2026 OPPS & HCPCS Changes

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Agenda

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Agenda – OPPS & HCPCS

1. Overview OPPS High Level Changes for 2026
2. Review of the Conversion Factor
3. Review expansion of inpatient to outpatient setting
4. Updates on Site Neutrality
5. Update to outpatient quality reporting
6. Updates to Price Transparency Requirement
7. HCPCS Code Updates for 2026

Objectives – OPPS & HCPCS Code Changes

By the end of the webinar, the audience will be able to identify key changes for 2026, Identify the conversion factor for 2026 and key department impacts

- The calendar year (CY) 2026 conversion factor for OPPS
- Identify continued Shift of Services from Inpatient to Outpatient Settings· Understand the updates to global surgical package payment accuracy strategy
- Expansion of Site-Neutral Payment Policies
- Strengthening Hospital Price Transparency Requirements
- Updates to Outpatient Quality Reporting and Performance Measurement
- Be able to state where to find HCPCS Code changes and chargemaster implementation

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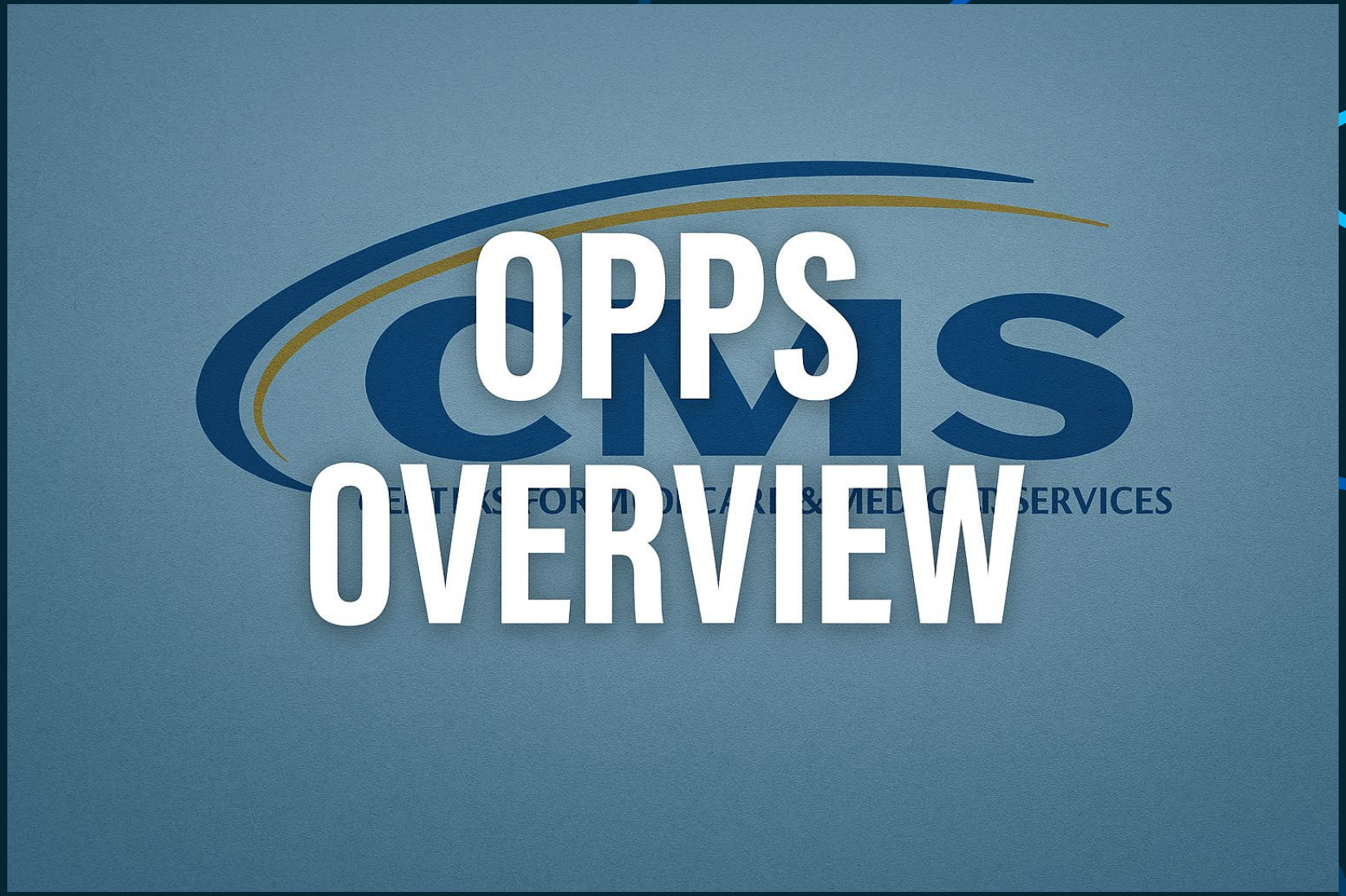
Source Authorities

- OPPS Fact Sheet:
  - https://www.cms.gov/newsroom/fact-sheets/calendar-year-2026-hospital-outpatient-prospective-payment-system-opps-ambulatory-surgical-center#:~:text=For%20CY%202026%2C%20we%20estimate,the%20Inpatient%20Only%20(IPO)%20List
- Final Rule – Federal Register
  - https://www.govinfo.gov/content/pkg/FR-2025-07-17/pdf/2025-13360.pdf
- Final Rule – Addenda
  - https://www.cms.gov/license/ama?file=/files/zip/2026-nprm-opps-addenda.zip
- HCPCS Code Changes
  - https://www.cms.gov/files/zip/january-2026-alpha-numeric-hcpcs-file.zip



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Overview

- For CY 2026, CMS is increasing the payment rates under the OPPS by an outpatient department (OPD) fee schedule increase factor of **2.6 percent**.
- This increase factor is based on the final inpatient hospital market basket percentage increase of 3.3 percent for inpatient services paid under the hospital inpatient prospective payment system (IPPS), reduced by a final productivity adjustment of 0.7 percentage point.
- Based on this update, CMS estimates that total payments to OPPS providers will be approximately $101.0 billion, an increase of approximately $8.0 billion compared to estimated CY 2025 OPPS payments.
- Continuing 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 0.9805 to the OPPS payments and copayments for all applicable services.

Overview

- Conversion factor of $91.415 in the calculation of the national unadjusted payment rates
  - Failed HQR will have a **2% reduction to $89.632**
  - Hospitals subject to **the 340B payment offset, the adjusted conversion factor will be $90.967**

Addendums to Rule

Addendum	Description
Addendum A	OPPS APCs for CY 2026
Addendum B	OPPS Payment by HCPCS Codes for CY 2026
Addendum C	Final HCPCS Codes Payable Under the 2026 OPPS by APC
Addendum D1	OPPS Payment Status Indicators for CY 2026
Addendum D2	OPPS Comment Indicators for CY 2026
Addendum E	HCPCS Codes that Would Be Paid Only as Inpatient Procedure for CY 2026
Addendum J	Comprehensive APCs for CY 2026
Addendum L	Final Out-Migration Adjustment for CY 2026
Addendum M	HCPCS Codes for Assignment to OPPS Composite APCs for CY 2026
Addendum N	Final Bypass List for CY 2026
Addendum O	Final Long Descriptors for new Category I CPT, Category III CPT, C-codes, and G-Codes effective January 1, 2026
Addendum P	Final Device-Intensive Procedures for CY 2026
Addendum Q	CY 2026 Final Rule Payment Rates for Drugs Qualifying for Add-on Payment to IHS and Tribal Hospitals (based on CY 2025 AIR)
Addendum R	List of Providers Subject to the Reduction to Non-Drug item and service payments due to the 340B Payment Policy Remedy

Compare Addendum “E” from 2025 to 2026

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Background

- *“The IPO list was created to identify services for which Medicare will make payment only when furnished in the inpatient hospital setting 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 post-operative 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 which are performed on an inpatient basis virtually all of the time for the Medicare population because* ***performing these procedures on an outpatient basis would not be safe or appropriate****, and therefore, not reasonable and necessary under Medicare rules”*
  - *[OPPS Final Rule – Federal Register / Vol. 90, No. 225 / Tuesday, November 25, 2025]*

Background

- *“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”*

Rationale for Change

- **Placing the decision back on the physician** – "expect in every case the surgeon and the hospital will assess the risk of a procedure or service to the individual patient, taking site of service into account, and will act in that patient's best interests"
- Advancement of medical technology and safety standards
- Parties have supported the IPO because procedures on the IPO were considered to satisfy the 2-midnight rule
- Advancement in infection control since COVID
- Increased delivery of services outside the inpatient setting – advancement in care provided in the home.

Rationale for Change

- *CMS stated "medical practice continues to develop, we believe that the difference between the need for inpatient care and the appropriateness of outpatient care will continue to be less and less distinct for many services."*
- "As stated in previous rulemaking (84 FR 61354; 82 FR 59384; 81 FR 79697),services that are no longer included on the IPO list are payable in either the inpatient or 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."

Concerns Regarding RAC Activity

- RAC have a history of reviewing the site of service and the 2 – Midnight rule resulting in frequent denial activity.
- Commenters expressed concern about moving from inpatient to outpatient status and the complexities for the providers and hospitals and the administrative burden of these changes.

CMS stated: *"…Specifically, we proposed to continue the indefinite exemption from site-of-service claim denials, referrals to Recovery Audit Contractors (RACs), and RAC reviews for "patient status" procedures that are removed from the IPO list under the OPPS beginning on January 1, 2021,as part of the transition away from the IPO list (85 FR 86120)."*

Concerns Regarding RAC Activity

- *Pursuant to this exemption, initial medical review contractors may continue to review claims for procedures previously on the IPO list to provide education for practitioners and providers regarding compliance with the 2-midnight rule, but will not deny claims identified as noncompliant with respect to the site-of Service under Medicare Part A*
- *"Regarding changes made by commercial insurance providers and site selection for outpatient services as a result of CMS 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****."*
  - *In other words, Medicare may not audit and deny but it the provider must adhere to the contract and medical guidelines of the specific payer*

Cost Sharing

- CMS does not expect increased cost sharing with the beneficiary
- They do not expect multiple APCs to be charged resulting in multiple copayments
- *The policy that the OPPS cost-sharing for an individual service is capped at the applicable Part A hospital inpatient deductible amount for that year for each service remains applicable, which is that the OPPS cost sharing for an individual service is capped at the applicable Part A hospital inpatient deductible amount for that year for each service.*
- Most of the IPO list of procedures being moved in 2026 are already included within the C-APC and a singular payment and copayment will occur

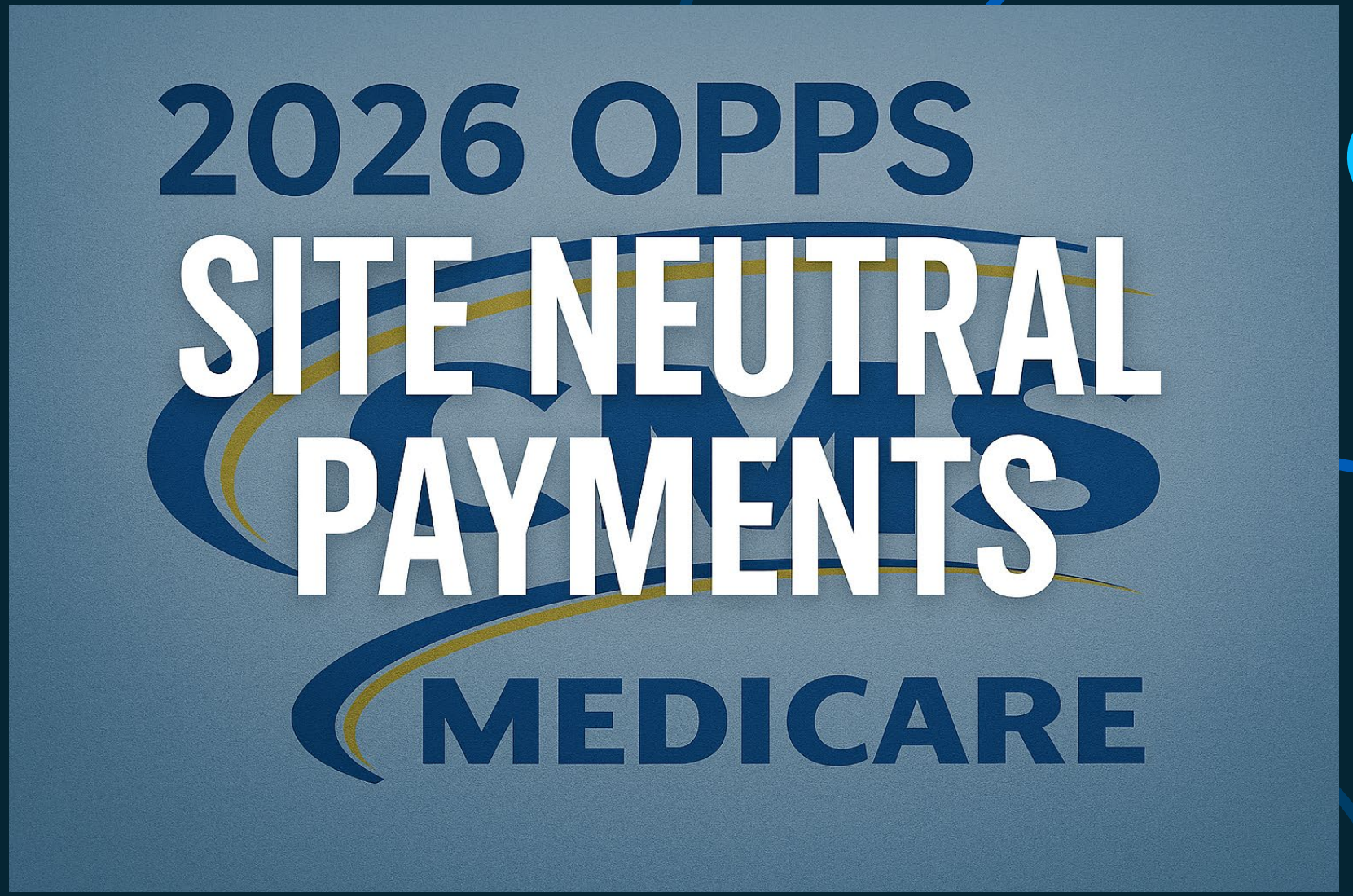
TABLE 119: FINAL PROCEDURES FOR REMOVAL FROM THE IPO LIST FOR CY 2026

- Table 119 within the Federal Register version of the Final Rule details the **285 IPO procedures being removed for 2026**.
- Providing this as an appendix to this presentation
- Example below:

HCPCS Code	Long Descriptor	Final CY 2026 SI	Final CY 2026 APC
00192	Anesthesia for procedures on facial bones or skull; radical surgery (including prognathism)	N	N/A
00474	Anesthesia for partial rib resection; radical procedures (eg, pectus excavatum)	N	N/A
00604	Anesthesia for procedures on cervical spine and cord; procedures with patient in the sitting position	N	N/A
00904	Anesthesia for; radical perineal procedure	N	N/A
0095T	Removal of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, cervical (list separately in addition to code for primary procedure)	N	N/A
0098T	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, cervical (list separately in addition to code for primary procedure)	N	N/A
01140	Anesthesia for interpelviabdominal (hindquarter) amputation	N	N/A
01150	Anesthesia for radical procedures for tumor of pelvis, except hindquarter amputation	N	N/A
01212	Anesthesia for open procedures involving hip joint; hip disarticulation	N	N/A
01232	Anesthesia for open procedures involving upper two-thirds of femur; amputation	N	N/A
01234	Anesthesia for open procedures involving upper two-thirds of femur; radical resection	N	N/A
01274	Anesthesia for procedures involving arteries of upper leg, including bypass graft; femoral artery embolectomy	N	N/A
01404	Anesthesia for open or surgical arthroscopic procedures on knee joint; disarticulation at knee	N	N/A
01634	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; shoulder disarticulation	N	N/A

Final IPO Changes

- Finalize eliminating the IPO list over the course of the next 3 years, starting with the removal of 285 mostly musculoskeletal-related services, as provided in Table 119 (Appendix Excel)
- We finalize our proposal eliminating the criteria for removing procedures from the IPO list currently codified at § 419.23, as a conforming change
- *We are also finalizing amending § 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, 2028.*



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Background Control of Costs

- *"We continued to be **concerned that beneficiaries are being driven into a higher cost setting 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 the beneficiary in the form of increased coinsurance."*
- *"Taking into account that any payment differential occurs across millions of claims for drug administration and other 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 can be performed safely in a different setting"*

Drug Administration Facts – Site Neutral

- *"We believed the **OPPS payment rate for drug administration** APCs being several times greater than the PFS rate provides this payment incentive and that the growth in drug administration services paid under the OPPS over time is unnecessary."*
- *"There was evidence that increased volume and intensity of certain covered OPD services was 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"*
- *"This site-of-service selection had an impact on not only the Medicare program, but also on **Medicare beneficiary out-of-pocket spending**"*
- For CY 2026, the estimated savings are $290 million, with $220 million of the savings accruing to Medicare, and **$70 million saved by Medicare beneficiaries in the form of reduced beneficiary coinsurance**.

Drug Administration Facts – Site Neutral

- Final rule presents a number of commenter legal challenges to the authority to make the volume adjustments.
- Ultimately CMS continues to show the growth in OPD departments for APCs related to drug administrations.
  - Demonstrated CPT 96413 has had a 70% growth from 2011-2023 in the OPD.
  - Rate for physician office in 2025 was $119 but in OPD under OPPS was $341
  - Increased cost to the programme and the beneficiary
  - Commenters challenged every assumption !
- Focus on continued vertical integration of physician services into hospital systems as a cause of steering toward OPD. CMS stated ***"There continues to be a link between integration and increased costs."***

Other Facts – Site Neutral

- Focus on continued vertical integration of physician services into hospital systems as a cause of steering toward OPD. CMS stated "*There continues to be a link between integration and increased costs.*"
- Studies show that hospitals newly participating 340B compared to non-participating led to a higher volume of drug administration in off-campus OPDs.
- Rural Sole Community Hospital **will be excluded** from site-specific PFS equivalent payment for drug administration services when furnished at an off-campus PBD exempted. – They need to continue to bill with the PO modifier.

Final Decision

- CMS is finalizing their 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 nonexcepted items and services furnished by a nonexcepted off campus
- PBD (the PFS payment rate) for 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) without modification
- Rural Sole Community Hospital is excluded form the off-campus clinic visit policy currently and will be excluded for drug administration APCs

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Background

- Direct supervision through virtual methodology has been around but solidified under the Public Health Emergency (PHE)
- For 2026, CMS proposed to revise the definition of direct supervision to make permanent the availability of virtual direct supervision of therapeutic and diagnostic service under the Physician Fee Schedule
- Note: CMS recommended that the virtual direct supervision not apply to those services with a global surgery indicator of 10 or 90
- CMS proposal was also due to the desire for uniformity under the Physician Fee Schedule and the OPPS methodology.
- *CMS stated: "The physician or nonphysician practitioner should use his or her complex professional judgment to determine the appropriate supervision modality on a case-by-case basis." – indicating audio-visual modality may not always be appropriate*

Final Virtual Supervision

- *"After consideration of the public comments we received, we are finalizing, without modification, our proposal to revise § 410.27(a)(1)(iv)(B)(1) and § 410.28(e)(2)(iii) to make the availability of the direct supervision of CR, ICR, PR services and diagnostic services via audio-video real-time communications technology (excluding audio-only) permanent,* ***except*** *for diagnostic services that have a global surgery indicator of 010 or 090."*

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Skin Substitutes

- In 2026 all existing HCPCS codes describing skin substitutes will be assigned to **S1 status indicator**.
- Finalized policy to **separately pay** for the provision of certain groups of substitute products as supplies when they are used during covered application procedure.
- 3 new APCs for HCPCS codes that describe products
- Will divide substitutes by FDA regulatory pathway
- APC are:
  - APC 6000 (PMA), 6001(510(k) and 6002(361 HCT/P)
  - Initial payment rate of $127.14 / cm^2
  - Policy is non-facility, ambulatory surgery and outpatient hospital setting

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Background & Prior Rule Making

- The Exclusion of Non-Opioid Products for Pain Relief under Section 4135 of the Consolidated Appropriations Act, 2023 from the C-APC Policy
- This exclusion removes non-opioid products from the packaging methodology and results in separate payment.
- *Section1833(t)(16)(G) 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*
- Finalized in 2025 that payment shall not be bundled into a C-APC
- For 2026, finalized that payment shall be made separately and not packaged into C-APC

Add-on Payment for Technetium-99m (Tc-99m) Derived from Domestically Produced Molybdenum-99 (Mo-99)

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Background

- *“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”*
- This provision expired in 2025 and it was thought that costs were not equal to that produced internationally. Therefore, the additional payment was no longer needed.
- Research demonstrated that international sources were highly subsidized by governments and resulted in prices below true cost due to the subsidy
- CMS et al, recognized that the new information did raise concerns about domestically produced radioisotope being more costly to utilize

2026 Rule

- 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
- Will develop technical implementation guidelines and documentation requirements, as previously done with the prior add-on payment.
- Provide transparency and clarity to the providers
- *"Additionally, DOE/NNSA recommended, and we proposed 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 eluted111 at a radiopharmacy in the U.S."*

2026 Rule

- New **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.
- CMS stated that hospitals could report new HCPCS C-code C9176 once per dose, along with any diagnostic scan or scans furnished using Tc-99m derived from domestically produced Mo-99, if they could certify that at least 50 percent of the Mo-99 in the Tc-99m generator to produce the Tc-99m was domestically produced Mo-99.
- CMS stated: *"We find that $10 remains an appropriate estimate of the incremental per-dose cost for Tc-99m derived from domestically produced Mo-99 given the uncertainties of the true cost of Tc-99m derived from domestically produced Mo-99 at this time."*

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Background

- Key Regulations:
  - *Section 1001 of the Patient Protection and Affordable Care Act*
  - *Amended by section 10101 of the Health Care and Education Reconciliation Act of 2010*
  - *Amended Title XXVII of the Public Health Service Act (the PHS Act), in part, by adding a new section 2718(e). Section 2718 of the PHS Act, entitled "Bringing Down the Cost of Health Care Coverage"*
- Requirements:
  - *Requires each hospital operating within the United States for each year to establish and update, and make public a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups*

Background

- 2020:
  - *Adopted requirements for hospitals to make public their standard charges in two ways:*
  - *(1) as a comprehensive machine-readable file (MRF); and*
  - *(2) in a consumer-friendly format.*
- 2022:
  - *(1) increased the penalty amount for noncompliance through the use of a scaling factor based on hospital bed count;*

Background

- 2022 (continued):
  - *“(2) deemed state forensic hospitals that meet certain requirements to be in compliance with the requirements of 45 CFR part 180; and (3) prohibited certain actions that we concluded were barriers to accessing the standard charge information, including prohibiting hospitals from designing their MRFs so as to make them inaccessible to automated searches and direct downloads.”*
- 2024:
  - *“Revised several HPT requirements to improve access to, and the usability of, hospital standard charge information; standardize the way hospital charges are presented; align, where feasible, certain HPT requirements and processes with requirements in the Transparency in Coverage (TiC)initiative; and strengthen and streamline our monitoring and enforcement capabilities.”*

Background

- February 2025
  - Executive Order called "*Making America Healthy Again by Empowering Patients with Clear, Accurate, and Actionable Healthcare Pricing Information*." This has 3 directives:
    - Require disclosure of actual prices of items and services, not estimates;
    - Ensure pricing information is standardized and easily comparable across hospitals and health plans; and
    - Update their enforcement policies designed to ensure compliance with transparent reporting of complete, accurate, and meaningful data.

Final 2026 Price Transparency

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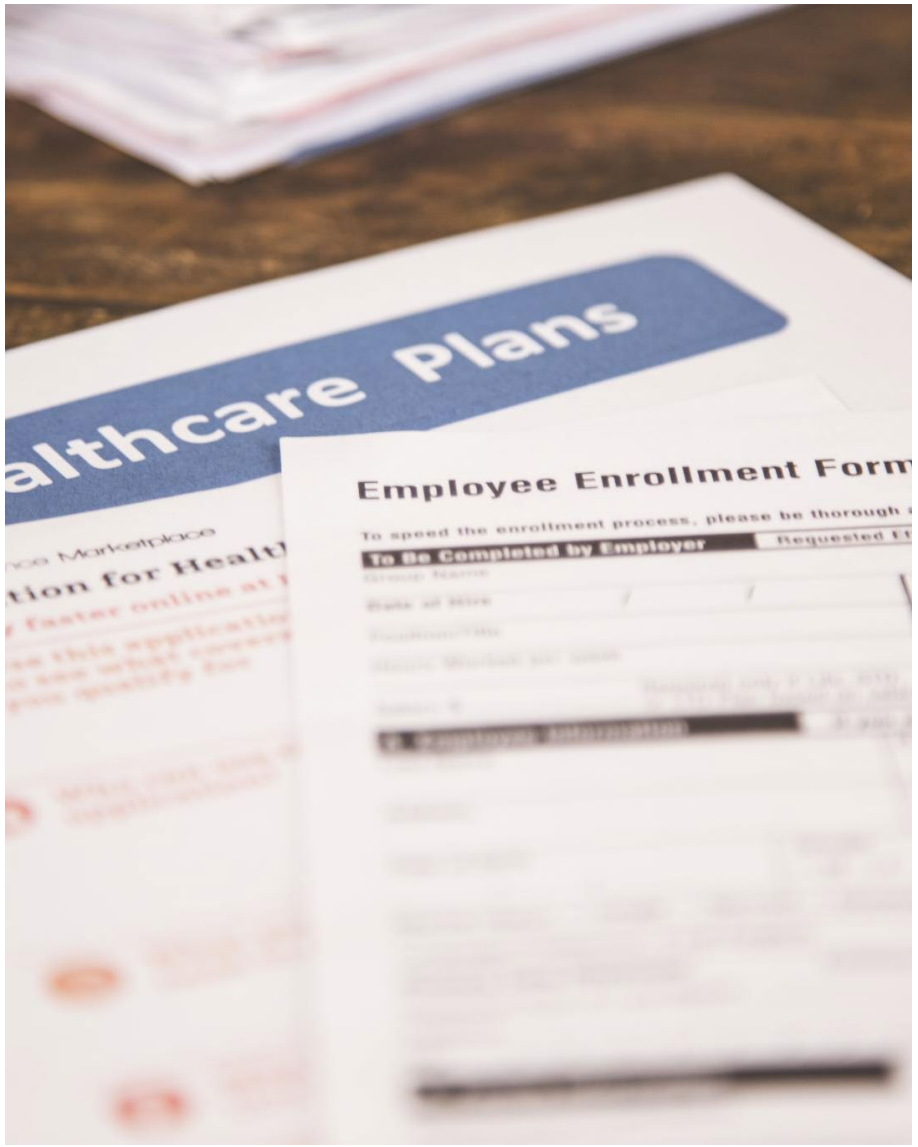

Summary of Revisions

Revised Pricing Data Standards

CMS updated machine-readable file structure to enhance clarity and accuracy of hospital pricing information.

Updated Disclosure and Attestation

New disclosure requirements and attestation standards improve data integrity and public trust.

Compliance and Enforcement

Policies introduce enforcement timelines and penalties to ensure timely and accurate implementation by hospitals.

Goal of Transparency

Revisions aim to increase healthcare pricing transparency to support informed patient decisions and reduce confusion.

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New Definitions and Requirements Allowed Amount Calculations Standardized Percentile Metrics

CMS defines **10th, median, and 90th percentile** allowed amounts to standardize payment disclosures.

Replacement of Estimated Amounts

Percentile-based disclosures replace estimated allowed amounts to improve precision and consistency.

Accurate Calculation Requirements

Hospitals must calculate metrics based on historical remittance data using CMS methodologies.

Enhanced Transparency and Comparability

New requirements provide clearer, reliable representations of negotiated rates for stakeholders.

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Disclosure Elements- MRF

Required Data Elements

Hospitals must report the 10th, median, and 90th percentile allowed amounts plus the count used to calculate these values.

Accuracy of Data

Reported data must reflect actual remittance experiences within the lookback period, eliminating estimated values.

Regulatory Compliance

Standardizing disclosures creates a framework for comparison across hospitals, ensuring compliance with CMS regulations.

Consequences of Non-Compliance

Hospitals risk enforcement actions and penalties if they fail to provide complete and accurate disclosure information.

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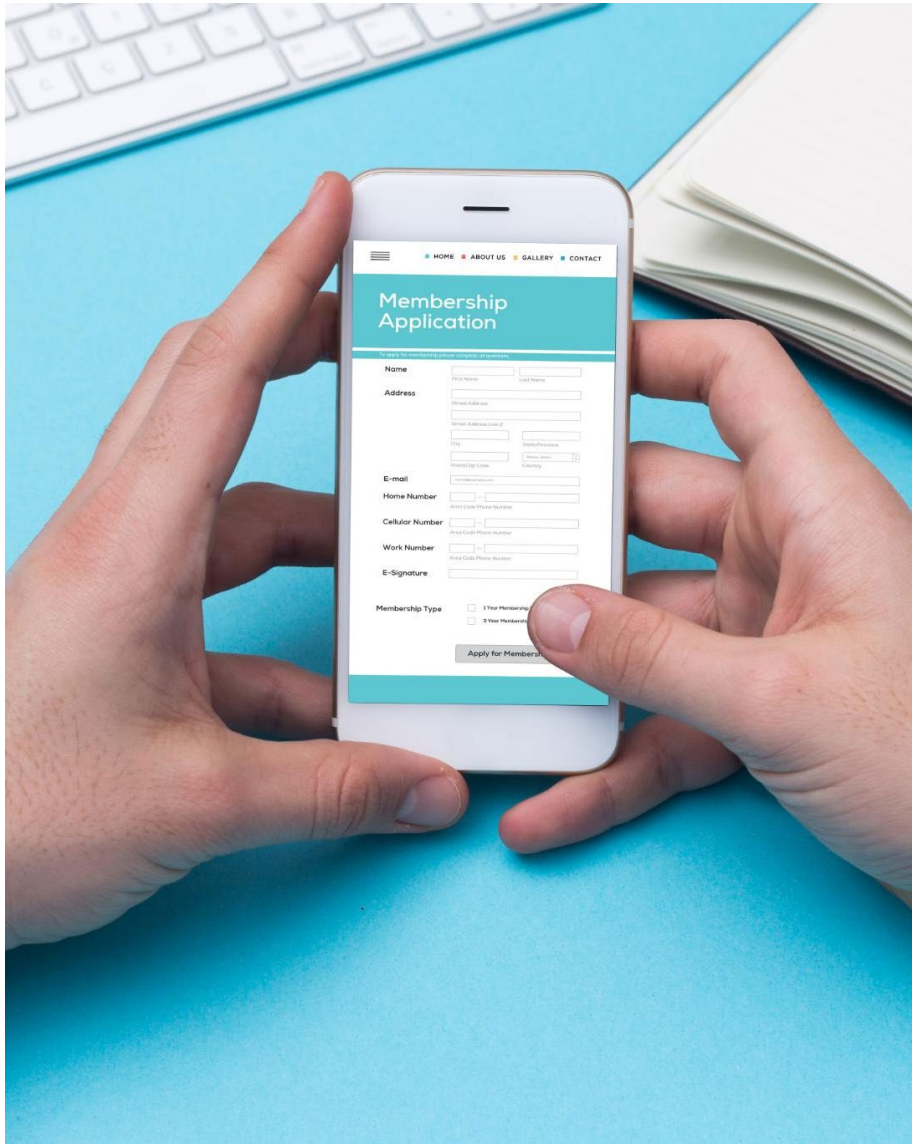

Required data sources - Use of EDI 835 ERA Data

Accurate Allowed Amount Calculations

Hospitals must use EDI 835 ERA data to ensure allowed amounts are calculated based on actual payment data, not estimates.

CMS Compliance and Methodologies

Hospitals must follow CMS guidelines including lookback periods and standardized calculation instructions for consistency.

Data System Assessment

Hospitals should evaluate their data systems and workflows to ensure proper extraction and processing of remittance data.

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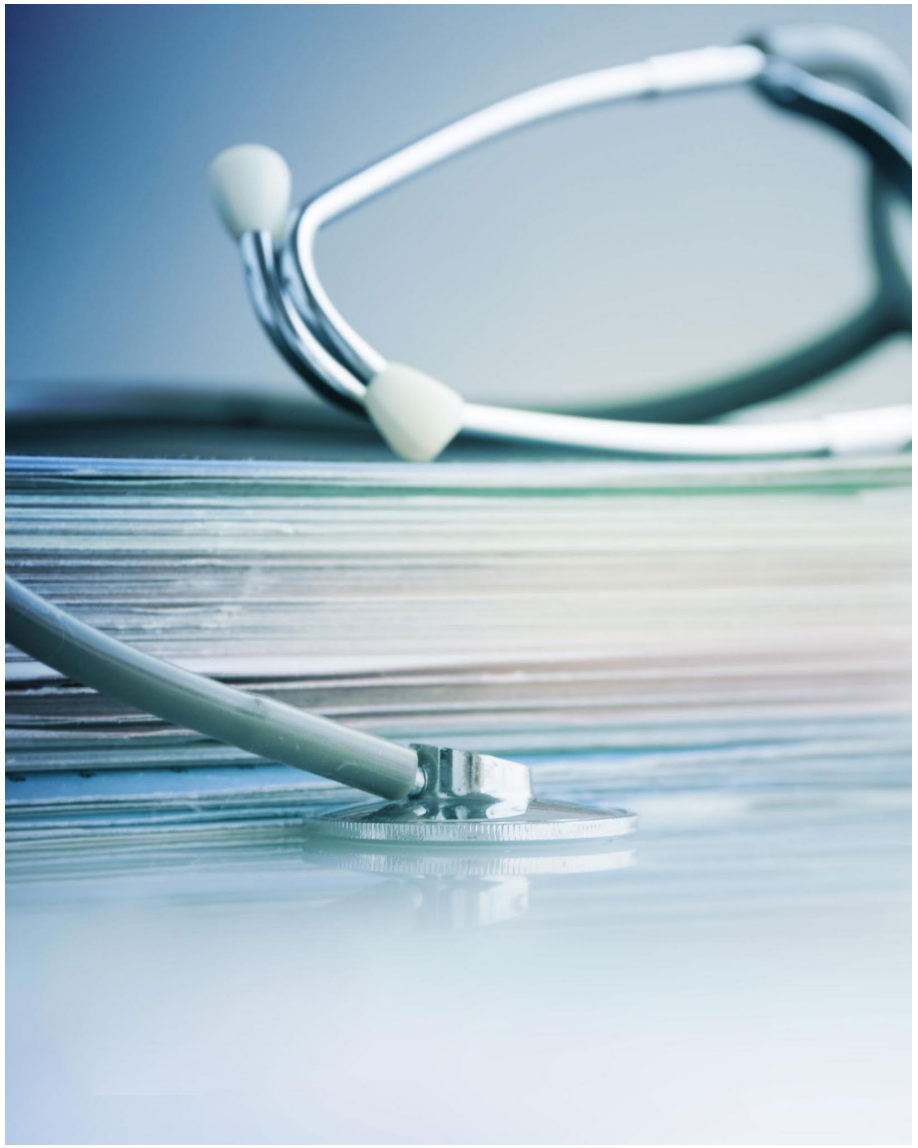

Hospital Responsibilities for Attestation

Attestation of Charge Data

Hospitals must confirm all standard charge information is accurate and complete in the machine-readable file.

Disclosure of Negotiated Charges

Hospitals must include all payer-specific negotiated charges that can be expressed as dollar amounts.

Transparency for Non-Standard Charges

Hospitals must provide fee schedules, formulas, or algorithms for charges not expressible as fixed dollar amounts.

Accountability and Compliance

Attestations ensure hospital accountability; non-compliance can lead to enforcement actions and penalties.

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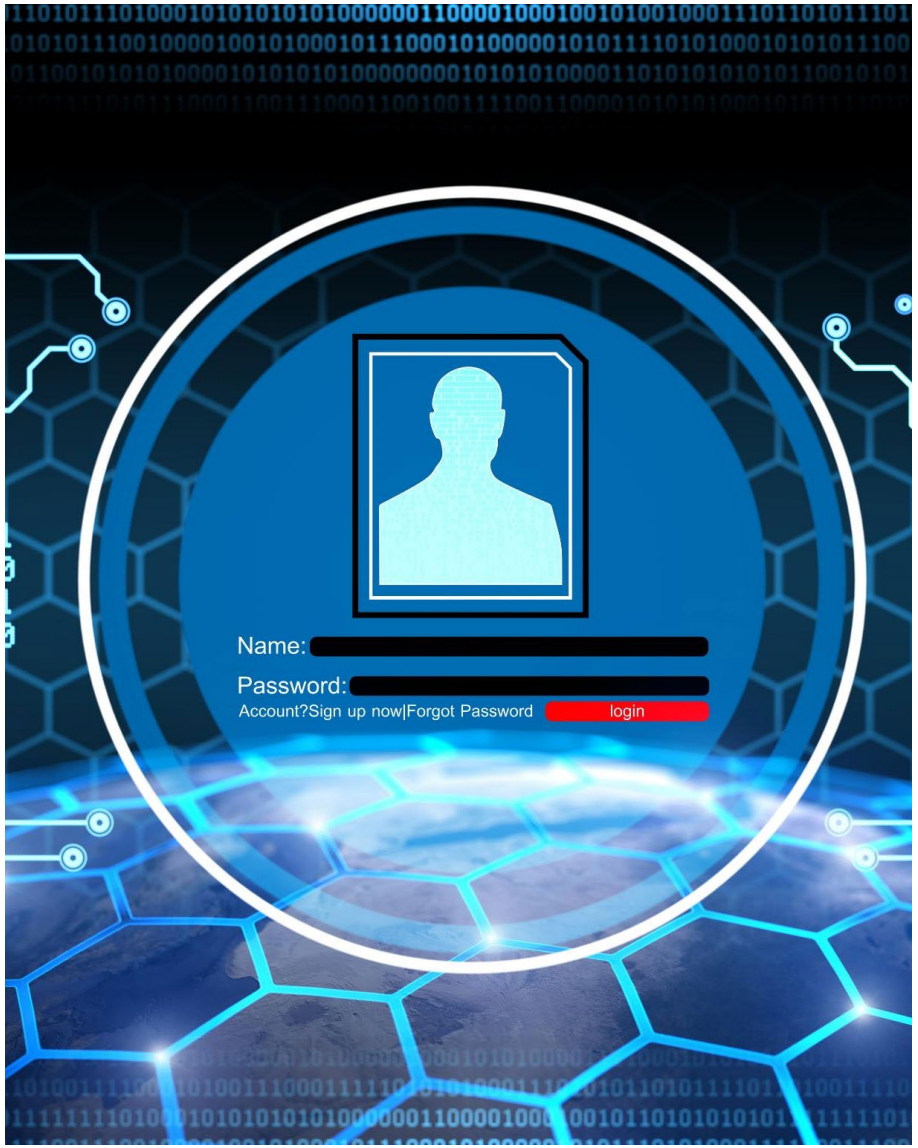

Executive Oversight and NPIs

Executive Accountability

Hospitals must include the name of the CEO, president, or senior official in the MRF to ensure data accuracy and responsibility.

Use of National Provider Identifier

Hospitals must include their organizational Type 2 NPI in the MRF to enable comparison with other healthcare datasets.

Strengthening Data Governance

These measures promote transparency and strengthen governance by clearly identifying responsible individuals and entities.

Verification Processes

Hospitals should establish processes to verify the accuracy and currency of identifiers included in the MRF.

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Penalty Reduction Policy

Policy Overview

CMS allows a **35% reduction in civil monetary penalties for hospitals admitting HPT violations and waiving ALJ hearings**.

Eligibility Criteria

Hospitals must admit non-compliance and **waive their right to an Administrative Law Judge hearing** to qualify for the penalty reduction.

Purpose and Implications

The policy aims to speed compliance resolution and reduce administrative burdens, requiring consideration of admitting violations.

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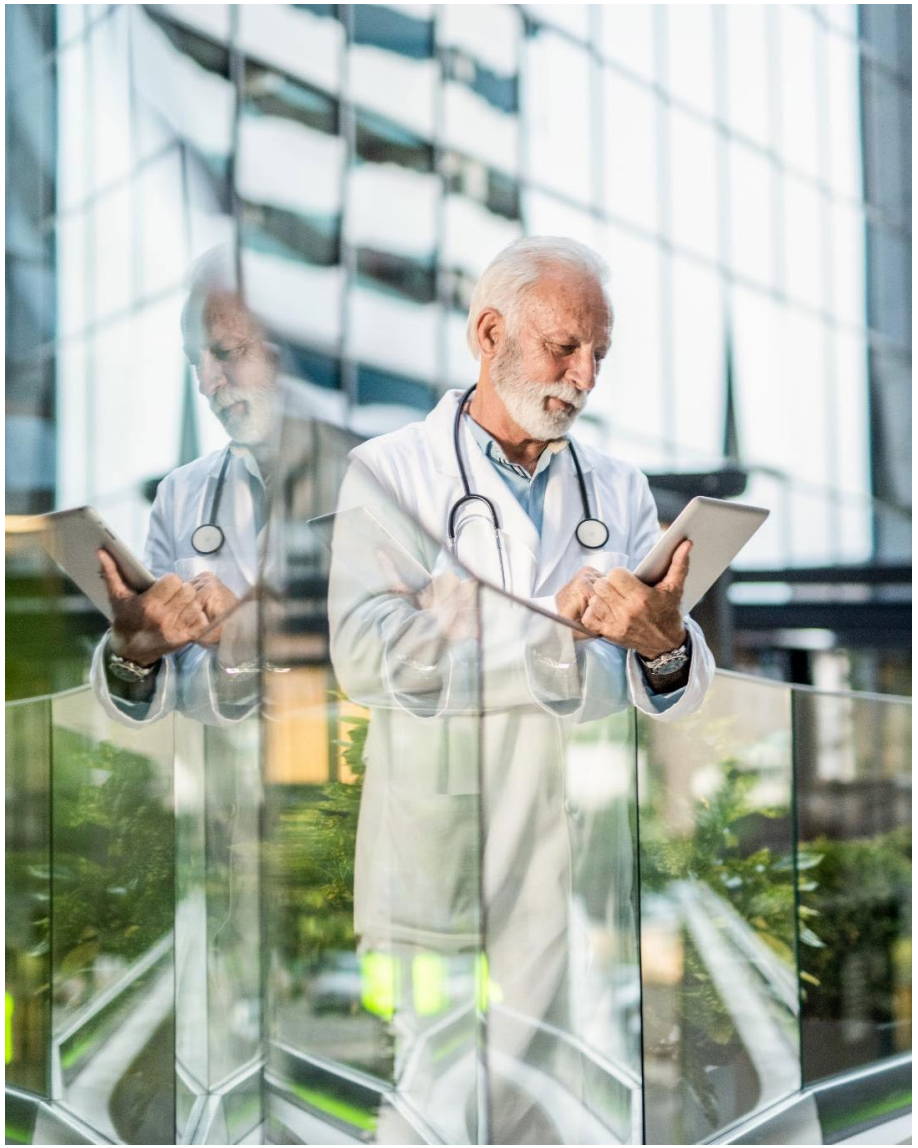

Summary of Compliance Priorities

Standardized Pricing Transparency

HPT policies enforce percentile-based transparency, **shifting from estimates to remittance-based hospital pricing data**.

New Compliance Measures

Hospitals must implement attestation, accountability protocols, and organizational identifiers in disclosures.

Readiness and Enforcement Timeline

Enforcement begins April 1, 2026; hospitals should focus on system upgrades, training, and audits for compliance readiness.

Consumer Empowerment

Enhanced transparency and data comparability empower consumers to make informed healthcare decisions.

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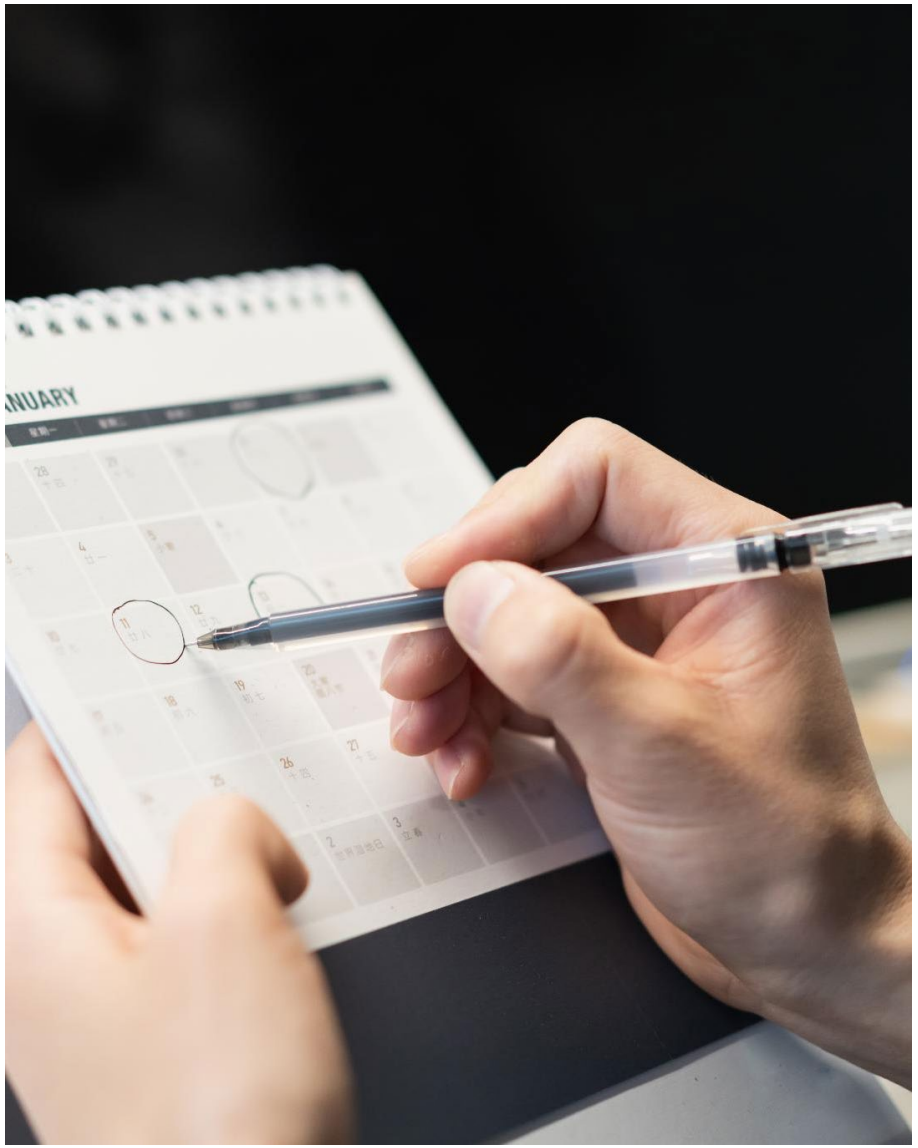

Implementation Timeline

Policy Effective Date

Finalized policies take effect January 1, 2026, giving hospitals time to prepare for compliance.

Enforcement Delay

CMS will **delay enforcement until April 1, 2026**, allowing a phased rollout.

Hospital Preparation

Hospitals should use this period to make system changes, train staff, and validate data accuracy.

Compliance Gap Assessment

Conduct readiness assessments and address gaps to avoid penalties after enforcement begins.

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Hospital Outpatient Quality Reporting (OQR)& Rural Emergency Hospital Quality Reporting (REHQR), Programs

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Cross Program Updates for 2026

- Finalizing **removal** of the Hospital Commitment to Health Equity (HCHE) measure from the Hospital OQR and REHQR Programs, and the Facility Commitment to Health Equity (FCHE) measure from the ASCQR Program, effective CY 2025 reporting period / CY 2027 payment or program determination.
- Finalizing **removal** of the Screening for Social Drivers of Health (SDOH) measure and the Screen Positive Rate for SDOH measure from the Hospital OQR, REHQR, and ASCQR Programs, effective CY 2025 reporting period.
- Acknowledging stakeholder comments on well-being and nutrition measure concepts for potential future consideration in the Hospital OQR, REHQR, and ASCQR Programs.
- Finalizing updates to the Extraordinary Circumstance Exception (ECE) policy to clarify CMS's discretion to grant extensions in response to ECE requests for the Hospital OQR, REHQR, and ASCQR Programs.

Hospital Outpatient Quality Reporting 2026 Changes

Policy Change	Measure(s)	Reporting Requirement	Effective Timeline
Adoption of Emergency Care Access & Timeliness eCQM	Emergency Care Access & Timeliness eCQM	Voluntary → Mandatory	Voluntary: CY 2027 Mandatory: CY 2028 (CY 2030 payment determination+)
Removal of ED Throughput Measures	• Median Time from ED Arrival to ED Departure (Discharged Patients) • Left Without Being Seen	Removed from program	CY 2028 reporting period (CY 2030 payment determination)
Modification of Excessive Radiation eCQM	Excessive Radiation Dose or Inadequate Image Quality for Diagnostic CT in Adults (Hospital Outpatient)	Remains voluntary	CY 2027 and subsequent years

Rural - Background: Emergency Care Access & Timeliness (ECAT) eCQM

Background: Emergency Care Access & Timeliness (ECAT) eCQM

Why it matters

- Timely emergency care is linked to:
  - Improved patient outcomes
  - Reduced overcrowding
  - Better patient experience

Why CMS is adopting it

- Supports national priorities around:
  - Emergency department throughput
  - Access to care in rural and underserved communities
  - Increased use of standardized, electronically reported quality measures

Rural - Background: Emergency Care Access & Timeliness (ECAT) eCQM

Why flexibility is included

- Recognizes variability in:
  - Rural ED volumes
  - EHR capabilities
  - Operational readiness
- Allows REHs to transition at a sustainable pace

Rural Hospital New Additions

- **New eCQM finalized**
  - *Emergency Care Access & Timeliness (ECAT) eCQM*
- **First applicable reporting period**
  - **CY 2027**
- **Program determination year**
  - **CY 2029**
- **Focus of the new measure**
  - Timely access to emergency care
  - Efficiency of emergency department patient flow

Rural Hospital - Changes

REHQR Reporting Requirements

- **Updated eCQM submission and reporting requirements**
- **New reporting flexibility beginning CY 2027**
  - REHs may report **one of the following**:
    - *Emergency Care Access & Timeliness (ECAT) eCQM*, **or**
    - *Median Time from ED Arrival to ED Departure for Discharged ED Patients*
- **Continued alignment**
  - Cross-program quality measure and policy updates

Overall Hospital Quality Star Rating Modification

- Purpose
  - Update the Overall Hospital Quality Star Rating to emphasize Safety of Care
  - **Prevent** hospitals from receiving high ratings despite poor safety performance
- Impact
  - **Safety of Care becomes a key driver** of overall hospital ratings
  - Aligns Star Ratings more closely with patient and workforce safety outcomes

Overall Hospital Quality Star Rating Modification

- Rationale
  - Addresses cases where hospitals ranked in the lowest safety quartile still achieved high Star Ratings
  - Reinforces CMS's commitment to high-quality, safe care as a core measure of performance

Stages

Stage 1: Transitional Update (2026 Star Ratings)

- Applies to hospitals in the **lowest quartile of Safety of Care**
- Requires **at least three Safety of Care measure scores**
- Limits hospitals to a **maximum of 4 stars**
- Prevents 5-star ratings when safety performance is poor

Stage 2: Full Implementation (2027 and Beyond)

- Replaces the transitional methodology
- Hospitals in the lowest Safety of Care quartile receive a **1-star reduction**
- Minimum possible rating: **1 star**
- Establishes safety as a **foundational requirement** for high ratings

Conduct a Medicare OPPS Drugs Acquisition Cost Survey

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Statutory & Regulatory Background

- Statutory Authority:
  - Section 1833(t)(14)(D)(ii) of the Social Security Act requires HHS to periodically survey hospital acquisition costs for specified OPPS outpatient drugs
- Payment Purpose:
  - Survey data support setting Medicare OPPS payment rates for separately payable outpatient drugs
- Executive Order 14273: Signed April 18, 2025, “Lowering Drug Prices by Once Again Putting Americans First”
- E.O. Direction:
  - Section 5 directs HHS to publish a Federal Register plan to survey hospital outpatient drug acquisition costs

Survey Scope, Timing, and Policy Use

- Scope:
  - Acquisition costs for all separately payable covered outpatient drugs acquired by OPPS hospitals
- Timing:
  - Survey submission window expected to open by early CY 2026
- Policy Use:
  - Results will inform OPPS and ASC drug payment policy
- Rulemaking Impact:
  - Data intended to support CY 2027 OPPS/ASC proposed rule development

The exemptions

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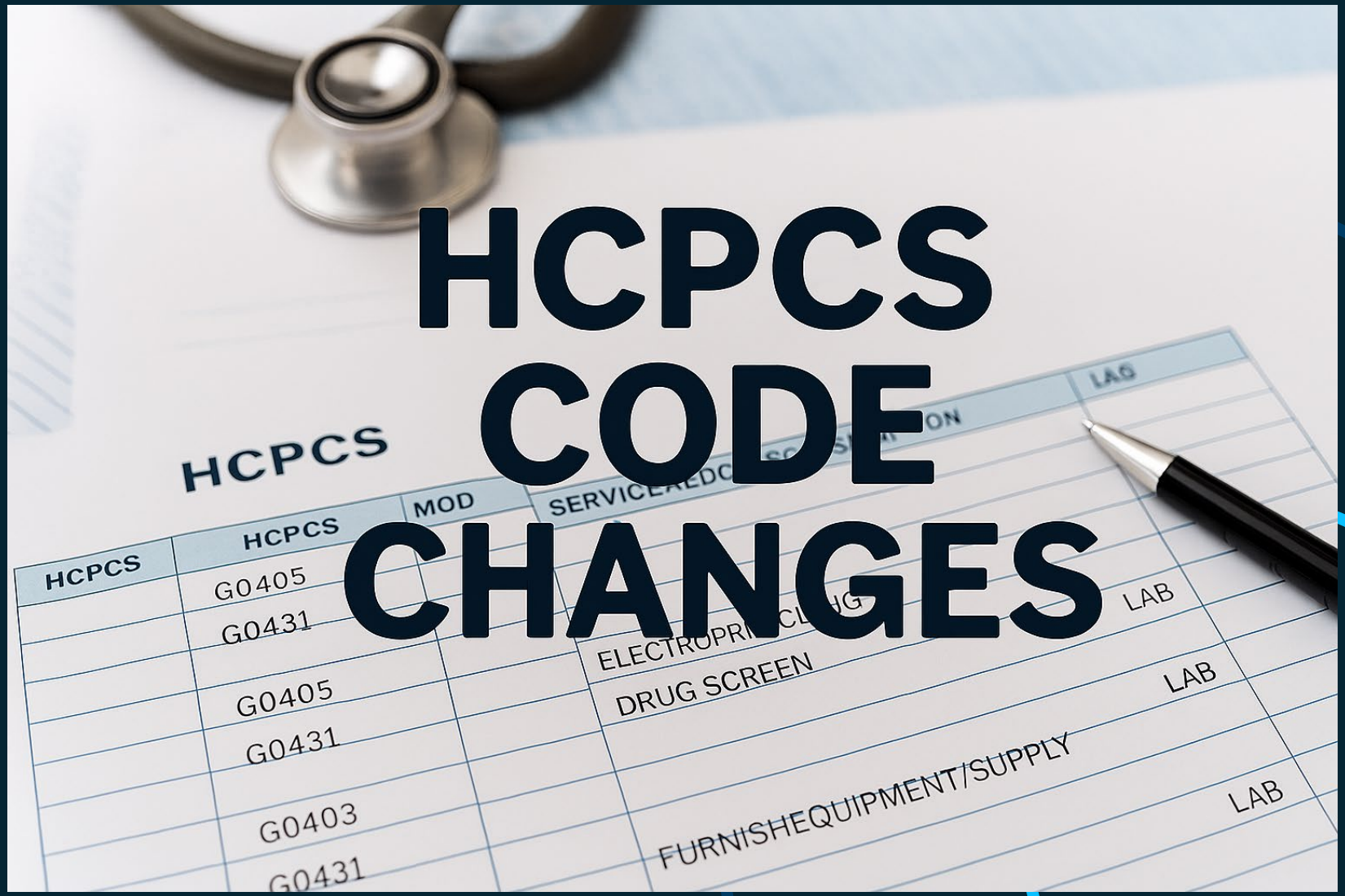
Two Midnight Rule Exemptions

- *Continuing existing policy exempting procedures that are removed from the IPO list under the OPPS from certain medical review activities related to the two-midnight policy.*
- *Under this policy, procedures removed from the IPO list are exempted:*
  - *From site-of-service claim denials,*
  - *Medicare review contractor referrals to the Recovery Audit Contractor (RAC) for persistent noncompliance with the 2-midnight rule, and RAC reviews for "patient status" (that is, site-of service)until claims data demonstrates that the procedures are more commonly billed in the outpatient setting than the inpatient setting.*
  - *Revising 42 CFR 412.3(d)(2) for clarity*



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2026 Overview

- **160** Additions for 2026
- **95** Deletions
- **294** Changes or Revisions

“C” HCPCS Code Additions

Code	Short Description	Full Description
C1607	Neurostim integ rechg	Neurostimulator, integrated (implantable), rechargeable with all implantable and external components including charging system
C1608	Prosthesis, dual mob cmc1	Prosthesis, total, dual mobility, first carpometacarpal joint (implantable)
C7566	Fuse finger joints w/grafts	Arthrodesis, interphalangeal joints, with or without internal fixation, with autografts
C7567	Bronch/needle bx(s) w/ nav	Bronchoscopy with transbronchial needle aspiration biopsy and computer-assisted navigation

“C” HCPCS Code Additions

Code	Short Description	Full Description
C7568	Cor angio w/flow resrv	Coronary angiography with intravascular doppler or pressure-derived coronary flow reserve
C7569	Ptca w/ ivus or oct	Percutaneous transluminal coronary angioplasty with IVUS or OCT
C7570	Cor angio w/ffr & 3d map	Coronary angiography with FFR and 3D functional mapping
C7571	Pcta w/ cor lithotrip	Percutaneous transluminal coronary angioplasty with coronary lithotripsy

“C” HCPCS Code Additions

Code	Short Description	Full Description
C9176	Dom nonheu tc99m add-on/dose	Tc-99m from domestically produced non-HEU Mo-99 add-on
C9307	Inj linvoseltamab-gcpt 1 mg	Injection, linvoseltamab-gcpt, 1 mg
C9308	Inj, carboplatin (avyxa)	Injection, carboplatin (avyxa), 1 mg
C9810	Cold therapy non-opioid dev	Water circulating motorized cold therapy device

“C” HCPCS Code Additions

Code	Short Description	Full Description
C9811	Elec amb pmp nonopioid dev	Electronic ambulatory infusion pump
C9812	Echgnc nv ndls nonopioid dev	Echogenic nerve block needles
C9813	Prf infs cth nonopioid dev	Perforated continuous infusion catheter set
C9814	Echognc cathr nonopioid dev	Continuous anesthesia echogenic conduction catheter set

“C” HCPCS Code Additions

Code	Short Description	Full Description
C9815	Peristlc pmp nonopioid dev	Linear peristaltic pain management infusion pump
C9816	Pmp prs reusbl nonopioid dev	Rotary peristaltic reusable infusion pump
C9817	Crypnm cmprs nonopioid dev	Electronic cryo-pneumatic compression pain management system

“G” HCPCS Code Additions

G Code	Short Description	Long Description
G0568	Int psych care mng, 1 cal mo	Initial psychiatric collaborative care management, in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional, initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan, review by the psychiatric consultant with modifications of the plan if recommended, entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant, and provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies (list separately in addition to the advanced primary care management code)

“G” HCPCS Code Additions

G0569	Subs psych care mng, subs mo	Subsequent psychiatric collaborative care management, in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: tracking patient follow-up and progress using the registry, with appropriate documentation, participation in weekly caseload consultation with the psychiatric consultant, ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers, additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant, provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies, monitoring of patient outcomes using validated rating scales, and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment (list separately in addition to advanced primary care management code)

“G” HCPCS Code Additions

G Code	Short Description	Long Description
G0660	Team remote e/m new pt 10 mn	Team remote e/m new pt 10 mins
G0661	Team remote e/m new pt 20 mn	Team remote e/m new pt 20 mins
G0662	Team remote e/m new pt 30 mn	Team remote e/m new pt 30 mins
G0663	Team remote e/m new pt 45 mn	Team remote e/m new pt 45 mins

“G” HCPCS Code Additions

G Code	Short Description	Long Description
G0664	Team remote e/m new pt 60 mn	Team remote e/m new pt 60 mins
G0665	Team remote e/m est pt 10 mn	Team remote e/m est pt 10 mins
G0666	Team remote e/m est pt 15 mn	Team remote e/m est pt 15 mins
G0667	Team remote e/m est pt 25 mn	Team remote e/m est pt 25 mins

“G” HCPCS Code Additions

G Code	Short Description	Long Description
G0668	Team remote e/m est pt 40 mn	Team remote e/m est pt 40 mins
G9871	Bhv couns dm prev, onln 60 m	Behavioral counseling for diabetes prevention, online, 60 minutes

“G” HCPCS Code Additions

G Code	Short Description	Long Description
G0668	Team remote e/m est pt 40 mn	Team remote e/m est pt 40 mins
G9871	Bhv couns dm prev, onln 60 m	Behavioral counseling for diabetes prevention, online, 60 minutes

“J” Code Additions

J Code	Short Description	Long Description
J0013	Esketamine, nasal spray	Esketamine, nasal spray, 1 mg
J0162	Inj epinephrine (fresenius)	Injection, epinephrine (fresenius), not therapeutically equivalent to j0165, 0.1 mg
J0654	Inj, liothyronine, 1 mcg	Injection, liothyronine, 1 mcg
J1073	Testosterone pellet 75 mg	Testosterone pellet, implant, 75 mg
J1736	Inj meloxicam (delova) 1mg	Injection, meloxicam (delova), 1 mg
J1737	Inj meloxicam (azurity) 1mg	Injection, meloxicam (azurity), 1 mg
J1837	Inj, posaconazole, 1 mg	Injection, posaconazole, 1 mg
J2516	Inj, pentamidine isethionate	Injection, pentamidine isethionate, 1 mg

“J” Code Additions

J Code	Short Description	Long Descripton
J2596	Vasopressin (long grove) 1 u	Injection, vasopressin (long grove), not therapeutically equivalent to j2598, 1 unit
J2711	Inj neostigmin/glycopyrrolat	Injection, neostigmine methylsulfate 0.1 mg and glycopyrrolate 0.02 mg
J3291	Tranexamic acid in sod chlor	Injection, tranexamic acid in sodium chloride, 5 mg
J3376	Inj vancomycin (hikma) 10mg	Injection, vancomycin hcl (hikma), not therapeutically equivalent to j3373, 10 mg
J3379	Inj, valproate sod, 5 mg	Injection, valproate sodium, 5 mg
J3387	Inj elivaldogene autotemecel	Injection, elivaldogene autotemcel, per treatment
J3389	Topi adm prad zami per treat	Topical administration, prademagene zamikeracel, per treatment
J7299	Intraut copp cont (miudella)	Intrauterine copper contraceptive (miudella)
J7528	Mycophen mofetil for susp	Mycophenolate mofetil, for suspension, oral, 100 mg
J9184	Inj gemcitabin (avyxa) 200mg	Injection, gemcitabine hydrochloride (avyxa), 200 mg
J9256	Inj, nipocalimab-aahu, 3 mg	Injection, nipocalimab-aahu, 3 mg
J9282	Mitomycin intravesical inst	Mitomycin, intravesical instillation, 1 mg
J9326	Telisotuzumab vedotin-tllv	Injection, telisotuzumab vedotin-tllv, 1 mg

“Q” Code Additions

Q Code	Short Description	Long Description
Q4398	Summit ac per sq cm	Summit ac, per square centimeter (add-on, list separately in addition to primary procedure)
Q4399	Summit fx per sq cm	Summit fx, per square centimeter (add-on, list separately in addition to primary procedure)
Q4400	Polygon3 per sq cm	Polygon3 membrane, per square centimeter (add-on, list separately in addition to primary procedure)
Q4401	Absolv3 per sq cm	Absolv3 membrane, per square centimeter (add-on, list separately in addition to primary procedure)
Q4402	Xwrap 2.0 per sq cm	Xwrap 2.0, per square centimeter (add-on, list separately in addition to primary procedure)
Q4403	Xwrap dual plus per sq cm	Xwrap dual plus, per square centimeter (add-on, list separately in addition to primary procedure)

“Q” Code Additions

Q Code	Short Description	Long Description
Q4404	Xwrap hydro plus per sq cm	Xwrap hydro plus, per square centimeter (add-on, list separately in addition to primary procedure)
Q4405	Xwrap fenestra plus sq cm	Xwrap fenestra plus, per square centimeter (add-on, list separately in addition to primary procedure)
Q4406	Xwrap fenestra per sq cm	Xwrap fenestra, per square centimeter (add-on, list separately in addition to primary procedure)
Q4407	Xwrap tribus per sq cm	Xwrap tribus, per square centimeter (add-on, list separately in addition to primary procedure)
Q4408	Xwrap hydro per sq cm	Xwrap hydro, per square centimeter (add-on, list separately in addition to primary procedure)
Q4409	Amniomatrixf3x per sq cm	Amniomatrixf3x, per square centimeter (add-on, list separately in addition to primary procedure)

“Q” Code Additions

Q Code	Short Description	Long Description
Q4410	Amchomatrixdl per sq cm	Amchomatrixdl, per square centimeter (add-on, list separately in addition to primary procedure)
Q4411	Amniomatrixf4x per sq cm	Amniomatrixf4x, per square centimeter (add-on, list separately in addition to primary procedure)
Q4412	Choriofix per sq cm	Choriofix, per square centimeter (add-on, list separately in addition to primary procedure)
Q4413	Cygnus solo per sq cm	Cygnus solo, per square centimeter (add-on, list separately in addition to primary procedure)
Q4414	Simplichor per sq cm	Simplichor, per square centimeter (add-on, list separately in addition to primary procedure)
Q4415	Alexiguard st-l per sq cm	Alexiguard sl-t, per square centimeter (add-on, list separately in addition to primary procedure)

“Q” Code Additions

Q Code	Short Description	Long Description
Q4416	Alexiguard tl-t per sq cm	Alexiguard tl-t, per square centimeter (add-on, list separately in addition to primary procedure)
Q4417	Alexiguard dl-t per sq cm	Alexiguard dl-t, per square centimeter (add-on, list separately in addition to primary procedure)
Q4420	Nuform per sq cm	Nuform, per square centimeter (add-on, list separately in addition to primary procedure)
Q4431	Pma skin substitute, nos	Pma skin substitute product, not otherwise specified (list in addition to primary procedure)
Q4432	510(k) skin subs, nos	510(k) skin substitute product, not otherwise specified (list in addition to primary procedure)
Q4433	361 hct/p skin subs, nos	361 hct/p skin substitute product, not otherwise specified (list in addition to primary procedure)
Q5160	Inj, jobevne, 10 mg	Injection, bevacizumab-nwgd (jobevne), biosimilar, 10 mg

Deletions and Changes

- These are provided in an Excel that is provided as part of this presentation

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Where to Focus

- Conversion Factors and Updates
- Two main areas of focus
  - Coding and billing – such as skin substitutes
  - Hospital Price Transparency as there are significant changes
  - Phase out of the Inpatient Only List
- Ensure that policies and procedures are created to ensure a smooth transition from the inpatient only list (IOP) to outpatient services
- Work with your vendor to ensure that you are compliant with the significant changes for 2026 and the Hospital Price Transparency (HPT) regulations.
- Ensuring new HCPCS codes are added to your chargemaster
- Along with this presentation are a series of tables for HCPCS code changes, changes to Inpatient Only List and Excepted versus Non-Excepted

Questions?

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