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Hospital Outpatient Prospective Payment System: January 2026 Update

Related CR Release Date: January 28, 2026	**MLN Matters Number:** MM14361
Effective Date: January 1, 2026	**Related Change Request (CR) Number:** CR 14361
Implementation Date: January 5, 2026	**Related CR Transmittal Number:** R13573CP
Related CR Title: January 2026 Update of the Hospital Outpatient Prospective Payment System (OPPS)	

Affected Providers

- Hospitals
- Physicians
- Home health agencies
- Hospices
- Other providers billing Medicare Administrative Contractors (MACs) for outpatient hospital services

Action Needed

Make sure your billing staff knows about these Hospital Outpatient Prospective Payment System (OPPS) updates, effective January 1, 2026:

- Coding
- Device pass-through status
- Comprehensive ambulatory payment classification (APC)
- Drugs, biologicals, and pharmaceuticals
- OPPS Pricer logic

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Background

CR 14361 implements changes to and billing instructions for various payment policies in the January 2026 Hospital OPPS update. This CR also instructs you about coding changes and policy updates, effective January 1, 2026, for the Hospital OPPS.

Note: Learn more about Hospital OPPS status indicators and the latest definitions in Addendum D1 of the CY 2026 Hospital OPPS and Ambulatory Surgical Center (ASC) final rule.

Key Updates

COVID-19 CPT Code Changes

Descriptor Revision for CPT Code 90480 & APC Title Revision for APC 9398

Because the CPT Editorial Panel is revising the descriptor for CPT code 90480, effective January 1, 2026, as listed in Table 1, CMS is also revising the APC title for APC 9398, effective January 1, 2026. See Table 2 for the updated APC title.

New COVID-19 Add-On CPT Code 90481

The American Medical Association (AMA) CPT Editorial Panel established new COVID-19 add-on CPT code 90481. See Table 3 for the long descriptor and status indicator. Also, see the January 2026 Hospital OPPS Addendum B for the short descriptor and status indicator. We added the code to the January 2026 Integrated Outpatient Code Editor (I/OCE) with an effective date of January 1, 2026.

CPT Proprietary Laboratory Analyses Coding Changes

The AMA CPT Editorial Panel established 14 new proprietary laboratory analyses (PLA) codes (CPT codes 0600U–0613U), effective January 1, 2026. See Table 4 and the January 2026 Hospital OPPS Addendum B for the long descriptors and status indicators.

Hospital OPPS Device Pass-Through

New Device Pass-Through Category

Section 1833(t)(6)(B) of the Social Security Act requires that, under the Hospital OPPS, categories of devices be 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 we create additional categories for transitional pass-through payment of new medical devices not described by existing or previously existing categories of devices.

Through our quarterly review process, we preliminarily approved 2 new device HCPCS codes, C1607 and C1608, for pass-through status under the Hospital OPPS with an effective date of January 1, 2026. We'll include and discuss the device applications associated with these codes in the CY 2027 Hospital OPPS and ASC proposed and final rules.

See Table 5A for the long descriptor, status indicator, and offset amount. See Table 6 for the complete list of device category HCPCS codes and definitions we used for past and present transitional pass-through payment.

Device Offset from Payment

Section 1833(t)(6)(D)(ii) of the Social Security Act requires that we deduct an amount that reflects the device portion of the APC amount from pass-through payments for devices. This deduction is the device offset or the portion of the APC amount that's associated with the cost of the pass-through device. The device offset from payment represents a deduction from pass-through payments for the applicable pass-through device.

Descriptor Update to Existing Device Pass-Through Category HCPCS Code C1741

In CR 14223, we noted that we preliminarily approved HCPCS code C1741 as part of the device pass-through quarterly review process with an effective date of October 1, 2025. We'll include and discuss the device application associated with this code in the CY 2027 Hospital OPPS and ASC proposed and final rules.

Effective October 1, 2025, we're updating the long descriptor for HCPCS code C1741 to "Anchor/screw for bone fixation, absorbable, metallic (implantable)." See Table 5B for the long descriptor, status indicator, APC, and offset amount.

Updates for Device Offset Amounts to Existing Device HCPCS Codes C1735 & C1736

Effective January 1, 2025, we require CPT codes 0338T and 0339T to be billed with either:

- HCPCS code C1735 (Catheter(s), intravascular for renal denervation, radiofrequency, including all single use system components)
- HCPCS code C1736 (Catheter(s), intravascular for renal denervation, ultrasound, including all single use system components) as listed in CR 13933.

We're updating the device offset amount for the CPT codes a Hospital OPPS must pair with HCPCS codes C1735 and C1736 to $0, effective January 1, 2026.

Addition of CPT Codes to an Existing Device Code

Effective 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 that we listed in CR 13933
- 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 removing procedures from the inpatient-only (IPO) procedure list in addition to the CPT codes listed in CR 13933

For pass-through payments, you should only bill C1737 when you perform both a sacroiliac joint fusion procedure (27279 or 27280) and a lumbar fusion procedure (22612, 22630, or 22633) in the same operative session.

CPT Codes Updates to Existing Device Code C1602

Effective January 1, 2026, we're updating the status indicator and APC for the CPT codes to be billed with HCPCS code C1602 (Orthopedic/device/drug matrix/absorbable bone void filler, antimicrobial-eluting (implantable)) due to removing procedures from the IPO procedure list.

CPT Codes Removed from Existing Device Code C1601

Effective January 1, 2026, we're removing CPT codes 31780, 31781, 31786, 31800, 31805, and 32815 from the list of CPT codes to be billed with HCPCS code C1601 (Endoscope, single-use (i.e. disposable), pulmonary, imaging/illumination device (insertable)) since these procedures are identified as IPO procedures (status indicator = C).

You can use a single-use (disposable) endoscope for procedures that take place in the tracheobronchial tree. We established HCPCS code C1601 for a bronchoscope to use only for a single procedure, and it can't be reprocessed.

Transitional Pass-Through Payments & Offsets for Designated Devices

We assign certain designated new devices to APCs, and the I/OCE identifies them as eligible for payment based on their reasonable cost reduced by the amount included in the APC for the procedure that reflects the packaged payment for devices used in the procedure. The I/OCE determines the proper payment amount for these APCs as well as the coinsurance and applicable deductible. We'll return all related payment calculations on the same APC line and identify it as a designated new device.

Review the current Hospital OPPS HCPCS device offset amounts in Addendum P of the CY 2026 Hospital OPPS and ASC final rule. See the Device Intensive tab for HCPCS codes with device offset amounts that are device intensive and the HCPCS Offsets tab for HCPCS codes with device offset amounts.

Alternative Pathway for Devices that Have an FDA Breakthrough Designation

We provide an alternative pathway to device pass-through status for devices that got FDA marketing authorization and a breakthrough device designation. We don't use current substantial clinical improvement criteria to determine pass-through payment status. Such devices would still need to meet other criteria for pass-through status. This applies to devices that get pass-through payment status, effective on or after January 1, 2020.

See device criteria information for more information.

Expiring Pass-Through Status for 3 Device Category HCPCS Codes

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

Things to remember for Hospital OPPS billing:

- Report device category HCPCS codes on claims whenever you provide them in the hospital outpatient department (OPD) setting
- Report all HCPCS codes consistent with their descriptors, CPT, our instructions, and correct coding principles
- Charge for all services you provide even if we make payment separately or packaged

See Table 3 and the Medicare Claims Processing Manual, Chapter 4, section 60.4.2 for the current and historical device category codes we created since we implemented the Hospital OPPS on August 1, 2000.

Changes to the IPO List

We list procedures typically only provided in the inpatient setting and not paid under the Hospital OPPS in the Medicare IPO list. We're phasing out the IPO list over a 3-year period beginning in CY 2026. For CY 2026, we're removing 285 procedures, mostly musculoskeletal services. See Table 7 for the changes.

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 8 for the short descriptors, long descriptors, status indicators, and APC assignments for CPT codes 0870T–0875T. Refer to Addendum B for the short descriptors, status indicators, and payment rates.

Add-On Payment for Technetium-99m Produced by Non-Highly Enriched Uranium Sources

The $10 add-on payment for Technetium-99m (Tc-99m) when you produce the Tc-99m without using highly enriched uranium ended December 31, 2025. We terminated HCPCS code Q9969 (Tc-99m from non-highly enriched uranium source, full cost recovery add-on, per study dose), effective December 31, 2025.

Add-On Payment for Tc-99m Derived from Domestically Produced Molybdenum-99

Effective January 1, 2026, we're implementing a new $10 per dose add-on payment for radiopharmaceuticals that use Tc-99m derived from domestically produced Molybdenum-99 (Mo-99). We established a new HCPCS code C9176 (Tc-99m from domestically produced non-HEU Mo-99, [minimum 50 percent], full cost recovery add-on, per study dose) to describe Tc-99m derived from domestically produced Mo-99 and used in a diagnostic procedure.

For a dose to qualify for this add-on payment, at least 50% of the Mo-99 used in the Tc-99m generator that produced the dose of Tc-99m must be domestically produced. See Table 9 for the short descriptor, long descriptor, status indicator, and APC assignment. See Addendum B for the short descriptor, status indicator, and payment rate.

Drugs, Biologicals & Radiopharmaceuticals

New CY 2026 HCPCS Codes & Dosage Descriptors for Certain Drugs, Biologicals & Radiopharmaceuticals Receiving Pass-Through Status

We created 6 new HCPCS codes for reporting drugs and biologicals in the hospital outpatient setting where specific codes weren't previously available starting on January 1, 2026. See Table 10 for the list of codes that will receive drug pass-through status starting January 1, 2026.

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

Two existing HCPCS codes for certain drugs, biologicals, and radiopharmaceuticals in the outpatient setting will have their pass-through status start on January 1, 2026, with a status indicator of G. See Table 11 for the list of codes.

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

Four HCPCS codes for certain drugs, biologicals, and radiopharmaceuticals in the outpatient setting will have their pass-through status end on December 31, 2025, with a new status indicator of K. See Table 12 for the list of codes. Refer to Addendum B for the short descriptors and status indicators.

Newly Established HCPCS Codes for Drugs, Biologicals & Radiopharmaceuticals

We're establishing 25 new drug, biological, and radiopharmaceutical HCPCS codes on January 1, 2026. See Table 13 for the list of codes.

Deleted HCPCS Codes for Drugs, Biologicals & Radiopharmaceuticals

We're deleting 57 drug, biological, and radiopharmaceutical HCPCS codes on December 31, 2025. See Table 14 for the list of codes.

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

We're changing the payment status indicators for 129 drug, biological, and radiopharmaceutical HCPCS codes on January 1, 2026. See Table 15 for the list of codes. We're making these changes in the January 2026 I/OCE update, effective January 1, 2026.

Descriptor Changes to HCPCS Codes for Drugs, Biologicals & Radiopharmaceuticals

We're making a substantial descriptor change to 1 drug, biological, and radiopharmaceutical HCPCS code as of January 1, 2026. See Table 16 for this code.

Drugs & Biologicals with Payments Based on Average Sales Price

For CY 2026, we pay for most non-pass-through drugs, biologicals, and therapeutic 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 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 update payments for drugs and biologicals based on ASPs quarterly as later-quarter ASP submissions become available.

Effective January 1, 2026, we've changed the payment rates for many drugs and biologicals from the values we published in the CY 2026 Hospital OPPS and ASC final rule because of new ASP calculations from sales price submissions in the third quarter of CY 2025. When we need to adjust payment rates, we'll incorporate them into the January 2026 Fiscal Intermediary Standard System release. We aren't publishing the updated payment rates in this CR; however, you can find the updated payment rates, effective January 1, 2026, in the January 2026 Hospital OPPS Addendums A and B.

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 drugs and biologicals with corrected payment rates on the first date of each quarter.

You may resubmit claims affected by adjustments to a prior quarter's payment files.

Drug & Biologic Invoice Pricing

Starting for dates of service on and after January 1, 2026, we're implementing value code 92 for providers to report invoice pricing for certain drugs and biologicals with status indicator E2 where pricing isn't available but other applicable requirements are met and the claim includes 1 of these revenue categories: 0343, 0344, 0636, or 089X.

The National Uniform Billing Committee approved value code 92 for provider use when federal regulations require separate payment and invoice pricing for drug and biological services. Drug and biological lines that contain services with a status indicator E2 and 1 of the revenue categories 0343, 0344, 0636, or 089X may qualify for Medicare invoice pricing.

In recent years, there's been an increasing number of drug and biological HCPCS codes for which ASP, wholesale acquisition cost (WAC), average wholesale price (AWP), and mean unit cost (MUC) information isn't available. These are often HCPCS codes for new drugs or biologicals that were approved for marketing when the manufacturer doesn't have sales data, and the WAC, AWP, and MUC information isn't available. Due to a lack of payment data, we're unable to assign a payable status indicator to these drugs or biologicals.

Effective CY 2026, we updated our system to allow using the provider invoice amount to set a payment rate for a separately payable drug, biological, or radiopharmaceutical until its payment amount becomes available, and we provide a payment rate in Addendum B.

HCPCS codes with missing payment rates in Addendum B for a separately payable drug, biological, or radiopharmaceutical will indicate that we don't have pricing information (specifically, that the ASP, WAC, AWP, and MUC information isn't available) for a product, and we would then calculate the payment for the product based on provider invoices if the applicable per-day cost has been met. If all requirements are met, we'll bypass reason code W7013 and apply the invoice payment policy. If a drug or biological line doesn't meet these requirements, we'll continue to apply reason code W7013 to that service line.

Skin Substitutes

New Skin Substitute APCs & Their Payment Rates

For CY 2026, we're unpackaging skin substitute products from their application services and establishing several 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 you use them during a covered application procedure paid under the Hospital OPPS (described by CPT codes 15271–15278).

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

See Table 17 and Addendum A for the APC titles and payment rates. See Addendum B for individual HCPCS code APC assignments.

New Skin Substitute Status Indicator S1

We created a new status indicator S1 for sheet-form skin substitute products to allow for separate payment under the Hospital OPPS. We're assigning status indicator S1 to all skin substitute products we assigned to APCs 6000–6002. See Table 18 for the definition of status indicator S1.

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 19 for the codes, long descriptors, APC assignments, and payment rates. See Addendum B for the short descriptors, status indicators, and payment rates.

Deletion of Certain Previous Skin Substitute Application HCPCS Codes

To achieve our policy to pay separately for skin substitute products as incident-to supplies, we deleted the HCPCS C-codes describing the application of skin substitutes assigned to the low-cost group. Effective December 31, 2025, we deleted HCPCS codes C5271–C5278. Application CPT codes 15271–15278 remain to describe skin substitute application procedures. We'll continue to package CPT add-on application codes 15272, 15274, 15276, and 15278 in the outpatient hospital setting. See Table 20 for the deleted HCPCS skin substitute application codes.

Payment for Drug Administration Services at Excepted Provider-Based Departments

In the CY 2026 Hospital OPPS and ASC final rule, we used our authority under section 1833(t)(2)(F) of the Social Security Act to apply an amount equal to the site-specific Physician Fee Schedule (PFS) payment rate for non-excepted items and services provided by a non-excepted off-campus provider-based department (PBD) (the PFS equivalent payment rate) for HCPCS codes assigned to the drug administration services (APCs 5691–5694) when provided at an off-campus PBD excepted from section 1833(t)(21) of the Social Security Act (departments that bill the modifier PO on claim lines).

Payment for Radiation Therapy Services at Non-Excepted Off-Campus PBDs

We don't apply the PFS relativity adjuster to radiation therapy services (radiation treatment delivery and related imaging guidance services) provided by non-excepted off-campus PBDs. Due to section 1848(c)(2)(K) of the Social Security Act, when the section 603 requirements were implemented in 2017, we instructed non-excepted off-campus PBDs to bill HCPCS codes G6001–G6017 for these services and append modifier PN to each applicable claim line for non-excepted items and services. We paid them the technical component rate for the code under the PFS.

At the September 2024 AMA CPT Editorial Panel meeting, the Panel approved revising radiation therapy CPT codes 77402, 77407, and 77412 to establish a technique-agnostic family of codes and bundle imaging into the 3 CPT codes.

Consequently, effective January 1, 2026, we're deleting existing radiation therapy HCPCS codes G6001–G6017 that describe imaging guidance for radiation treatment (G6001, G6002, and G6017) and radiation treatment delivery (G6003–G6015) because you'll use CPT codes 77402, 77407, and 77412 to report these services instead.

Effective January 1, 2026, non-excepted off-campus PBDs will use CPT codes 77402, 77407, and 77412 with the PN modifier to continue the existing policy of paying the PFS-equivalent rate for these services to these departments.

Payment Adjustment for Certain Cancer Hospitals

For certain cancer hospitals that get interim monthly payments associated with the cancer hospital adjustment at 42 CFR 419.43(i), section 16002(b) of the 21st Century Cures Act requires that we reduce the target payment-to-cost ratio (PCR) we use in calculating the interim monthly payments and at final cost report settlement by 0.01. For CY 2026, the target PCR after including the reduction required by section 16002(b) is 0.87.

HCPCS Codes, Status Indicator, 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. We evaluated applicable non-opioid treatments against the statutory eligibility criteria and determined the products in Table 21 meet the statutory definition of 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), won't exceed the estimated average of 18% of the OPD fee schedule amount for the OPD service (or group of services) with which the non-opioid treatment for pain relief is furnished, as determined by the Secretary. We update the finalized payment limitation amount for each product annually, which can be found in Table 22.

Changes to OPPS Pricer Logic

- Rural sole community hospitals (SCHs) and essential access community hospitals (EACHs) continue to get a 7.1% payment increase for most services in CY 2026. The rural SCH and EACH payment adjustment exclude:
  - Drugs
  - Biologicals
  - Items and services paid at charges reduced to cost
  - Items paid under the pass-through payment policy
- New Hospital OPPS payment rates and copayment amounts will be effective January 1, 2026. We limit copayment amounts to a maximum of 40% of the APC payment rate, and they can't exceed the CY 2026 inpatient deductible of $1,736. For most Hospital OPPS services, copayments are set at 20% of the APC payment rate.
- There's no change in the 1.75 multiple threshold for hospital outlier payments under the Hospital OPPS for 2026. We multiply the threshold of 1.75 by the total line-item APC payment to determine eligibility for outlier payments. We also use this factor to determine the outlier payment, which is 50% of estimated costs minus 1.75 times the APC payment amount. The payment formula is (cost – (APC payment x 1.75)) / 2.
- The fixed-dollar threshold for Hospital OPPS outlier payments decreases in CY 2026 compared to CY 2025. The estimated cost of a service must be greater than the APC amount plus $6,225 to qualify for outlier payments.
- There's no change in the 3.4 multiple threshold for outliers for community mental health centers (CMHCs) (type of bill 76x). We multiply 3.4 by the total line-item APC payment for the assigned partial hospitalization program or intensive outpatient program APC (5851–5854) to determine eligibility for outlier payments. We use this amount to determine the outlier payment, which is 50% of estimated costs minus 3.4 times the APC payment amount. The payment formula is (cost – (APC payment x 3.4)) / 2.

- Continuing current policy, the Hospital OPPS Pricer will apply a reduced update ratio of 0.9805 to payment and copayment for hospitals that fail to meet their hospital outpatient quality data reporting requirements or fail to meet our validation edits. We'll use the reduced payment amount to calculate outlier payments.
- Effective January 1, 2026, we apply a reduction to Hospital OPPS payments and copayments for non-drug items and services for providers that aren't excepted from the 340B remedy offset due to being new providers. We calculate these payments and copayments for non-drug items and services by applying a ratio of 0.9951.
- Effective January 1, 2026, we're adopting the FY 2026 Inpatient Prospective Payment System (IPPS) post-reclassification wage index values we published in the FY 2026 IPPS final rule, with application of the CY 2026 out-commuting adjustment to non-IPPS hospitals as implemented through Pricer logic.
- Effective January 1, 2026, we're capping payment rates associated with Hospital OPPS status indicators K1 and H1 for the qualifying non-opioid treatments for pain policy as listed in Table 21. We'll evaluate qualifying non-opioid treatments for pain relief for approval throughout CY 2026. We'll effectuate payment for qualifying products through the Hospital OPPS CR and quarterly update process.

Update to the Outpatient Provider Specific File

Effective January 1, 2026, MACs will maintain the accuracy of the provider records in the outpatient provider specific file (OPSF) as changes occur in data element values.

Updating the OPSF for the Supplemental Wage Index & Supplemental Wage Index Flag Fields & Transitional Exception Policy

In CY 2026, we'll use the Supplemental Wage Index and Supplemental Wage Index Flag fields to implement a cap on the wage index decrease policy. The Pricer requires the hospital's applicable CY 2025 Hospital OPPS wage index in the Supplemental Wage Index field to apply all wage index policies and determine the hospital's CY 2026 Hospital OPPS wage index. To accurately pay claims for providers paid through the Hospital OPPS for whom we expect the capped wage index policy to apply, the Supplemental Wage Index Flag must be 1 and have a wage index in the Supplemental Wage Index field.

MACs will ensure no Hospital OPPS providers have a 1 or 2 in the Special Payment Indicator field and no wage index value in the Special Wage Index field with an effective date of January 1, 2026. Unless we instruct otherwise, MACs must seek approval from the CMS Central Office to use a 1 or 2 in the Special Payment Indicator field and a wage index value in the Special Wage Index field.

Several types of assignments for the supplemental wage index field would apply under the Hospital OPPS. In all these cases, the Supplemental Wage Index field would be 1 and the effective date of such changes included for the steps we're outlining would be January 1, 2026.

If the MAC gets approval from our Central Office to assign a Hospital OPPS provider a special wage index in CY 2025 and the MACs use 1 or 2 in the Special Payment Indicator field, MACs will:

- Enter the value from the Special Wage Index for CY 2025 into the Supplemental Wage Index field
- Enter 1 in the Supplemental Wage Index Flag field
- Ensure the Special Wage Index and Special Payment Indicator fields are blank
- Establish the record with an effective date of January 1, 2026

If the MAC didn't email us during CY 2025 for a provider's CY 2025 wage index and the claim concerns IPPS hospitals also paid under the Hospital OPPS, MACs should obtain the 2025 wage index from Table 2 associated with the FY 2026 IPPS final rule, per instructions in MAC Implementation File 5.

In other instances where MACs derive an IPPS value through the steps outlined in the MAC Implementation File 5 document, that same FY 2025 wage index value is entered into the Supplemental Wage Index for the Inpatient Provider Specific File and into the Supplemental Wage Index field and would apply into the Hospital OPPS on a CY basis.

In these cases, MACs should:

- Enter the value from the Special Wage Index for CY 2025 (from Table 2 or through the steps outlined in MAC Implementation File 5) into the Supplemental Wage Index field
- Enter 1 in the Supplemental Wage Index Flag field
- Ensure the Special Wage Index and Special Payment Indicator fields are blank
- Establish the record with an effective date of January 1, 2026

If the MAC didn't email us during CY 2025 for a provider's CY 2025 and the claims concern non-IPPS hospitals, CMHCs, and other Hospital OPPS providers, we made the Supplemental Wage Index assignments (based on the CY 2025 Hospital OPPS wage index) and Special Wage Index assignments (for the transitional exception policy) available on our website under Annual Policy Files.

In these cases, MACs should:

- Enter the CY 2025 Wage Index from the spreadsheet file available online into the Supplemental Wage Index field
- Enter 1 in the Supplemental Wage Index Flag field
- Ensure the Special Wage Index and Special Payment Indicator fields are blank
- Establish the record with an effective date of January 1, 2026

For all applicable providers, if a Special Wage Index value for CY 2026 would apply due to the transitional exception, in addition to the steps above:

- Enter a value of "1" into the Special Payment Indicator field
- Enter the 2026 Special Wage Index from the spreadsheet file available online into the Special Wage Index field

Updating the OPSF for Expiration of Transitional Outpatient Payments

We hold cancer and children's hospitals harmless under section 1833(t)(7)(D)(ii) of the Social Security Act. Both entities will continue to get hold harmless transitional outpatient payments permanently. For CY 2026, cancer hospitals will continue to get an additional payment adjustment.

Updating the OPSF for the Hospital Outpatient Quality Reporting Program Requirements

Effective for Hospital OPPS services provided on or after January 1, 2009, subsection (d) hospitals that haven't submitted timely hospital outpatient quarterly data as required in section 1833(t)(17)(A) of the Social Security Act will get payment under the Hospital OPPS that reflects a 2% reduction from the annual Hospital OPPS update for failure to meet the Hospital Outpatient Quality Reporting (HOQR) program requirements. This reduction won't apply to hospitals not required to submit quality data or hospitals not paid under the Hospital OPPS.

For January 1, 2026, MACs will maintain the accuracy of the provider records in the OPSF by updating the Hospital Quality Indicator field. We'll release a Technical Direction Letter that lists subsection (d) hospitals that are subject to and that fail to meet the HOQR program requirements. Once we release this list, MACs will:

- Update the OPSF by removing the 1
- Leave the Hospital Quality Indicator field blank for all hospitals identified on the list
- Ensure the OPSF Hospital Quality Indicator field contains a 1 for all hospitals that aren't on the list

Note: If hospitals subsequently meet HOQR program requirements, MACs will update the OPSF. See CR 6072 for more information.

Updating the OPSF for Cost-to-Charge Ratios

MACs must maintain the accuracy of the data and update the OPSF as changes occur in data element values, including changes to provider cost-to-charge ratios (CCRs) and device department CCRs when applicable. The Annual Policy Files have the Hospital OPPS upper limit CCRs and statewide CCRs files.

Updating the County Code Field

Prior to CY 2018, to include the outmigration in a hospitals' wage index, we provided a separate table that assigned wage indexes for hospitals that got the outmigration adjustment. For the CY 2026 Hospital OPPS, the Pricer will continue to assign the outmigration adjustment using the County Code field in the OPSF. MACs will ensure every hospital has the Federal Information Processing Standards county code where the hospital is located listed in the County Code field to maintain accuracy of the OPSF data fields.

Updating the Wage Index Location Core-Based Statistical Area Field

Under historical and current Hospital OPPS wage index policy, hospitals that have wage index reclassifications for wage adjustment purposes under the IPPS would also have those wage index reclassifications applied under the Hospital OPPS on a CY basis. Under the FY 2026 IPPS, MACs will apply wage index reclassifications and make sure they're also reflected in the OPSF for CY 2026.

Updating the Payment Core-Based Statistical Area Field

In the prior OPSF layout, there were only 2 core-based statistical area (CBSA)-related fields:

1. Actual Geographic Location CBSA
2. Wage Index Location CBSA

If there isn't an assigned Special Wage Index, we use these fields to wage adjust Hospital OPPS payment through the Pricer. Historically, we used these fields to assign the wage index for hospitals receiving the outmigration adjustment.

In CR 9926, we created an additional field for the Payment CBSA, similar to the IPPS, to allow for consistency between the data in the 2 systems and identify when hospitals get dual reclassifications. In such cases, we'll use the Payment CBSA field to note the Urban to Rural reclassification under section 1886(d)(8)(E) of the Social Security Act. This Payment CBSA field isn't used for wage adjustment purposes but to identify when the 42 CFR 412.103 reclassification applies because rural status is considered for rural SCH adjustment eligibility. The IPPS Pricer allows the Payment CBSA, even when applied as the sole CBSA field (without a Wage Index CBSA), for wage adjusting payment. However, the Hospital OPPS doesn't use that field used for wage adjustment.

Wage Index Policies in CY 2026 OPPS Final Rules

In the FY 2026 IPPS and CY 2026 Hospital OPPS final rules, we made the following changes to the wage index:

- Discontinued the log wage index hospital policy
- Continued to apply a 5% cap for CY 2026 on any wage index values that decreased relative to CY 2025
- Implemented a transitional exception policy for hospitals that benefitted from the CY 2024 low wage index hospital policy

Coverage Determinations

When we assign a HCPCS code and payment rate to a drug, device, procedure, or service under the Hospital OPPS, 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 that it's reasonable and necessary to treat the patient's condition and whether it's excluded from payment.

More Information

We issued CR 14361 to your MAC as the official instruction for this change. For more information, find your MAC's website.

Document History

Date of Change	Description
February 4, 2026	Initial article released.