AAOS
American Association of Orthopaedic Surgeons

Fiscal Year 2026 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgery Center (ASC) Payment System Proposed Rule

On July 15th, the Centers for Medicare & Medicaid Services (CMS) released the CY 2026 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgery Center (ASC) Payment System proposed rule. AAOS has prepared the summary below of key proposals in the rules and their potential impact on our members and patients. We will be submitting formal comments to the agency in response to the rule ahead of the September 15, 2025, deadline. **We welcome your feedback on any provisions below.**

In accordance with Medicare law, CMS proposes updating OPPS payment rates by 2.4% for hospitals that meet applicable quality reporting requirements. This update is based on a projected hospital market basket percentage increase of 3.2%, reduced by a 0.8 percentage point productivity adjustment.

Similarly, CMS proposes an update factor of 2.4% for ASC payments rates for ASCs that meet quality reporting requirements. This update is based on the same 3.2% projected market basket, minus the 0.8% productivity adjustment, consistent with the methodology used in IPPS.

CMS also proposes to revise the OPPS and the ASC payment systems and proposes updates to requirements for the Hospital Outpatient Quality Reporting (OQR) Program and the ASC Quality Reporting (ASCQR) Program.

CMS proposes to eliminate the Medicare Inpatient Only List (IPO) over three years, beginning in 2026 with nearly all of the musculoskeletal procedures. Alongside this, CMS proposes to provide an indefinite exemption from the 2-Midnight rule once a procedure is removed from the IPO. Along with the IPO elimination, CMS is proposing to revise the Ambulatory Surgical Center Covered Procedures List (ASC CPL) criteria to modify the general standard criteria and to eliminate five of the general exclusion criteria, moving them into a new section as nonbinding physician considerations for patient safety. As a result of these changes, CMS is proposing to add 276 surgery or surgery-like codes to the ASC CPL that are not on the CY 2025 IPO list and 271 mostly MSK surgery or surgery-like codes to the ASC CPL that are currently on the IPO list. To help absorb the new codes, CMS is proposing to create a new MSK Level 7 Ambulatory Payment Classification (APC) that will contain six high-cost procedures.

In the Ambulatory Surgical Center Quality Reporting Program, CMS proposes to adopt the Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery, Patient Reported Outcome-Based Performance Measure (Information Transfer PRO–PM) beginning with voluntary reporting for the CY 2027 and CY 2028 reporting periods followed by mandatory reporting beginning with the CY 2029 reporting period.

CMS proposes to continue temporary additional payments for non-opioid pain management treatments in both the HOPD and ASC settings from January 1, 2025, through December 31, 2027, consistent with statutory requirements. CMS is also seeking input through a Request for Information (RFI) on future quality measure concepts related to well-being and nutrition, aligned with broader public health goals. Finally, the proposed rule includes updates to Graduate Medical Education Accreditation requirements, which may affect hospital-based training programs across specialties.

CMS Proposal	Prior AAOS Comments	AAOS Relevance
Updates Affecting OPPS and ASC Payment Rates **CMS proposes updating OPPS payment rates for hospitals that meet applicable quality reporting requirements by 2.4%. This update is based on the projected hospital market basket percentage increase of 3.2%, reduced by a 0.8 percentage point productivity adjustment.** **For CY 2026, using the hospital market basket update, CMS proposes an update factor to the ASC rates of 2.4%. The update applies to ASCs meeting relevant quality reporting requirements. This update is based on the proposed IPPS market basket percentage increase of 3.2%, reduced by 0.8 percentage point for the productivity adjustment.**	AAOS has supported using the hospital market basket update to determine updates to payment rates for ASCs.	AAOS continues to support the use of the hospital market basket to update payment rates for ASCs.
CMS propose that the OPPS payment rates used for ratesetting under the ASC payment system for CY 2026 and subsequent years would not include the 2-percent prospective offset to the OPPS conversion factor as a result of the 340B remedy offset that we are	N/A	AAOS supports CMS' proposal that the ASC payment rates should not include this 2% offset since the 340B program does not include ASCs.

proposing to implement in this proposed rule.		
Proposed OPPS Ambulatory Payment Classification (APC) Group Policies (P 209)	CMS last proposed major changes to the MSK APCs in CY2019 when they considered creating a new APC between the current levels 5 and 6. At the time, we stated that TKA and any future arthroplasty procedures removed from the IPO list would warrant assignment to the higher APC level. This applies to all procedures recommended by the AAOS through the 2018 OPPS rulemaking (i.e., shoulder, ankle, and hip arthroplasty). Moreover, should there be an influx of procedures added to the ASC CPL as a result of the elimination of the IPO, we request that CMS update the OPPS APC Policies to reflect these additions. Currently, musculoskeletal procedures are categorized into six APCs (5111-5116). AAOS believes that the addition of more complex procedures, such as total hip arthroplasty, warrant assignment to a higher APC level. **A seventh musculoskeletal APC level would account for the greater level of preparation requisite to the successful performance of these procedures in the outpatient setting, such as discharge planning, care coordination, and durable medical equipment.**	CMS is proposing to add a new Level 7 MSK APC (5117) by splitting the current Level 6 MSK APC (5116). The geometric mean of the Level 6 APC would drop slightly from $18,613.09 in CY2025 to $18,337.97 in CY2026. The geometric mean of the new Level 7 APC will be $28,285.22. Several HCPCS codes proposed to be removed from the IPO List that are currently assigned to the Level 6 MSK APC have significant CY 2024 claims volume, with several codes having greater than a thousand single claims from which to calculate their geometric mean costs. The significant claims volume associated with these procedures makes these codes relevant for two times rule evaluation purposes and provides a meaningful basis for establishing the additional APC level. CMS believes creating an additional level would allow for the appropriate placement of procedures newly removed from the IPO List to an APC with an applicable range of estimated costs, due to the large volume of claims data available for procedures with similar clinical and resource characteristics.

Complexity Adjustments	AAOS recommends that as CMS considers moving specific procedures to the ASC-CPL, we urge the agency to also consider the inclusion of "add-on" services that are crucial for patient safety. These add-on services, which trigger a complexity adjustment in the hospital outpatient setting, should be reimbursed separately in the ASC setting to incentivize physicians to perform these important add-on services.	CMS will allow for certain add-on codes to qualify for a "complexity adjustment." For those primary service and add-on code combinations that are determined to be sufficiently frequent and sufficiently costly, CMS believes that a payment adjustment is warranted and, thus, when those code pairs are submitted together, CMS will increase the payment to the next highest level APC. This year, CMS is opening up comments to rethink the complexity adjustment policy including the appropriate cost and frequency thresholds that could be used to identify which code clusters "truly reflect complex and resource-intensive code combinations." For the first time, CMS appears to be entertaining the idea that "code clusters" rather than just a "code pair" could be used as a trigger to evaluate a case for a complexity adjustment.
OPPS Payments for Devices	AAOS appreciates CMS's efforts to enhance access to innovative technologies for Medicare beneficiaries and supports the add-on payments for new technologies with demonstrated efficacy and effectiveness. We encourage CMS to consider expanding this program to encompass a broader range of devices, thereby increasing the	CMS provides an overview of the criteria that devices must meet to be eligible for transitional pass-through payment under the OPPS (p. 224), along with additional background on related polices that have been finalized over the years.

	frequency of Medicare coverage approvals for new and promising technologies. AAOS previously expressed support for innovation and expanded coverage for devices that improve patient safety and outcomes in response to the Transitional Coverage for Emerging Technologies (TCET) proposed notice. We believe it would be prudent to extend coverage to additional devices under the TCET pathway. Increased competition among device manufacturers would, ideally, stimulate the expected benefits of an open and free market, assuming participation in an evidence-based development plan.	CMS received 8 complete applications for device pass-through status. CMS seeks public comment on whether the devices listed below meet the device pass-through payment criteria discussed, including the cost criterion for device pass-through payment status: • aprevo® Cervical ACDF system, aprevo® Cervical ACDF-X system, aprevo® Cervical ACDF-X NO CAM system: designed to stabilize the cervical spinal column and facilitate fusion. • Axoguard HA+ Nerve Protector™: designed to be a protective interface between the nerve and the surrounding tissue to minimize the potential for soft tissue attachments and tethering that restricts the nerve's ability to glide and move through the tissue structures during anatomic movement.
Payment for Skin Substitutes **CMS proposes, starting January 1, 2026, to separately pay for the provision of**	N/A	These provisions are relevant to orthopaedic surgeons who perform wound care and other procedures that require the use of skin substitutes.

certain groups of skin substitute products as incident-to supplies when, for those products that are coverable under Medicare's rules, they are used during a covered application procedure paid under the PFS in the non-facility setting or under the OPPS. This proposal does not apply to biological products which will continue to be paid under the ASP methodology. **One of CMS' primary policy objectives is to ensure a consistent and uniform payment approach for skin substitute products across the physician office and hospital outpatient department settings.**		CMS has proposed the same payment methodology in both the OPPS and PFS rules.
For CY 2026 and subsequent years, CMS proposes to eliminate the Inpatient Only (IPO) List through a 3-year transition, completing the elimination by January 1, 2029. **CMS proposes to remove the criteria for removing procedures from the IPO. The criteria are as follows:** **(1) Most outpatient departments are equipped to provide the service or procedure to the Medicare population.** **(2) The simplest service or procedure described by the code may be**	AAOS has previously opposed elimination of the IPO list due to concerns about patient safety if these complex and intense procedures shift to the outpatient setting.	CMS proposes that 269 musculoskeletal services would be in the first group of services that would be removed from the IPO list starting on January 1, 2026. CMS argues that because they have previously removed codes corresponding to MSK services from the IPO list that are similar clinically and in terms of resource cost and assigned them to C-APCs, these APCs generally describe appropriate ranges and placements for the MSK codes being proposed for removal in CY 2026, which will allow for appropriate payment. CMS is

performed in most outpatient departments. **(3) The service or procedure is related to codes that CMS has already removed from the Inpatient Only List.** **(4) CMS determines that the service or procedure is being performed in numerous hospitals on an outpatient basis.** **(5) 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.**		proposing to create a new MSK Level 7 APC as part of this transition.
2-Midnight Rule: CMS proposes to maintain the indefinite exemption period for procedures that are removed from the IPO list.	AAOS has historically supported the indefinite exemption of the 2-midnight rule. CMS proposes to continue 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.	Maintaining the exemption for procedures removed from the IPO is important to reducing the likelihood of inappropriate denials of coverage by Medicare Advantage plans as well as general confusion surrounding the applicability of the rule.
ASC-CPL Procedures	In previous comment letters, AAOS has been supportive of moving procedures to the ASC that can be performed safely based on the	For CY 2026, CMS proposes to update the ASC CPL by adding 276 surgery or surgery-like codes that are not on the CY 2025 IPO list.

	patient's needs and clinical considerations. AAOS supported the removal of certain procedures from the IPO for which there is evidence that they can safely be performed in the outpatient setting, such as total shoulder arthroplasty and total ankle arthroplasty. We agree with the agency that with developments in the practice of medicine, these procedures can safely be done in the outpatient setting. The AAOS believes that determining the appropriate setting of care should be done through the lens of patient safety and peer-reviewed evidence, and that physicians are best qualified for leading this individualized decision-making process with their patients. Additionally, we advocate for the separate reimbursement of essential "add-on" services in ASCs, critical to patient safety.	Additionally, CMS proposes to add 271 mostly-MSK surgery or surgery-like codes to the ASC CPL that are currently on the IPO list if it finalizes removal of these services from the IPO list. These codes are listed in Table 80 and Table 81 of the proposed rule.
ASC CPL Criteria: CMS proposes to revise the existing general standard criteria by retaining the condition that procedures be separately paid under the OPPS and moving the following two standards to a new a section outlining possible physician considerations in making site-of-service decisions:	AAOS has previously stated that it is imperative that only those patients who are strong candidates for the procedure have the option of undergoing the surgery in the outpatient settings including at ASCs. Toward that end, we encourage CMS to consider the criteria for patient selection and the primacy of the physician-patient relationship in medical decision making. We advise	The shift of procedures to the ASC setting remains both promising and complex given considerations regarding patient appropriateness and reimbursement structure, along with quality reporting standards.

• not expected to pose a significant safety risk to a Medicare beneficiary when performed in an ASC **• standard medical practice dictates that the beneficiary would not typically be expected to require active medical monitoring and care at midnight following the procedure.** **CMS also proposes to eliminate the following five general exclusion criteria and move them to the new physician considerations section:** **1. Generally result in extensive blood loss;** **2. Require major or prolonged invasion of body cavities;** **3. Directly involve major blood vessels;** **4. Are generally emergent or life-threatening in nature; and** **5. Commonly require systemic thrombolytic therapy** **CMS will add surgical procedures to the ASC CPL through rulemaking as new procedures meeting the four criteria are identified.**	assessing the safety of both the procedure itself and the complexity of the patients generally undergoing the procedure. We also advocate for the separate reimbursement of essential "add-on" services in ASCs, critical to patient safety.	
Site Neutral Payments for drug administration services delivered at off-campus hospital outpatient departments	N/A	CMS is proposing to lower payments for drug administration services in non-excepted off-campus hospital outpatient departments. Instead of paying at the OPPS rate for these

		services, CMS will now pay at the PFS-equivalent rate using the PFS relativity adjuster of 40%, meaning the service will be paid 40% of the OPPS rate. CMS proposes to exempt Rural Sole Community Hospitals from this policy.
Request for Information: Expanding site-neutral payment to on-campus clinic visits	N/A	In the CY2019 OPPS rule, CMS finalized a policy to pay for clinic visits services furnished at non-excepted off-campus hospital outpatient departments at the PFS equivalent rate of 40% of the OPPS rate. CMS is requesting information on the possibility of expanding this policy to also apply to clinic visit services delivered at on-campus hospital outpatient departments.
Non-opioids Policies	AAOS's continuously encourages CMS to consider a wide range of non-opioid treatments, including but not limited to intravenous acetaminophen, regional nerve blocks, icing wraps, transcutaneous stimulators, and topical analgesics. Additionally, AAOS reiterates its support for incentivizing payment for alternative chronic pain management treatments such as acupuncture, chiropractic services, osteopathic manipulation, cognitive behavioral therapy, and physical therapy, when appropriate, in outpatient settings of care. As always, AAOS is supportive	CMS proposes to continue its policies to provide for temporary additional payments for non-opioid treatments for pain relief as required under the NO PAIN Act section of the *Consolidated Appropriations Act (CAA), 2023*.

	of utilization of non-opioid pain management where appropriate and commends CMS for taking steps to improve access to these treatments. AAOS continues to seek further clarity on whether the proposed separate payment would apply to specific treatments commonly used in orthopedics, such as indwelling nerve catheters and cryoneurolysis (e.g., Iovera)	
Request for Information: Adjusting Payment under the OPPS for Services Predominately Performed in the Ambulatory Surgical Center or Physician Office Settings	N/A	CMS is requesting information on a more systematic process for identifying ambulatory services at high risk of shifting to the hospital setting based on financial incentives rather than medical necessity and adjusting payments accordingly. CMS is interested in exploring the appropriateness of and methods for creating site neutral payment policies based on whether a service is most performed in a hospital outpatient department, ambulatory surgery center or physician office.
Proposed Market-Based Medicare Severity-Diagnosis Related Groups (MS-DRG) Relative Weight Data Collection and Change in Methodology for Calculating MS-DRG Relative Weights under the Inpatient Prospective Payment System **Beginning January 1, 2026, CMS proposes requiring hospitals to report**	N/A	This is a major change to the hospital inpatient payment system but does not directly impact physician payment or reporting requirements.

the median of the payer-specific negotiated charge that the hospital has negotiated with all its MAOs, by MS-DRG, for use in a market-based MS-DRG relative weight methodology, effective for the relative weights calculated for FY2029. CMS will utilize this data within a proposed methodology for calculating the IPPS MS-DRG relative weights to reflect relative market-based pricing.		
Cross-Program Proposals for the HOQR, REHRQ, and ASCQR Programs **CMS proposes to adopt the Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery, Patient Reported Outcome-Based Performance Measure (Information Transfer PRO–PM) beginning with voluntary reporting for the CY 2027 and CY 2028 reporting periods followed by mandatory reporting beginning with the CY 2029 reporting period.** **CMS proposes that ASCs must use the HQR system for data submission for any PRO–PM that CMS adopts for the ASCQR Program measure set. ASCs may choose to: (1) directly submit their PRO–PM data to CMS using the HQR system; or (2) utilize a third-party entity, such as a vendor or registry, to submit their data using the HQR system.**	AAOS had commented on this measure during the pre-rulemaking review process and requested clarity as to who is responsible for administering this instrument and who is responsible for funding survey implementation.	CMS proposes that the Information Transfer PRO–PM would be calculated based on PRO data collected by ASCs directly or through their authorized third-party vendors through the Information Transfer PRO–PM survey instrument distributed to patients or their caregivers by electronic mail or text. CMS notes that the Information Transfer PRO–PM survey is nonproprietary and free to use. CMS also proposes that the survey be distributed within 2 to 7 days post-procedure or surgery. This timeframe minimizes the influence of variables related to the surgery or procedure such as medications that could affect comprehension, fatigue, or acute pain, while ensuring timely reporting of patient experience related to recovery information. Based on pilot testing, CMS also proposes a 65-day window for patient response to the survey.

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Changes to the Hospital Price Transparency Program	AAOS supports efforts to provide patients with easily understandable cost and quality information to encourage the use of high-value care options. AAOS urges CMS to move towards a solution that is deliberate in its approach for navigating between present regulation and a future state of health care payment—one that is both markedly helpful to patients and limited in the administrative responsibility it places on providers.	CMS makes a series of proposals to update the requirements for hospitals to publicly post standard charges for hospital items and services. This includes new rules for including the "median allowed amount" as well as the 10th and 90th percentiles, an updated accuracy attestation statement, a requirement to begin reporting hospital NPIs, and the ability for noncompliant hospitals to waive their hearing rights in exchange for reduced CMP amounts.
Hospital Quality Star Rating Methodology **CMS proposes to update the methodology that will be used to calculate the Overall Hospital Quality Star Rating through implementation of a 2-stage methodologic update.**	N/A	The first-stage methodology update would be a narrow, but focused transitional step that would limit hospitals to a maximum of four out of five stars (based on at least three Safety of Care measure scores) if they performed in the lowest quartile of the Safety of Care measure group in the 2026 Overall Hospital Quality Star Rating. The second stage of the methodology update would replace the first-stage update and reduce the Star Rating of any hospital in the

		lowest quartile of Safety of Care (based on at least three Safety of Care measure scores) by one star, to a minimum 1-star rating for the 2027 Overall Hospital Quality Star Rating and later years.
Graduate Medical Education Accreditation	AAOS believes that Graduate Medical Education (GME) is imperative to the prosperity of our health care systems and must be invested in financially to ensure quality patient care from adequately trained physicians. AAOS recommends that physician manpower policies be developed in a deliberate and careful manner, considering the factors that influence how physicians choose their specialties. Furthermore, physician manpower policies should be designed in such a way that they do not endanger the quality of graduate medical education in specialties where shortages are expected. Attempts to increase the number of physicians in specific specialties by reducing training in others will impede access to care.	CMS provides background on Executive Order 14279 ("Reforming Accreditation to Strengthen Higher Education," April 23, 2025), which "directs that standards for training doctors should focus solely on providing the highest quality care, and should not require or encourage educational institutions to discriminate unlawfully on the basis of race" CMS concludes that "[t]hese programs raise particular concerns in the medical context, where patients and the larger society have a compelling need for medical education to be focused primarily on excellence and delivering the best possible care to patients" CMS proposes accreditors may not require as part of accreditation, or otherwise encourage institutions to put in place diversity, equity, and inclusion programs that encourage unlawful discrimination on the basis of race or other violations of Federal law, effective January 1, 2026

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See table 69 (p. 197/465) and Addendum B for services being removed from the IPO List. All addendums can be downloaded from the CMS website: https://www.cms.gov/license/ama?file=/files/zip/2026-nprm-opps-addenda.zip