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Ambulatory Surgical Center Payment: January 2026 Update

Related CR Release Date: January 28, 2026	**MLN Matters Number:** MM14359
Effective Date: January 1, 2026	**Related Change Request (CR) Number:** CR 14359
Implementation Date: January 5, 2026	**Related CR Transmittal Number:** R13578CP
Related CR Title: January 2026 Update of the Ambulatory Surgical Center [ASC] Payment System	

Affected Providers

- Ambulatory surgical centers (ASCs)
- Physicians
- Suppliers
- Other providers billing Medicare Administrative Contractors (MACs) for services

Action Needed

Make sure your billing staff knows about these payment system updates, effective January 1, 2026:

- New device categories, CPT codes, and HCPCS codes
- Drugs and biologicals
- Skin substitutes
- Non-opioid treatments for pain relief

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Background

CR 14359 provides changes to and billing instructions for various payment policies implemented in the January 2026 ASC payment system update. For information about the ASC payment system, see the Medicare Claims Processing Manual, Chapter 14, section 40.

Key Updates

Hospital Outpatient Prospective Payment System Pass-Through Devices

New Device Category

Section 1833(t)(6)(B) of the Social Security Act says that under the Hospital Outpatient Prospective Payment System (OPPS), categories of devices are eligible for transitional pass-through payments for at least 2 but not more than 3 years. Also, section 1833(t)(6)(B)(ii)(IV) of the Social Security Act requires that CMS create additional categories for transitional pass-through payment of new medical devices not described by existing or previously existing categories of devices. We also apply this policy in the ASC payment system.

For the January 2026 update, we approved 2 new devices for pass-through status under the Hospital OPPS and are establishing the new device categories in the ASC payment system. These HCPCS codes are effective January 1, 2026:

- C1607
- C1608

See Table 1 for the code descriptors and ASC payment indicators (PIs).

Long Descriptor Updates to an Existing Device Pass-Through Category C1741

HCPCS code C1741 was preliminarily approved as part of the device pass-through quarterly review process with an effective date of October 1, 2025, in CR 14246. We'll include and discuss the device application associated with C1741 in the CY 2027 Hospital OPPS and ASC proposed and final rules.

We're updating the long descriptor for HCPCS code C1741 to "Anchor/screw for bone fixation, absorbable, metallic (implantable)," effective October 1, 2025.

See Table 2 for the code, descriptors, and ASC PI. See the January 2026 ASC code pair file for CPT codes an ASC must perform with this code.

Device Offset Amount Updates to Existing Device HCPCS Codes C1735 & C1736

Section 1833(t)(6)(D)(ii) of the Social Security Act requires that we deduct an amount that reflects the device portion of the ambulatory payment classification (APC) payment amount from Hospital OPPS pass-through payments for devices. This deduction is the device offset or the part of the APC amount we associate with the cost of the pass-through device.

Effective January 1, 2025, we require CPT codes 0338T and 0339T to be billed with HCPCS code C1735 (Catheter(s), intravascular for renal denervation, radiofrequency, including all single use system components) or HCPCS code C1736 (Catheter(s), intravascular for renal denervation, ultrasound, including all single use system components) as listed in CR 13934.

We're updating the device offset amount for the CPT codes an ASC must pair with HCPCS codes C1735 and C1736 to $0, effective January 1, 2026. See the January 2026 ASC code pair file for the list of CPT codes an ASC must perform with HCPCS codes C1735 and C1736.

PI Updates for Existing Device HCPCS Codes C1604 & C1740

We're updating the PIs for HCPCS codes C1604 and C1740, effective January 1, 2026. See Table 3 for the codes, code descriptors, and ASC PIs.

Addition of CPT Codes to an Existing Device HCPCS Code C9610

Starting January 1, 2026, we're adding CPT codes 92930 and 92945 to be billed with HCPCS code C9610 (Catheter, transluminal drug delivery with or without angioplasty, coronary, non-laser (insertable)) in addition to the CPT codes we listed in CR 13934. See the January 2026 ASC code pair file for the list of CPT codes an ASC must perform with HCPCS code C9610.

Addition of CPT Codes to an Existing Device HCPCS Code C1737

Starting January 1, 2026, we're adding CPT code 27280 to be billed with HCPCS code C1737 (Joint fusion and fixation device(s), sacroiliac and pelvis, including all system components (implantable)) due to adding this procedure to the ASC covered procedures list (CPL) in addition to the CPT codes we listed in CR 13934. See the January 2026 ASC code pair file for the list of CPT codes an ASC must perform with HCPCS code C1737.

CPT Code Updates to an Existing Device HCPCS Code C1602

Starting January 1, 2026, we're updating the list of CPT codes to be billed with HCPCS code C1602 (Orthopedic/device/drug matrix/absorbable bone void filler, antimicrobial-eluting (implantable)) due to adding procedures to the ASC CPL. See the January 2026 ASC code pair file for the list of CPT codes an ASC must perform with this code.

Expiring Pass-Through Status for 3 Device Category HCPCS Codes

Section 1833(t)(6)(B) of the Social Security Act specifies that categories of devices are eligible for transitional pass-through payments for at least 2 but not more than 3 years. The pass-through status period and separate payment status for 3 device categories, specifically, HCPCS codes C1826, C1827, and C1747, will expire on December 31, 2025. We'll include payment in the primary services since these device category HCPCS codes will remain active. See Table 4 for the codes, code descriptors, and ASC PIs.

Newly Payable ASC Surgical Procedures & Covered Ancillary Services

We added 80 new separately payable procedure codes to the ASC-covered procedures and covered ancillary lists. We're now paying separately for 946 covered surgical procedures and ancillary services that were previously non-payable or packaged (ASC PI = N1/S1). This includes the 303 skin substitute products we now provide separate payment for under the ASC payment system, effective January 1, 2026.

Attachment B includes the HCPCS code, code descriptors, and ASC PIs associated with these newly payable covered surgical procedures and covered ancillary services. Attachment B doesn't include newly payable drugs, biologicals, and radiopharmaceuticals.

The ASC payment rates for the codes in Attachment B can be found in the January 2026 ASC Addenda AA and BB.

New Technology APC Assignment for Implantation of Peritoneal Ascites Pump System

We're assigning CPT codes 0870T and 0871T that describe the implantation and replacement procedure of a peritoneal ascites pump system to New Technology APCs. We assigned the other codes associated with this procedure to clinical APCs. See Table 5 for the codes, code descriptors, and ASC PIs.

Drugs, Biologicals & Radiopharmaceuticals

New HCPCS Codes & Dosage Descriptors for Certain Drugs, Biologicals & Radiopharmaceuticals Getting Pass-Through Status

We're establishing 6 new HCPCS codes for reporting drugs and biologicals in the hospital outpatient setting starting on January 1, 2026, where there weren't specific codes available previously. These drugs and biologicals will get drug pass-through status starting January 1, 2026. See Table 6 for these codes.

Existing HCPCS Codes for Certain Drugs, Biologicals & Radiopharmaceuticals Starting Pass-Through Status

One existing HCPCS code for a certain drug, biological, and radiopharmaceutical in the outpatient setting will have the Hospital OPPS pass-through status start on January 1, 2026. See Table 7 for this code.

Newly Established HCPCS Codes for Drugs, Biologicals & Radiopharmaceuticals

We're establishing 11 new drug, biological, and radiopharmaceutical HCPCS codes on January 1, 2026. See Table 8 for these codes.

Deleted HCPCS Codes for Drugs, Biologicals & Radiopharmaceuticals

We're deleting 2 drug, biological, and radiopharmaceutical HCPCS codes on December 31, 2025. See Table 9 for these codes.

Payment Status Indicator Changes to HCPCS Codes for Drugs, Biologicals & Radiopharmaceuticals

We're changing the PI status for 86 drug, biological, and radiopharmaceutical HCPCS codes on January 1, 2026. See Table 10 for the codes, long descriptors, and PIs.

Descriptor Changes to HCPCS Codes for Drugs, Biologicals & Radiopharmaceuticals

We're making a substantial descriptor change to 1 drug, biological, and radiopharmaceutical HCPCS code. See Table 11 for this code.

Drugs & Biologicals with Payments Based on Average Sales Prices

For CY 2026, we pay for most non-pass-through drugs, biologicals, and radiopharmaceuticals at a single rate of average sales price (ASP) +6% (or ASP +6% or 8% of the reference product for biosimilars). In CY 2026, we make a single payment of ASP +6% for pass-through drugs, biologicals, and radiopharmaceuticals to pay for both the acquisition cost and pharmacy overhead costs of these pass-through items (or ASP +6% or 8% of the reference product for biosimilars). We'll update payments for drugs and biologicals based on ASPs on a quarterly basis as later-quarter ASP submissions become available.

Starting January 1, 2026, we'll change payment rates for many drugs and biologicals from the values published in the CY 2026 Hospital OPPS and ASC final rule because of the new ASP calculations based on sales price submissions from the third quarter of CY 2025. For the updated payment rates, effective January 1, 2026, see the January 2026 ASC Addendum BB.

Drugs & Biologicals Based on ASP Methodology with Restated Payment Rates

We retroactively correct payment rates for some drugs and biologicals on a quarterly basis. Find the latest list of corrected payment rates on the first day of the quarter.

You may request an adjustment of previously processed claims if you think you received an incorrect payment for drugs and biologicals impacted by these corrections.

Skin Substitutes

New Skin Substitute APCs & Their Payment Rates

For CY 2026, we're unpackaging skin substitute products from the application services and establishing 3 new APCs:

- APC 6000 (Pre-Market Approval (PMA) Skin Substitute Products)
- APC 6001 (510(k) Skin Substitute Products)
- APC 6002 (361 Human Cells, Tissues, and Cellular and Tissue-Based Products (HCT/P) Skin Substitute Products)

We're assigning skin substitute products to the new APCs based on relevant product characteristics rather than stated prices for provision of these products when ASCs use them during a covered application procedure paid under the ASC payment system (described by CPT codes 15271–15278).

We're aligning the skin substitute categorization for payment purposes consistent with their FDA regulatory status for 361 HCT/P and the device types: PMA and 510(k)s. For CY 2026, we'll use a single payment rate of $127.14 per cm2 for APCs 6000–6002.

We listed individual HCPCS code APC assignments in the January 2026 ASC Addendum BB.

New Unlisted Skin Substitute Product HCPCS Codes

Starting January 1, 2026, we're creating 3 new unlisted codes to describe skin substitute products that are FDA authorized or cleared but haven't gotten a specific individual HCPCS or CPT code:

- Q4431 (Unlisted PMA skin substitute product)
- Q4432 (Unlisted 510(k) skin substitute product)
- Q4433 (Unlisted 361 HCT/P skin substitute product)

We assigned the unlisted HCPCS codes to the appropriate APCs based on the product's FDA approval or clearance. Specifically, we assigned:

- HCPCS code Q4431 to APC 6000
- HCPCS code Q4432 to APC 6001
- HCPCS code Q4433 to APC 6002

See Table 12 for the codes, code descriptors, APCs, and ASC PIs. See also the January 2026 ASC Addendum BB for these codes and their short descriptors, status indicators, and payment rates.

HCPCS Codes, PIs, APC Assignments & Payment Limitations for Qualifying Non-Opioid Treatments for Pain Relief

Section 4135 of the Consolidated Appropriations Act, 2023 established the eligibility criteria for temporary additional payments for certain non-opioid treatments for pain relief, and we finalized the payment policy in the CY 2025 Hospital OPPS and ASC final rule. We fully evaluated applicable non-opioid treatments against the statutory eligibility criteria and determined the products in Table 13 meet the statutory definition of a non-opioid treatment for pain relief and should be paid according to the finalized policy for CY 2026. Section 1833(t)(16)(G)(iii) of the Social Security Act states that the separate payment amount specified in clause (ii) shall not exceed the estimated average of 18% of the outpatient department (OPD) fee schedule amount for the OPD service (or group of services) with which the non-opioid treatment for pain relief is provided, as determined by the Secretary. We update the finalized payment limitation amount for each product annually.

Coverage Determinations

When we assign a HCPCS code and payment rate under the ASC payment system to a drug, device, procedure, or service, it doesn't imply Medicare coverage. It only indicates how we pay for the product, procedure, or service if covered. MACs decide whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, MACs decide if it's reasonable and necessary to treat the patient's condition and whether it's excluded from payment.

More Information

We issued CR 14359 to your MAC as the official instruction for this change. For more information, find your MAC's website

Document History

Date of Change	Description
January 29, 2026	Initial article released.