CY 2026 Hospital Outpatient Prospective Payment System (HOPPS), CMS-1834-P Proposed Rule Summary

Introductory Summary and Background

On July 15, 2025, the Centers for Medicare & Medicaid Services (CMS) issued the proposed rule for the Hospital Outpatient Prospective Payment System (HOPPS) for Calendar Year (CY) 2026. The rule is in its entirety at the following link: https://www.federalregister.gov/documents/2025/07/17/2025-13360/medicare-and-medicaid-programs-hospital-outpatient-prospective-payment-and-ambulatory-surgical.

Key Proposals Effecting IR

- CMS proposed a 2.4 percent increase to the outpatient department (OPD) fee schedule for HOPPS and Ambulatory Surgery Centers (ASCs).
    - Based on the market update from the Inpatient Prospective Payment System (IPPS) of 3.2 percent and a 0.8 percent productivity adjustment decrease.
- CMS proposed a conversion factor (CF) of $91.747 for hospitals that meet the Hospital Outpatient Quality Reporting (OQR) requirements; and applying the 2 percent reduction to those that do not with a CF equal to $89.958.
    - Under the 340B Final Remedy Rule, CMS proposed to impose an annual 2 percent reduction to HOPPS CF beginning in CY 2026 for non-drug items and services for hospitals in which this adjustment applies. The proposed CF for these hospitals is $89.958.
    - Ambulatory Surgery Centers (ASCs) are not impacted by the 2 percent reduction for the 340B offset remedy.
- CMS estimates total payments to HOPPS providers will be approximately $100.0 billion, which is an increase of approximately $8.1 billion compared to CY 2025 HOPPS payments.
- Cancer hospital payment payment-to-cost ratio (PCR) proposed for CY 2026 at 0.87 for the 11 designated hospitals.
- CMS 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.
    - Standard APC assignments will continue to apply for single imaging procedures and multiple imaging procedures performed across imaging families. A single imaging session performed “with contrast” is part of a composite APC when at least one or more imaging procedures from the same family are also performed with contrast on the same date of service. For example, if a hospital performs one MRI without contrast during the same session as one with contrast, the payment rate will be for the “with contrast” composite APC.
- CMS proposes to assign several new technologies to new APCs for CY 2025.
- Proposed for services to New Technology APCs based on Requestor applications
    - LimFlow TADV procedure CPT Code 0620T (APC 1579)
    - Liver Histotripsy Service CPT Code 0686T (APC 1579)
- CMS proposed a per day cost threshold of $655 for qualifying nonpass-through, separately payable diagnostic radiopharmaceuticals.
- CMS proposed to phase out the inpatient only list (IPO) list over a 3-year period, beginning with removal of 285 mostly musculoskeletal procedures for CY 2026 and completing the changes by January 1, 2029.

- For interventional radiology this includes the proposed removal of CPT codes 37182 *(Insertion of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract formation/dilatation, stent placement and all associated imaging guidance and documentation)* and 61624 *(Transcatheter permanent occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; central nervous system (intracranial, spinal cord))* from the IPO only list effective January 1, 2026.

- Approved application for device pass-through payment during the quarterly review process for VasQ, a nitinol implant which is surgically placed outside and/or around an artery and/or vein to provide external support to arteriovenous fistulas created for vascular access by means of vascular surgery.

Payment Rates

CMS used the CY 2024 claims data for ratesetting for CY 2026 which follows the usual 2-year difference in data for ratesetting due to allowance for 1-year of timely filing for billing. The Outpatient Department (OPD) increase factor is equal to the hospital inpatient market basket percentage increase applicable to hospital charges.

- CMS proposed a 2.4 percent increase to the OPD fee schedule for HOPPS and Ambulatory Surgery Centers (ASCs).
  - Based on the market update from the Inpatient Prospective Payment System (IPPS) of 3.2 percent and a 0.8 percent productivity adjustment decrease.
- CMS proposed a conversion factor (CF) of $89.379 for hospitals that meet the Hospital OQR reporting requirements; and applying the 2 percent reduction to those that do not with a CF equal to $87.636.
  - Based on proposed 2 percent reduction as part of the Remedy for the 340B-Acquired Drug Payment Policy for Calendar Years 20128-2022 as provided in detail below.
  - Ambulatory Surgery Centers (ASCs) are not impacted by the 2 percent reduction for the 340B offset remedy.
- CMS estimates total payments to HOPPS providers will be approximately $100.0 billion, which is an increase of approximately $8.1 billion compared to CY 2025 HOPPS payments.
- CMS proposed an increase of 2.4 percent to payment rates for ambulatory surgical centers (ASCs) that meet the quality reporting requirements under the ASCQR Program.
  - This increase is based on the extension of the hospital market percentage increase and will be continued for 2025 as a continuous response to impacts due to the COVID-19 public health emergency (PHE). CMS estimates total payments to ASC providers will be approximately $9.2 billion, which is an increase of $480 million compared to CY 2025 payments.
- CMS proposed a CF for Ambulatory Surgery Centers (ASCs) of $56.207 for ASCs meeting Medicare's quality reporting requirements, and a CF of $55.109 for ASCs not meeting quality reporting requirements.
- Cancer hospital payment payment-to-cost ratio (PCR) proposed for CY 2026 at 0.87 for the 11 designated hospitals.

Wage Index

CMS proposed to continue applying a wage index of 1.0000 for frontier state hospitals. This policy has been in place since CY 2011. This ensures the lower population states are not "penalized" in reimbursement due to the low number of people per square mile when compared to other states.

Consistent with the FY 2026 IPPS proposed rule, for CY 2026 and subsequent years, CMS proposed to discontinue the low wage index hospital policy under HOPPS. CMS would no longer apply a low wage index budget neutrality factor to the standardized amounts. CMS also proposed to use their authority under section 1886(d)(5)(I)(i) of the Act to adopt a 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 that would be implemented in a budget neutral manner.

Standardizing Ambulatory Payment Classifications (APCs) Payment Weights

Ambulatory payment classifications (APCs) group services are considered clinically comparable to each other with respect to the resources utilized and the associated costs. For CY 2026, CMS proposed to continue using HCPCS code G0463 (Hospital outpatient clinic visit for assessment and management of a patient), in APC 5012 (Level 2 Examinations and Related Services) as the standardized code for the relative payment weights. A relative payment weight of 1.00 is proposed to be assigned to APC 5012 (code G0463).

For CY 2026, CMS proposed to continue to pay code G0463 at a payment rate of 40 percent of the HOPPS rate for any outpatient off-campus hospital setting, excepted and nonexcepted. This continues to be the method for controlling the overutilization of this code in the outpatient setting.

Exclusion of Non-Opioid Products for Pain Relief from Packaging

The Consolidated Appropriations Act, 2023 addressed the need for CMS to provide additional payments for non-opioid treatments for pain relief on or after January 1, 2025, and before January 1, 2028. The Secretary of Health and Human Services cannot package payment for non-opioid treatment for pain relief with other covered outpatient hospital department services. Instead, a separate payment must be made for the non-opioid treatment for pain relief.

CMS proposed five drugs, and six devices qualify as non-opioid treatments for pain relief, and CMS proposed these products to be paid separately in both the HOPD and ASC settings, starting in CY 2026. CMS is seeking comments and supporting documentation from stakeholders on additional products that may qualify for separate payment under this provision for CY 2026. Ensuring non-opioid treatments for pain relief are available can help reduce use of opioids and incidence of opioid use disorder, helping to prevent this chronic disease from occurring in more Americans.

Procedures Assigned to New Technology APC Groups

When new technology is assigned a billing code, the establishment of a payment rate by CMS can be difficult because there is no claims data to determine utilization and cost by the hospital. Due to this, CMS created New Technology APCs which are similar to pass-through payments for new drugs, biologicals, radiopharmaceuticals and devices. The new technology is assigned to a temporary APC until claims data is available. Typically, this is a minimum of two years, but it can be less if there is sufficient data available sooner. Once there is sufficient data, the new technology is moved to a clinically appropriate APC.

LimFlow TADV procedure CPT Code 0620T (APC 1579)

The LimFlow TADV procedure is an endovascular procedure used to treat patients with chronic limb-threatening ischemia that are no longer eligible for conventional endovascular or open bypass surgery to treat their artery blockage, and without the procedure are likely to face limb amputation. The LimFlow TADV procedure is reported with 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)

For CY 2026, CMS proposed to designate this service as a low volume service under their universal low volume APC policy and continue to assign HCPCS code 0620T to APC 1579 with a payment rate of $35,000.50.

Liver Histotripsy Service CPT Code 0686T (APC 1579)

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 primary or metastatic tumors located in the liver. These services are reported with CPT code 0686T *(Histotripsy (i.e., non-thermal ablation via acoustic energy delivery) of malignant hepatocellular tissue, including image guidance)*.

For CY 2026, CMS proposed to reassign CPT code 0686T from APC 1576 to APC 1579 with a payment rate of $35,000.50, this is based on CY 2024 claims data which were just shy of the threshold. For final rulemaking, CMS will update values with any additional CY 2024 claims data that may have been additionally processed.

Supervision of Diagnostic Services

Supervision requirements for diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests paid under the HOPPS are outlined at the code level in the MPFS files provided by CMS. Revisions were made during the public health emergency to ensure an adequate number of health care professionals were available to support critical COVID-19-related and other diagnostic testing needs and provide needed medical care during the PHE as outlined in the President's Executive Order 13890 on ''Protecting and Improving Medicare for Our Nation's Seniors''.

For 2025, CMS finalized extending the definition of direct supervision of CR, ICR, PR services and diagnostic services via audio-video real-time communications technology (excluding audio-only) through December 31, 2025. For 2026, CMS proposed to make the availability of the direct supervision of Cardiac Rehabilitation (CR), Intensive Cardiac Rehabilitation (ICR), Pulmonary Rehabilitation (PR) services and diagnostic services furnished to hospital outpatients 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.

CMS emphasized the permanent adoption of the definition of direct supervision to allow for "immediate availability" of the supervising practitioner using audio/video real-time communications technology (excluding audio-only), for CR, ICR, PR and diagnostic services does not mean it is appropriate to allow virtual presence for every service for every Medicare beneficiary in every clinical scenario. The physician or nonphysician practitioner should continue to use their professional judgment and expertise to determine the appropriate supervision on a case-by-case basis.

Proposed Payment for Diagnostic Radiopharmaceuticals

In the CY 2025 HOPPS/ASC final rule, CMS finalized to pay for qualifying nonpass-through, separately payable diagnostic radiopharmaceuticals with per day costs above the threshold of $630. CMS proposed to continue this payment policy but have proposed an updated threshold value for CY 2026.

For CY 2026, CMS proposed a per day cost threshold of $655 for qualifying nonpass-through, separately payable diagnostic radiopharmaceuticals. In future years CMS proposed to utilize the most recently available fourth-quarter average Producer Price Index (PPI) levels for establishing the threshold for diagnostic radiopharmaceuticals. For example, for CY 2026 CMS would update the threshold amount using data from

the third quarter of 2024 to the third quarter of 2025. The amount would be rounded to the next $5 increment for each proposal and finalized threshold.

CMS included Table 4 which reflects the qualifying diagnostic radiopharmaceuticals with per day costs exceeding $655, as proposed for CY 2026, and are assigned a status indicator of "K", which indicates a separate payment to be made based on the HCPCS code's arithmetic MUC.

TABLE 4: Proposed Qualifying Diagnostic Radiopharmaceuticals with Per Day Costs Exceeding $655

HCPCS Code	Short Descriptor	Proposed CY 2026 Status Indicator Assignment
A9507	In111 capromab	K
A9508	I131 iodobenguate, dx	K
A9515	Choline c-11	K
A9521	Tc99m exametazime	K
A9532	I125 serum albumin, dx	K
A9547	In111 oxyquinoline	K
A9548	In111 pentetate	K
A9553	Cr51 chromate	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	Gallium g 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
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 diagnostic	K
Q9983	Florbetaben f18 diagnostic	K

*HCPCS code A9608 will be assigned to status indicator "G" until its pass through expiration on September 30, 2026. For the remainder of CY 2026, we would propose to assign it to status indicator "K" and paid based on its arithmetic MUC calculated.

Multiple Imaging Composite APC

For CY 2026, CMS 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. For a full discussion of the development of the multiple imaging composite APC methodology, readers are referred to

the CY 2009 OPPS/ASC final rule with comment period (73 FR 68559 through 68569). For CY 2026, CMS proposed to use the costs derived from CY 2024 claims data to set the CY 2026 proposed payment rates, except where otherwise indicated. Standard APC assignments will continue to apply for single imaging procedures and multiple imaging procedures performed across imaging families. A single imaging session performed "with contrast" is part of a composite APC when at least one or more imaging procedures from the same family are also performed with contrast on the same date of service. For example, if a hospital performs one MRI without contrast during the same session as one with contrast, the payment rate will be for the "with contrast" composite APC.

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).

Table 3 within the CY 2026 HOPPS proposed rule contains the imaging families and multiple imaging procedures for the composite APCs.

Applications for Device Pass-Through Status

Currently, there are 17 device categories eligible for pass-through payment. CMS received eight complete applications by March 3, 2025, quarterly deadline, which was the last quarterly deadline for applications to be received in time to be included in this proposed rule. An application was approved for device pass-through payment during the quarterly review process: VasQ, which was preliminarily approved upon quarterly review under the alternative pathway effective July 1, 2024.

VasQ™

Laminate Medical applied for a new device category for transitional pass-through payment status for VasQ™ for CY 2026. Per the applicant, VasQ™ is a nitinol implant which is surgically placed outside and/or around an artery and/or vein to provide external support to arteriovenous fistulas created for vascular access by means of vascular surgery. The Applicant indicated this device would be most commonly reported with CPT codes 36818, 36819, 36820, 36821, 36832, and 36833. Per CMS, the applicant has met the first three cost thresholds as required for transitional pass-through payment policy.

Eliminating the Inpatient Only (IPO) List

CMS believes the evolving nature of the practice of medicine allows more procedures to be performed on an outpatient basis with a shorter recovery time. To give beneficiaries more choices on where to obtain care with the potential for lower out-of-pocket expenses, CMS proposed to phase out the inpatient only list (IPO) list over a 3-year period, beginning with removal of 285 mostly musculoskeletal procedures for CY 2026 and completing the changes by January 1, 2029.

This proposal would allow these services to be paid for by Medicare in the hospital outpatient and ambulatory surgical center settings when determined to be clinically appropriate, giving physicians greater flexibility in determining the most appropriate site of service. CMS specifically addressed their belief as technology has advanced the ability to perform some of the historically defined "inpatient only" procedures can now be safely performed in outpatient settings. Regarding ASCs, CMS stated, " …*while several of the identified procedures may typically require hospital care that lasts beyond midnight, we expect that appropriately selected patient populations in the ASC setting would be healthier and less complex and would likely not require active monitoring or medical care past midnight beyond the procedure."*

Table 69 within the proposed rule includes the full list of 285 mostly musculoskeletal services, (16 services are non-musculoskeletal representing cardiovascular, lymphatic, digestive, gynecological, and endovascular procedures recommended by the 2020 HOP Panel) to be removed from IPO list.

For interventional radiology this includes the proposed removal of CPT codes 37182 *(Insertion of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract formation/dilatation, stent placement and all associated imaging guidance and documentation)* and 61624 *(Transcatheter permanent occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; central nervous system (intracranial, spinal cord))* from the IPO only list effective January 1, 2026.

CMS is seeking comments about whether 3 years is sufficient time frame to complete the changes, and which services should be addressed next from the list.