annual Private Sector Costs, and Table 119, Estimated Annual Administrative Costs to CMS. Tables 118 and 119 combine to convey the overall economic cost impact to the health sector for the new services, which is illustrated in Table 117.

Based on the estimate, the overall economic cost impact is approximately $9.6 million in the first year for the new services. The 5-year impact is approximately $48 million, and the 10-year impact is approximately $95.9 million. Additional administrative paperwork costs to private sector providers and an increase in Medicare spending to conduct reviews combine to create the financial impact; however, this impact is offset by Medicare savings. Annually, we estimate an overall Medicare savings of $25 million. We believe there are likely to be other benefits that result from the prior authorization requirement for the new services, though many of those benefits are difficult to quantify. For instance, we expect to see savings in the form of

reduced unnecessary utilization, fraud, waste, and abuse, including a reduction in improper Medicare fee-for-service payments (we note that not all improper payments are fraudulent). We solicited public comments on the potentially increased costs and benefits associated with this proposed provision for the new services, but we did not receive any comments on this matter.

TABLE 117: OVERALL ECONOMIC COST IMPACT ON THE HEALTH SECTOR

	Year 1	5 Years	10 Years
Private Sector Costs	$1,957,592	$9,787,962	$19,575,924
Medicare Costs	$7,632,439	$38,162,195	$76,324,390
Total Economic Impact to Health Sector	$9,590,031	$47,950,157	$95,900,314

According to the RFA's use of the term, most suppliers and providers are small entities. Likewise, the vast majority of physician and nurse practitioner (NP) practices are considered small businesses according to the SBA's size standards of having total revenues of $10 million or less in any 1 year. While the economic costs and benefits are substantial in the aggregate, the economic impact on individual entities compliant with Medicare program coverage and utilization rules and regulations will be relatively small. We estimate that 90 to 95 percent of providers who provide these services are small entities under the RFA definition. The rationale behind requiring prior authorization is to control unnecessary increases in the volume of covered OPD services. The impact on providers not in compliance with Medicare coverage, coding, and payment rules and regulations could be significant, as the proposed rule may change the billing practices of those providers. The purpose of the statute and this final rule with comment period is to avoid unnecessary increases in utilization of OPD services. Therefore, we do not view decreased revenues from the additional OPD services to be a condition that we must mitigate. We believe that the effect would be minimal on providers who are compliant with Medicare coverage, coding, and payment rules and requirements. Adding the new services would offer additional protection to a provider's cash flow as the provider would know in advance if the Medicare requirements were met.

b. Anticipated Specific Cost Effects

(1) Private Sector Costs

We do not believe that this final rule with comment period would significantly affect the number of legitimate claims submitted for the new services. However, we expect a decrease in the overall amount paid for the services resulting from a reduction in unnecessary utilization of the services requiring prior authorization.

We estimate that the private sector's per-case time burden attributed to submitting documentation and associated clerical activities in support of a prior authorization request for the additional services will be equivalent to that of submitting documentation and clerical activities associated with prepayment review, which is 0.5 hours. We apply this time burden estimate to initial submissions and resubmissions.

TABLE 118: ANNUAL PRIVATE SECTOR COSTS

Activity	Responses Per Year (i.e. number of reviewed claims)	Time Per Response (hours) or Dollar Cost	Total Burden Per Year (hours)	Total Burden Costs Per Year Using Loaded Rate
Fax and Electronic Submitted Requests- Initial Submissions	41,299	0.5	20,649	$914,351
Fax and Electronic Submitted Requests- Resubmissions	13,552	0.5	6,776	$300,041
Mailed in Requests- Initial Submissions	17,699	0.5	8,850	$391,865
Mailed in Requests- Resubmissions	5,808	0.5	2,904	$128,589
Mailing Costs	23,507	5		$117,537
Provider Demonstration- Education	792	3	2,376	$105,209
Total			41,555	$1,957,592

(2) Administrative Costs to CMS

CMS would incur additional costs associated with processing the prior authorization requests for the new services. We use the range of potentially affected cases (submissions and resubmissions) and multiply it by $95, the estimated cost to review each request. The combined cost also includes other elements such as appeals, education, outreach, and system changes.

TABLE 119: ANNUAL ESTIMATED ADMINISTRATIVE COSTS TO CMS

Additional Services	Estimated Annual Administrative Cost
Botulinum Toxin Injections	$7,632,439

(3) Estimated Beneficiary Costs

We expect a reduction in the utilization of the new Medicare OPD services when such utilization does not comply with one or more of Medicare's coverage, coding, and payment rules. While there may be an associated burden on beneficiaries while they wait for the prior authorization decision, we are unable to quantify that burden. Although this final rule with comment period permits utilization that is medically necessary, OPD services that are not medically necessary may still provide convenience or usefulness for beneficiaries; any rule-induced loss of such convenience or usefulness constitutes a cost of the rule that we lack data to quantify. Additionally, beneficiaries may have out-of-pocket costs for those services that are determined not to comply with Medicare requirements and, thus, are not eligible for Medicare payment. We lack the data to quantify these costs as well.

(4) Estimated Benefits

There will be quantifiable benefits for this final rule with comment period because we expect a reduction in the unnecessary utilization of the new Medicare OPD services subject to prior authorization. It is difficult to project the exact decrease in unnecessary utilization; however, based on a 25 percent savings percentage, we estimate an overall gross savings of $25 million. These savings represent a Medicare benefit from more efficient use of health care resources while still maintaining the same health outcomes for necessary services. We will closely monitor utilization and billing practices. The expected benefits would also include changed billing practices that would also enhance the coordination of care for the beneficiary. For example, requiring prior authorization for the additional OPD services would help ensure that the primary care practitioner recommending the service and the facility collaborate more closely to provide the most appropriate OPD services to meet the needs of the beneficiary. The

practitioner recommending the service would evaluate the beneficiary to determine what services are medically necessary based on the beneficiary's condition. This would require the facility to collaborate closely with the practitioner early in the process to ensure the services are truly necessary and meet all requirements and that their supporting documentation is complete and correct. Improper payments made because the practitioner did not evaluate the patient, or the patient does not meet the Medicare requirements, would likely be reduced by requiring a provider to submit clinical documentation as part of its prior authorization request.

We solicited comments on the potential additional burden associated with applying prior authorization requirements to these additional botulinum toxin injection codes, including any impacts on providers and beneficiaries. We received comments regarding the potential additional burden associated with applying prior authorization requirements to these additional Botulinum Toxin Injection services, including impacts on providers and beneficiaries. We summarized and responded to these comments in the section XIX. of this final rule with comment period.

D. Regulatory Review Cost Estimation

Due to the uncertainty involved with accurately quantifying the number of entities that will review the rule, we assume that the total number of unique commenters on last year's proposed rule will be the number of reviewers of this final rule with comment period. We acknowledge that this assumption may understate or overstate the costs of reviewing this rule. It is possible that not all commenters reviewed this year's rule in detail, and it is also possible that some reviewers chose not to comment on the proposed rule. For these reasons we believe that the number of past commenters would be a fair estimate of the number of reviewers of this rule. We welcomed comments on the approach in estimating the number of entities that would review the proposed rule.

We also recognize that different types of entities are in many cases affected by mutually exclusive sections of this final rule with comment period, and therefore for the purposes of our

estimate we assume that each reviewer reads approximately 50 percent of the rule. We sought comments on this assumption.

Using the wage information from the Bureau of Labor Statistics (BLS) for medical and health service managers (Code 11-9111), we estimate that the cost of reviewing this rule is $119.10 per hour, including overhead and fringe benefits (*https://www.bls.gov/oes/current/oes_nat.htm*). Assuming an average reading speed, we estimate that it would take approximately 8 hours for the staff to review half of this final rule with comment period. For each entity that reviews the rule, the estimated cost is $952.80 (8 hours x $119.10). Therefore, we estimate that the total cost of reviewing this regulation is $2,898,418 ($952.80 x 3,042).

E. Regulatory Flexibility Act (RFA) Analysis

The RFA requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. The great majority of hospitals and most other health care providers and suppliers are small entities, either by being nonprofit organizations or by meeting the Small Business Administration (SBA) definition of a small business (having revenues of less than $9.0 million to $47.0 million in any 1 year). (For details, see the SBA's website at *http://www.sba.gov/content/small-business-size-standards* (refer to the 620000 series or Sector 62, Health Care and Social Assistance).)

The North American Industry Classification System (NAICS) was adopted in 1997 and is the current standard used by the Federal statistical agencies related to the U.S. business economy. We utilized the NAICS U.S. industry title "Hospitals" and corresponding NAICS code 622 in determining impacts for small entities for this rule. The NAICS code 622 has a size

standard of $47 million.[236] Table 120 shows the number of firms, revenue, and estimated impact per hospital category.

TABLE 120: NUMBER OF FIRMS, REVENUE, AND AVERAGE REVENUE PER FIRM OF HOSPITALS FOR NAICS CODE 622

NAICS	NAICS Description	Enterprise Size ($1,000)	Number of Firms	Number of Establishments	Receipts ($1,000)	Average Receipts Per Firm ($1,000)
622	Hospitals	<100	68	68	3,235	48
622	Hospitals	00-499	176	176	47,198	268
622	Hospitals	500-999	61	62	43,484	713
622	Hospitals	1,000-2,499	36	36	55,875	1,552
622	Hospitals	2,500-4,999	43	46	160,867	3,741
622	Hospitals	5,000-7,499	45	47	285,858	6,352
622	Hospitals	7,500-9,999	77	80	653,169	8,483
622	Hospitals	10,000-14,999	158	165	1,852,000	11,722
622	Hospitals	15,000-19,999	173	193	2,919,720	16,877
622	Hospitals	20,000-24,999	154	158	3,391,347	22,022
622	Hospitals	25,000-29,999	128	135	3,342,680	26,115
622	Hospitals	30,000-34,999	126	131	3,876,502	30,766
622	Hospitals	35,000-39,999	87	93	3,061,225	35,186
622	Hospitals	40,000-49,999	162	179	6,839,652	42,220
622	Hospitals	50,000-74,999	276	312	15,547,026	56,330
622	Hospitals	75,000-99,999	144	178	11,728,762	81,450
622	Hospitals	100,000+	1,222	5,654	1,300,730,378	1,064,427
622	Hospitals	Total	3,136	7,713	1,354,538,978	431,932

Source: Data obtained from United States Census Bureau table "us_6digitnaics_rcptsize_2022" (SOURCE: 2022 SUSB Annual Data Tables by Establishment Industry) Release Date: 4/10/2025: *https://www2.census.gov/programs-surveys/susb/tables/2022/us_6digitnaics_rcptsize_2022.xlsx.*
Notes: The 'Average Receipts Per Firm' is calculated as the Receipts ($1,000)/Number of Firms. The 'Total' row represents all the hospital firms under NAICS 622. Overall receipts (revenue) for the 3,136 firms (NAICS 622) are approximately $1,355 billion.

TABLE 121: ESTIMATED IMPACT ON SMALL BUSINESSES*

	Total Facilities	Estimated Small Businesses	Total Impact ($1 million)	Estimated Impact of Payment Update to Small Businesses	Effect of Additional OPPS Policies**	Estimated Average Impact per Small Business
OPPS Hospitals	3,621	1,669	$1,780	$32,040,000	$136,500,000	$100,983
ASCs	6,179	5,560	$170	$59,200,000		$10,647

[236] *https://www.sba.gov/sites/sbagov/files/2023-03/Table%20of%20Size%20Standards_Effective%20March%2017%2C%202023%20%281%29%20%281%29_0.pdf.*

* Based on the assumptions that small firms represent 46.1 percent of OPPS Hospitals and account for approximately 1.8 percent of total industry revenues, and, small firms represent 90.0 percent of ASCs and account for approximately 34.8 percent of total industry revenues using the SBA size standards.
**Individual impact of each additional OPPS policy is displayed in Table 122.

TABLE 122: ESTIMATED EFFECT OF SPECIFIC OPPS POLICIES ON SMALL BUSINESSES

	ALASKA/ HAWAII COLA	340B Payment Policy	Volume Control Method for Imaging without Contrast Services	340B Remedy Offset	Net Effect of Specified Policies
Impact on Small Businesses	$1,500,000	$214,000,000	-$6,000,000	-$73,000,000	**$136,500,000**

For purposes of the RFA, approximately half of all hospitals are considered to be small entities. As shown in Table 120, hospitals with enterprise size of $49 million or less (1,494) are approximately 48 percent of total firms (3,136). Because roughly half of hospitals qualify as small entities under the RFA, the impacts described in this final rule with comment period generally affect small entities. Individuals and States are not included in the definition of a small entity. MACs are also not considered to be small entities because they do not meet the SBA definition of a small business.

HHS interprets the RFA to consider economic effects of a rule to impact a substantial number of small firms when more than 5 percent of providers incur significant impacts of at least 3 to 5 percent or more of total revenue or total costs. This final rule with comment period includes a number of policy changes that can significantly increase or decrease estimated 2027 payments at an individual level, including changes such as the final exceptions to the 340B drug payment proposal and the payment adjustment for imaging without contrast services furnished at provider-based departments. Based on this impact analysis, we estimate that the policies finalized in this rule would affect more than 5 percent of hospitals with changes in Medicare revenue of at least 3 to 5 percent.

Therefore, CMS expects that this final rule with comment period will have a significant economic impact on a substantial number of small entities.

We estimate that a majority of the 3,621 OPPS providers included in the impact analysis presented in Table 112 would experience average payment increases of approximately 1.7 percent. We attribute those changes primarily to the final OPPS update. Across hospital categories, we estimate that impacts would range from an increase of 7.7 percent for rural sole community hospitals to an estimated decrease of 4.2 percent for hospitals with a DSH patient percentage greater than 35 percent.

As shown in Tables 115 and 116, we estimate that this final rule with comment period would result in aggregate transfers of approximately $1.78 billion to OPPS providers and $170 million to ASCs. In Table 121, we estimate the impact of this rule on small entities by applying the SBA size standards and approximating the share of affected firms and revenues attributable to small entities. Specifically, we assume that small firms represent 46.1 percent of affected entities and account for approximately 1.8 percent of total industry revenues. Using these assumptions, we estimate that of the 3,621 OPPS providers, approximately 1,669 are small entities. Applying the 1.8 percent revenue share, we estimate that approximately $32.0 million of the OPPS rate update impacts would accrue to small entities. In Table 122, we estimate the impact of individual OPPS policies on the estimated 1,6669 small entities in this final rule. That results in an estimated increase in CY 2027 payment of about $136,500,000 as the combined result of the 340B Payment Policy, the COLA for hospitals in Alaska and Hawaii, the volume control method for imaging without contrast services, and the340B Remedy Offset for CY 2027. The combined effect of the approximately $32 million payment increase as a result of the OPPS update and the $136.5 million as a result of other OPPS payment policies across 1,669 small entities corresponds to an average impact of approximately $100,983 per small OPPS provider.

As discussed earlier in this section, this final rule with comment period includes a range of provisions. While none of these policies specifically target small businesses, there are a

number of significant policy changes that may affect them. These include the final 340B payment policy and its exception for rural sole community hospitals; the volume control method for imaging without contrast services furnished in excepted off-campus provider-based departments and its exception for rural sole community hospitals, the increase in the 340B remedy offset for CY 2027, and the cost-of-living adjustment (COLA) policy for hospitals in Alaska and Hawaii.

As noted earlier in this section, the update to the OPPS conversion factor will be positive for OPPS providers, including small businesses. While there may be differences in the impacts on individual small entities, the 340B Payment Policy will generally be positive for small businesses due to the increase to the OPPS conversion factor associated with the policy having a greater impact on small businesses overall than the reduction to 340B drug payments, as fewer small businesses have significant 340B drug payments compared with larger businesses. Additionally, the exception for rural sole community hospitals means 340B drug payments are not affected for these hospitals, many of which are small businesses. Overall, the small business category is expected to have payments increase by about $214 million in CY 2027 as a result of the 340B Payment Policy, including the associated budget neutral adjustment to the OPPS CF for non-drug services. Similarly, the volume control method for imaging without contrast services will reduce payments to some small businesses. Rural sole community hospitals, including those that qualify as small businesses, are excepted from this policy. As a result of the volume control method for imaging without contrast services and exception for rural sole community hospitals we expect that small businesses will see a payment decrease of about $6 million.

The increase in the 340B remedy offset for CY 2027 will reduce payments to small businesses subject to the offset in CY 2027. However, the larger offset is expected to reduce the need for a remedy offset in future years, thereby increasing revenue for affected small businesses in those years compared with the existing offset schedule. Additionally, hospitals that were not billing Medicare as of January 1, 2018, were excepted from the offset. The vast majority of those

excepted hospitals are small businesses, with about 273 small businesses anticipated to be excepted from the remedy offset. Finally, the COLA for hospitals in Alaska and Hawaii will increase payments to hospitals in Alaska and Hawaii that qualify as small businesses. We expect the policy to increase CY 2027 payments by about $1.5 million to 4 hospitals that are likely to be small businesses.

As noted earlier in this section and in section XIII. of this final rule with comment period, we are extending the hospital market basket update as the update factor for the ASC payment system for CY 2027, which will increase overall payment to ASCs, the majority of which qualify as small businesses. The increase in the device portion of device-intensive procedures as a result of the increase in OPPS payment for non-drug services otherwise reduces the payment for non device-intensive procedures and has varying impact on certain surgical specialties as shown in Table 113. Some small business ASCs could be multispecialty facilities that perform a wide range of surgical procedures while others may focus on a single specialty and perform only a limited range of surgical procedures, such as ophthalmology, gastrointestinal, or orthopedic procedures. Therefore, the combined effect of the final ASC payment system policies in this rule on an individual small business ASC would depend on the mix of surgical procedures the ASC will provide in CY 2027.

We describe the applicable statutory provisions, identify the policies, present the rationale for these provisions, and, where appropriate, in the corresponding sections of this final rule with comment period. We note that in many cases the individual effects for a provider will depend on multiple factors.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has 100 or fewer beds. This final rule with comment period

will affect payments to a substantial number of small rural hospitals and a small number of rural ASCs, as well as other classes of hospitals, CMHCs, and ASCs, and some effects may be significant. However, as noted in the impact analysis of this final rule with comment period, this rule is expected to generally increase OPPS payments to the approximately 512 small rural hospitals. Therefore, the Secretary has certified that this final rule with comment period will have a significant impact on the operations of a substantial number of small rural hospitals.

The analyses presented in this section and throughout the preamble of this final rule with comment period provides a regulatory flexibility analysis and a regulatory impact analysis.

F. Unfunded Mandates Reform Act (UMRA)

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2026, that threshold is approximately $193 million.

This final rule with comment period would not impose a mandate that will result in the expenditure by State, local, and Tribal Governments, in the aggregate, or by the private sector, of more than $193 million in any 1 year.

G. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications.

We have examined the OPPS and ASC provisions included in this final rule with comment period in accordance with Executive Order 13132, Federalism, and have determined that they would not have a substantial direct effect on State, local, or tribal governments, preempt State law, or otherwise have a federalism implication. As reflected in Table 112 of this final rule with comment period, we estimate that OPPS payments to governmental hospitals (including

State and local governmental hospitals) would decrease by 1.7 percent under this final rule with comment period. While we do not know the number of ASCs or CMHCs with government ownership, we anticipate that it is small. The analyses we have provided in this section of this final rule with comment period, in conjunction with the remainder of this document, demonstrate that this rule is consistent with the regulatory philosophy and principles identified in Executive Order 12866, the RFA, and section 1102(b) of the Act.

H. E.O. 14192, "Unleashing Prosperity Through Deregulation"

Executive Order 14192, entitled "Unleashing Prosperity Through Deregulation" was issued on January 31, 2025, and requires that "any new incremental costs associated with new regulations shall, to the extent permitted by law, be offset by the elimination of existing costs associated with at least 10 prior regulations". This rule is expected to be an E.O. 14192 regulatory action. We estimated that this rule will generate $6.23 million in net annualized costs at a 7 percent discount rate, discounted relative to year 2024, over a perpetual time horizon.

XXVIII. Waiver of Delay in Effective Date

The Congressional Review Act (CRA) (Pub. L. 104-121, Title II) requires a 60-day delay in the effective date for major rules unless an agency finds good cause that notice and public procedure are impracticable, unnecessary, or contrary to the public interest, in which case the rule shall take effect at such time as the agency determines. 5 U.S.C. 801(a)(3) and 808(2).

We believe that further notice and public procedure are unnecessary, and that it would be impracticable and contrary to the public interest to delay the effective date of the OPPS and ASC final rule with comment period for the following reasons.

If the effective date of this final rule with comment period is delayed by 60 days, the finalized OPPS and ASC payment system updated policies (including the Hospital Outpatient Quality Reporting (OQR) Program, the Ambulatory Surgical Center Quality Reporting (ASCQR) Program, prior authorization for additional Botulinum Toxin Injection services, implementation of certain Consolidated Appropriations Act, 2026 provisions for off-campus

outpatient departments of a provider, Graduate Medical Education (GME) policies, and hospital accrediting organization policies concerning certain Emergency Medical Treatment and Labor Act (EMTALA) administrative requirements) will not be effective as of the beginning of the payment year, and CMS will be compelled to continue to use obsolete reimbursement rates which will disadvantage health care providers and suppliers.

In accordance with sections 1833(t)(9) and 1833(i)(2)(D) of the Act, the OPPS and the ASC payment systems are calendar year payment systems. We typically issue the OPPS/ASC final rule with comment period by November 1 of each year to both comply with the statutory requirement under section 1833(t)(9)(A) of the Act to annually review and update the OPPS on a calendar year basis and ensure 60 days' notice so that the payment policies for these systems are effective on January 1, the first day of the calendar year to which the policies are intended to apply. The Hospital OQR Program, REHQR Program, and the ASCQR Program are intended to align with the OPPS and the ASC payment systems, respectively.

In this final rule with comment period, we review and revise payment rates for specific services and adopt or revise other policies that relate to the OPPS/ASC payment system for CY 2027. Section 1833(t)(9)(A) of the Act requires that no less often than annually, the Secretary shall review and revise the groups, the relative payment weights, and the wage and other adjustments for outpatient services to take into account changes in medical practice, changes in technology, the addition of new services, new cost data, and other relevant information and factors. In addition, section 1833(i)(2)(D) of the Act states that the payment amount made for facility services furnished in connection with a surgical procedure furnished to an individual in an ambulatory surgical center should be reviewed and updated annually to take account of varying conditions in different areas. We find that, in order to comply with the statutory requirements to annually review and update these payment systems, to ensure that the payment policies for these systems are effective on an annual basis, and to promote an orderly transition to a new payment year, it is in the public interest to ensure that the rule is effective no later than

1 full year after the effective date of the previous year's update (that is, January 1 of each year). Moreover, it is in the public interest to waive the 60-day delay of the effective date, so that providers and suppliers are adequately reimbursed starting at the beginning of the calendar year. Therefore, we find good cause exists to waive the 60-day delay in the effective date for this final rule with comment period.

Mehmet Oz, Administrator of the Centers for Medicare & Medicaid Services, approved this document on October 29, 2026.

List of Subjects

42 CFR Part 413

Diseases, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping Requirements

42 CFR Part 416

Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 419

Hospitals, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 427

Administrative practice and procedure, Biologics, Inflation rebates, Medicare, Prescription drugs.

42 CFR Part 488

Administrative practice and procedure, Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV as set forth below:

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES; PAYMENT FOR ACUTE KIDNEY INJURY DIALYSIS

1. The authority citation for part 413 continues to read as follows:

Authority: 42 U.S.C. 1302, 1395d(d), 1395f(b), 1395g, 1395l(a), (i), and (n), 1395m, 1395x(v), 1395x(kkk), 1395hh, 1395rr, 1395tt, and 1395ww.

2. Section 413.65 is amended--

a. In paragraph (a)(2) by adding the definition of "Off-campus outpatient department of a provider" in alphabetical order;

b. By revising paragraphs (b)(3)(ii) and (iii);

c. By adding paragraph (b)(6);

d. By revising paragraphs (e) introductory text, (g)(1)(i) and (ii), (h) introductory text, and (k).

The additions and revisions read as follows:

§ 413.65 Requirements for a determination that a facility or an organization has provider-based status.

(a) * * *

(2) * * *

* * * * *

Off-campus outpatient department of a provider means a department of a provider that is not located on the campus of the main provider (as defined in this section) or within 250 yards of a remote location of a hospital (as defined in this section).

* * * * *

(b) * * *

(3) * * *

(ii) If the facility is not located on the campus of the potential main provider or within 250 yards of a remote location of a hospital, the attesting provider would be required to submit an attestation stating that the facility meets the criteria in paragraphs (d) and (e) of this section, and if the facility is operated under a management contract, the requirements of paragraph (h) of this section. If the potential main provider is a hospital, the hospital also would be required to attest that it will fulfill the obligations of hospital outpatient departments and hospital-based entities described in paragraph (g) of this section. The provider would be required to maintain documentation of the basis for its attestations to CMS and to furnish such information upon request.

(iii) Whenever a provider submits an attestation of provider-based status for an on-campus facility or organization, as described in paragraph (b)(3)(i) of this section, CMS or its agents will send the provider written acknowledgment of receipt of the attestation, review the attestation for completeness, consistency with the criteria in this section, and consistency with information in the possession of CMS or its agents at the time the attestation is received, and make a determination as to whether the facility or organization is provider-based.

* * * * *

(6) As of January 1, 2028, for each off-campus outpatient department of a provider, a provider must submit an initial attestation of provider-based status within the 2-year period prior to furnishing services, and a subsequent attestation within a period not to exceed 5 years thereafter. This does not apply to Critical Access Hospitals and those entities described in paragraphs (m) or (n) of this section.

* * * * *

(e) *Additional requirements applicable to off-campus facilities or organizations.* Except as described in paragraphs (b)(2) and (5) of this section, any facility or organization for which

provider-based status is sought that is not located on the campus of a potential main provider or within 250 yards of a remote location of a hospital must meet both the requirements in paragraph (d) of this section and all of the following additional requirements, in order to be determined by CMS to have provider-based status.

* * * * *

(g) * * *

(1) * * *

(i) Any facility or organization that is located on the main hospital campus or within 250 yards of a remote location of a hospital and is treated by CMS under this section as a department of the hospital; and

(ii) Any facility or organization that is located off the main hospital campus that is treated by CMS under this section as a department of the hospital and is a dedicated emergency department, as defined in § 489.24(b) of this chapter.

* * * * *

(h) *Management contracts.* A facility or organization that is not located on the campus of the potential main provider or within 250 yards of a remote location of a hospital and otherwise meets the requirements of paragraphs (d) and (e) of this section, but is operated under management contracts, must also meet all of the following criteria:

* * * * *

(k) *Temporary treatment as provider-based*. If a provider submits an attestation of compliance with the requirements for provider-based status, as described in paragraph (b) of this section, for a facility or organization that has not previously been found by CMS to have been inappropriately treated as provider-based under paragraph (j) of this section, the provider may bill and be paid for services of the facility or organization as provider-based from the date it submits an attestation until the date that CMS determines that the facility or organization does not meet the provider-based rules. CMS may, at any time, initiate an extended review to validate

the attestation of compliance, including through site visits, remote audits, desk reviews, investigations, or any other means CMS determines appropriate. As part of such a review, the provider must submit supporting documentation sufficient to demonstrate compliance with the provider-based requirements set forth in this section, in the form and manner and within the timeframe specified by CMS. Failure to submit requested documentation within the timeframe specified by CMS may result in a determination of non-compliance and recovery of payments as described in this paragraph (k). If CMS determines that the requirements for provider-based status are not met, CMS will recover the difference between the amount of payments that actually was made since the date the attestation of compliance with provider-based requirements was submitted and the amount of payments that CMS estimates should have been made in the absence of compliance with the provider-based requirements.

* * * * *

PART 416—AMBULATORY SURGICAL SERVICES

3. The authority citation for part 416 is revised to read as follows:

Authority: 42 U.S.C. 273, 1302, 1320b-8, and 1395hh.

4. Section 416.171 is amended by revising paragraphs (a)(2)(iii) through (viii) to read as follows:

§ 416.171 Determination of payment rates for ASC services.

(a) * * *

(2) * * *

(iii) For CY 2019 through CY 2027, the update is the hospital inpatient market basket percentage increase as defined under section 1886(b)(3)(B)(iii) of the Act.

(iv) For CY 2028 and subsequent years, the update is the Consumer Price Index for All Urban Consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved.

(v) For CY 2014 through CY 2018, the Consumer Price Index for All Urban Consumers update determined under paragraph (a)(2)(ii) of this section was reduced by 2.0 percentage points for ASCs that failed to meet the standards for reporting of ASC quality measures as established by the Secretary for the corresponding calendar year.

(vi) For CY 2019 through CY 2027, the hospital inpatient market basket percentage increase determined under paragraph (a)(2)(iii) of this section is reduced by 2.0 percentage points for an ASC that fails to meet the standards for reporting of ASC quality measures as established by the Secretary for the corresponding calendar year.

(vii) For CY 2028 and subsequent years, the Consumer Price Index for All Urban Consumers update determined under paragraph (a)(2)(iv) of this section is reduced by 2.0 percentage points for an ASC that fails to meet the standards for reporting of ASC quality measures as established by the Secretary for the corresponding calendar year.

(viii)(A) For CY 2011 through CY 2018, the Consumer Price Index for All Urban Consumers determined under paragraph (a)(2)(ii) of this section, after application of any reduction under paragraph (a)(2)(v) of this section, was reduced by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act.

(B) For CY 2019 through CY 2027, the hospital inpatient market basket percentage increase determined under paragraph (a)(2)(iii) of this section, after application of any reduction under paragraph (a)(2)(vi) of this section, is reduced by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act.

(C) For CY 2028 and subsequent years, the Consumer Price Index for All Urban Consumers determined under paragraph (a)(2)(iv) of this section, after application of any reduction under paragraph (a)(2)(vii) of this section, is reduced by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act.

* * * * *

PART 419—PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

5. The authority citation for part 419 continues to read as follows:

Authority: 42 U.S.C. 1302, 1395l(t), and 1395hh.

6. Adding § 419.23 to subpart B to read as follows:

§ 419.23 Special rule for off-campus outpatient department of a provider.

(a) No payment may be made under this part for items and services furnished on or after January 1, 2028, by an off-campus outpatient department of a provider (as defined in paragraph (b) of this section) unless—

(1) Such department has obtained, and such items and services are billed under, a National Provider Identifier that is separate from such identifier for such provider;

(2) Such provider has submitted an initial attestation of provider-based status in accordance with § 413.65(b)(6) of this chapter; and

(3) After such provider has submitted an initial attestation under paragraph (a)(2) of this section, such provider has submitted a subsequent attestation within the timeframe specified in § 413.65(b)(6) of this chapter.

(b) For purposes of this section, off-campus outpatient department of a provider is defined at § 413.65(a)(2) of this chapter.

(c) A provider satisfies the submission requirement at paragraph (a)(2) of this section even if CMS has not made a determination of provider-based status before the first day on which the outpatient department renders services.

7. Section 419.32 is amended by--

a. Revising paragraph (b)(1)(iv)(B)(*12*); and

b. Adding paragraph (b)(1)(iv)(B)(*13*).

The revision and addition read as follows:

§ 419.32 Calculation of prospective payment rates for hospital outpatient services.

* * * * *

(b) * * *

(1) * * *

(iv) * * *

(B) * * *

(*12*) For calendar year 2026, a multifactor productivity adjustment (as determined by CMS), and 0.5 percentage point reduction, except that the 0.5 percentage point reduction shall not apply to hospital outpatient items and services, not including separately payable drugs or biologicals, furnished by a hospital with a CMS certification number (CCN) effective date of January 2, 2018, or later.

(*13*) Beginning in calendar year 2027, a multifactor productivity adjustment (as determined by CMS), and 2.0 percentage point reduction, except that the 2.0 percentage point reduction shall not apply to hospital outpatient items and services furnished by a hospital with a CMS certification number (CCN) effective date of January 2, 2018, or later. This reduction and associated exception to the reduction will be in effect until the estimated payment reductions made in accordance with paragraph (b)(1)(iv)(B)(*12*) of this section and this paragraph (b)(1)(iv)(B)(*13*) for all applicable hospital outpatient items and services reaches $7.769 billion, as further described in each calendar year's rule.

* * * * *

8. Section 419.41 is amended by--

a. Revising paragraph (d); and

b. Adding paragraph (k).

The revision and addition read as follows:

§ 419.41 Calculation of national beneficiary copayment amounts and national Medicare program payment amounts.

* * * * *

(d) Notwithstanding paragraphs (a) through (c) of this section, for a drug or biological for which payment is not packaged into a payment for a covered outpatient department (OPD) service (or group of services) and is not a rebatable drug that meets the conditions described in paragraph (e) of this section, CMS calculates the program payment and copayment amounts as follows:

(1) Determines the payment rate for the drug or biological for the quarter, which is:

(i) The amount determined by the Secretary pursuant to section 1833(t)(14)(A)(iii)(I) of the Act; or

(ii) If no amount is available under paragraph (d)(1)(i) of this section, the amount established under the methodology described by section 1842(o), section 1847A, or section 1847B of the Act, as the case may be, as calculated and adjusted by the Secretary as necessary for purposes of paragraph (14) of section 1833(t) of the Act.

(2) Subtracts from the amount determined under paragraph (d)(1) of this section the amount of the applicable Part B deductible provided under § 410.160 of this chapter.

(3) Multiples the amount determined under paragraph (d)(1) of this section (less any applicable deductible under paragraph (d)(2) of this section) by 20 percent. This is the beneficiary's copayment amount for the drug or biological.

(4) Subtracts the amount determined under paragraph (d)(3) of this section from the amount determined under paragraph (d)(1) of this section (less any applicable deductible determined under paragraph (d)(2) of this section). This amount is the preliminary program amount.

(5) Adds to the preliminary program amount determined under paragraph (d)(4) of this section the amount by which the copayment amount would have exceeded the inpatient hospital deductible for that year. This amount is the final Medicare program payment amount.

* * * * *

(k) Notwithstanding paragraphs (f) through (i) of this section, CMS calculates the program payment and copayment amounts as follows:

(1) The amount determined by the Secretary pursuant to section 1833(t)(14)(A)(iii)(I) of the Act; or

(2) If no amount is available under paragraph (k)(1) of this section, the amount determined under paragraphs (f) through (i) of this section, as applicable.

9. Section 419.43 is amended by adding paragraph (l) to read as follows:

§ 419.43 Adjustments to national program payment and beneficiary copayment amounts.

* * * * *

(l) *Cost-of-living adjustment.* An additional adjustment is made for hospitals located in Alaska and Hawaii to account for the higher cost-of-living in those States.

10. Section 419.46 is amended by revising paragraphs (f)(2), (f)(3) introductory text, (f)(4), and (g)(2)(vii) and (viii) to read as follows:

§ 419.46 Requirements under the Hospital Outpatient Quality Reporting (OQR) Program.

* * * * *

(f) * * *

(2) A hospital meets the validation requirements with respect to a calendar year if it achieves:

(i) An overall reliability score of at least 75-percent for chart-abstracted measure validation, as determined by CMS; and

(ii) Beginning with validation affecting the CY 2030 payment determination, an overall reliability score of at least 75-percent for eCQM validation, as determined by CMS. For the first year that an eCQM is eligible for validation, a hospital meets validation requirements for that eCQM for the year if it provides at least 75-percent of requested records.

(3) CMS will select a random sample of up to 200 hospitals, beginning with validation affecting the CY 2030 payment determination, or 450 hospitals, for validation affecting payment

determinations prior to CY 2030, for validation purposes, and will select up to an additional 200 hospitals, beginning with validation affecting the CY 2030 payment determination, or 50 hospitals for validation affecting payment determinations prior to CY 2030, for validation purposes based on the following criteria. For validation affecting the CY 2030 payment determination only, CMS will exclude from selection for validation any hospital that was selected for validation affecting the CY 2029 payment determination.

* * * * *

(4) Hospitals that are selected and receive a score for validation may request an educational review in order to better understand the results within 30 calendar days from the date the validation results are made available. If the results of an educational review indicate that a hospital's medical records selected for validation were incorrectly scored, the corrected validation score will be used to compute the hospital's final validation score at the end of the calendar year.

(g) * * *

(2) * * *

(vii) Except as provided in paragraph (g)(2)(viii) of this section, a copy of all materials that the hospital submitted to comply with the requirements of the affected Hospital OQR Program payment determination year; and

(viii) If the hospital is requesting reconsideration on the basis that CMS determined it did not meet the affected payment determination year's validation requirement set forth in paragraph (f)(2) of this section, the hospital must provide:

(A) A written justification of why the hospital believes CMS incorrectly determined that the hospital did not meet the applicable validation requirements, including, as applicable, identification of any data elements the hospital believes were improperly classified during the validation process as a mismatch. Only data elements that affect a hospital's validation score are eligible to be reconsidered; and

(B) Any evidence that supports the hospital's reconsideration request, including, as applicable, copies of patient charts, e-mails, and other documents. The hospital is not required to resubmit materials previously submitted to CMS unless specifically requested by CMS.

* * * * *

11. Section 419.83 is amended by revising paragraph (a) to read as follows:

§ 419.83 List of hospital outpatient department services requiring prior authorization.

(a) *Service categories for the list of hospital outpatient department services requiring prior authorization*. The following service categories comprise the list of hospital outpatient department services requiring prior authorization:

(1) Blepharoplasty.

(2) Botulinum toxin injections.

(3) Panniculectomy.

(4) Rhinoplasty.

(5) Vein ablation.

(6) Cervical Fusion with Disc Removal.

(7) Implanted Spinal Neurostimulators.

(8) Facet Joint Interventions.

* * * * *

PART 427—MEDICARE PART B DRUG INFLATION REBATE PROGRAM

12. The authority citation for part 427 continues to read as follows:

Authority: 42 U.S.C. 1395w-3a(i), 1302, and 1395hh.

13. Section 427.303 is amended by revising paragraph (b)(1)(iv) to read as follows:

§ 427.303 Determination of total number of billing units.

* * * * *

(b) * * *

(1) * * *

(iv) Separately payable billing units in claim lines billed with the "TB" modifier or successor billing modifiers to identify 340B units, for claims with dates of service on or after January 1, 2025.

* * * * *

PART 488—SURVEY, CERTIFICATION, AND ENFORCEMENT PROCEDURES

14. The authority citation for part 488 continues to read as follows:

Authority: 42 U.S.C. 1302 and 1395hh.

15. Section 488.5 is amended by—

a. Reserving paragraphs (a)(21) and (22); and

b. Adding paragraph (a)(23),

The addition reads as follows:

§ 488.5 Application and re-application procedures for national accrediting organizations.

(a) * * *

(23) For accrediting organizations seeking or maintaining CMS approval of accrediting programs for hospitals, Critical Access Hospitals, and Rural Emergency Hospitals, the application must include a description of the policies and procedures the organization will use to assess compliance with the EMTALA-administrative requirements set forth at § 489.20 (l), (m), (q), and (r) during accreditation and reaccreditation surveys, including—

(i) Procedures for reviewing required EMTALA signage;

(ii) Procedures for verifying that transfer records are maintained and retained for at least 5 years;

(iii) Procedures for verifying the on-call physician lists are maintained as required;

(iv) Procedures for verifying a central log of individuals presenting to the emergency department is maintained as required;

(v) Procedures for reporting identified noncompliance with § 489.20 to CMS in accordance with CMS oversight requirements; and

(vi) Procedures for reporting identified noncompliance with § 489.24 subsequently identified during survey to CMS in accordance with CMS oversight requirements.

* * * * *

Robert F. Kennedy, Jr.,

Secretary,

Department of Health and Human Services.

[FR Doc. 2026-22739 Filed: 11/4/2026 5:00 pm; Publication Date: 11/6/2026]