CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 13573	**Date: January 28, 2026**
	Change Request 14361

SUBJECT: January 2026 Update of the Hospital Outpatient Prospective Payment System (OPPS)

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to describe changes to and billing instructions for various payment policies implemented in the January 2026 OPPS update. The January 2026 Integrated Outpatient Code Editor (I/OCE) will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in this CR. This Recurring Update Notification (RUN) applies to Chapter 4, Section 50.8 (Annual Updates to the OPPS Pricer for Calendar Year (CY) 2007 and later).

EFFECTIVE DATE: January 1, 2026
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 5, 2026

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	4/20.6.11 /Modifier PO
R	4/180.7/Inpatient Only Services

III. FUNDING:

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Recurring Update Notification

Attachment - Recurring Update Notification

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II. GENERAL INFORMATION

A. Background: The purpose of this CR is to describe changes to and billing instructions for various payment policies implemented in the January 2026 OPPS update.
This RUN provides instructions on coding changes and policy updates that are effective January 1, 2026, for the Hospital OPPS. The updates include coding and policy changes for new PLA codes, changes to the Inpatient-Only list, new services, pass-through drug and devices, skin substitutes, and other items and services. The January 2026 revisions to I/OCE data files, instructions, and specifications are provided in the forthcoming January 2026 I/OCE CR.

B. Policy: 1. Covid-19 Current Procedural Terminology (CPT) Code Changes
a. Descriptor revision for CPT code 90480 and APC Title revision for APC 9398
Because the descriptor for CPT code 90480 is being revised effective January 1, 2026, by CPT Editorial Panel, as listed in Table 1, attachment A, we are also revising the APC title for APC 9398 effective January 1, 2026. An updated APC title for APC 9398 can be found in Table 2, attachment A.

b. 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. Table 3, attachment A, lists the long descriptor and status indicator for the code. The code has been added to the January 2026 I/OCE with an effective date of January 1, 2026. In addition, the code, along with its short descriptor and status indicator, is listed in the January 2026 OPPS Addendum B that is posted on the CMS website. For more information on OPPS status indicators, refer to OPPS Addendum D1 of the CY 2026 OPPS/ASC final rule for the latest definitions.

2. CPT Proprietary Laboratory Analyses (PLA) Coding Changes Effective January 1, 2026

The AMA CPT Editorial Panel established 14 new PLA codes, specifically, CPT codes 0600U through 0613U, effective January 1, 2026.

Table 4, attachment A, lists the long descriptors and status indicators for the codes. The codes have been added to the January 2026 I/OCE with an effective date of January 1, 2026. In addition, the codes, along with their short descriptors and status indicators, are listed in the January 2026 OPPS Addendum B that is posted on the CMS website. For more information on OPPS status indicators, refer to OPPS Addendum D1 of the CY 2026 OPPS/ASC final rule for the latest definitions.

3. Pass-Through Devices

a. New Device Pass-Through Category Effective January 1, 2026

Section 1833(t)(6)(B) of the Social Security Act requires that, under the OPPS, categories of devices be eligible for transitional pass-through payments for at least two, but not more than three years. In addition, section 1833(t)(6)(B)(ii)(IV) of the 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. We note that we preliminarily approved two new devices for pass-through status under the OPPS with an effective date of January 1, 2026, specifically, HCPCS codes C1607 and C1608. We note that HCPCS codes C1607 and C1608 were preliminarily approved as part of the device pass-through quarterly review process. The device applications associated with HCPCS codes C1607 and C1608 will be included and discussed in the CY 2027 OPPS/ASC proposed and final rules. Refer to Table 5A, attachment A, for the long descriptor, status indicator, APC, and offset amount for these two HCPCS codes.

Furthermore, we are adding these two new device category codes and their pass-through expiration dates to Table 6, attachment A. Refer to Table 6 for the complete list of device category HCPCS codes and definitions used for present and previous transitional pass-through payment.

b. Device Offset from Payment for the Following HCPCS Codes

Section 1833(t)(6)(D)(ii) of the Act requires that we deduct from pass-through payments for devices an amount that reflects the device portion of the APC payment amount. This deduction is known as the device offset, or the portion(s) of the APC amount that is 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.

c. Updates for Long Descriptor to an Existing Device Pass-through Category C1741

Section 1833(t)(6)(B) of the Social Security Act requires that, under the OPPS, categories of devices be eligible for transitional pass-through payments for at least two, but not more than three years. In addition, section 1833(t)(6)(B)(ii)(IV) of the 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.

In “October 2025 Update of the Hospital Outpatient Prospective Payment System (OPPS)”, CR 14223, Transmittal 13425, dated September 22, 2025, we note that HCPCS code C1741 was preliminarily approved as part of the device pass-through quarterly review process with an effective date of October 1, 2025. The device application associated with HCPCS code C1741 will be included and discussed in the CY 2027 OPPS/ASC proposed and final rules.

We note that the long descriptor for HCPCS code C1741 is being updated to “Anchor/screw for bone fixation, absorbable, metallic (implantable)”, effective October 1, 2025. Refer to Table 5B, attachment A, for the long descriptor, status indicator, APC, and offset amount for HCPCS code C1741.

d. Updates for Device Offset Amounts to an Existing Device Code C1735

Section 1833(t)(6)(D)(ii) of the Act requires that we deduct from pass-through payments for devices an amount that reflects the device portion of the APC payment amount. This deduction is known as the device offset, or the portion(s) of the APC amount that is 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.

We note that effective January 1, 2025, we paired 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), as listed in the "January 2025 Update of the Hospital Outpatient Prospective Payment System (OPPS)", CR 13933, Transmittal 13032, dated January 3, 2025.

We note that the device offset amount for the CPT codes that are paired with HCPCS code C1735 is being updated to $0.00, effective January 1, 2026.

e. Updates for Device Offset Amounts to an Existing Device Code C1736

Section 1833(t)(6)(D)(ii) of the Act requires that we deduct from pass-through payments for devices an amount that reflects the device portion of the APC payment amount. This deduction is known as the device offset, or the portion(s) of the APC amount that is 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.

We note that effective January 1, 2025, we paired CPT codes 0338T and 0339T to be billed with HCPCS Code C1736 (Catheter(s), intravascular for renal denervation, ultrasound, including all single use system components), as listed in the "January 2025 Update of the Hospital Outpatient Prospective Payment System (OPPS)", CR 13933, Transmittal 13032, dated January 3, 2025.

We note that the device offset amount for the CPT codes that are paired with HCPCS code C1736 is being updated to $0.00, effective January 1, 2026.

f. Addition of CPT Codes to an Existing Device Code C9610

Section 1833(t)(6)(D)(ii) of the Act requires that we deduct from pass-through payments for devices an amount that reflects the device portion of the APC payment amount. This deduction is known as the device offset, or the portion(s) of the APC amount that is 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.

We note that effective January 1, 2026, we are 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 the "January 2025 Update of the Hospital Outpatient Prospective Payment System (OPPS)", CR 13933, Transmittal 13032, dated January 3, 2025.

g. Addition of CPT Codes to an Existing Device Code C1737

Section 1833(t)(6)(D)(ii) of the Act requires that we deduct from pass-through payments for devices an amount that reflects the device portion of the APC payment amount. This deduction is known as the device offset, or the portion(s) of the APC amount that is 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.

We note that effective January 1, 2026, we are 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 the removals of procedures from the Inpatient Only (IPO) Procedure List, in addition to the CPT codes that we listed in the "January 2025 Update of the Hospital Outpatient Prospective Payment System (OPPS)", CR 13933, Transmittal 13032, dated January 3, 2025.

Additionally, we provide the following guidance for HCPCS code C1737: for pass-through payments, C1737 should only be billed when both a Sacroiliac Joint (SIJ) fusion procedure (27279 or 27280) and a lumbar fusion procedure (22612, 22630 or 22633) are performed in the same operative session.

h. Updates of CPT Codes to an Existing Device Code C1602

Section 1833(t)(6)(D)(ii) of the Act requires that we deduct from pass-through payments for devices an amount that reflects the device portion of the APC payment amount. This deduction is known as the device offset, or the portion(s) of the APC amount that is 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.

We note that effective January 1, 2026, we are updating the SI 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 the removals of procedures from the Inpatient Only (IPO) Procedure List.

i. Removal of CPT Codes from an Existing Device Code C1601

Section 1833(t)(6)(D)(ii) of the Act requires that we deduct from pass-through payments for devices an amount that reflects the device portion of the APC payment amount. This deduction is known as the device offset, or the portion(s) of the APC amount that is 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.

We note that effective January 1, 2026, we are 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 inpatient-only procedures (SI=C).

Additionally, we provide the following guidance for HCPCS code C1601: Single-use (i.e., disposable) endoscope with imaging (including linked color imaging if utilized), illumination, and working channels. This single-use (i.e., disposable) endoscope can be used for procedures that take place in the tracheobronchial tree. We note that HCPCS code C1601 was established for a bronchoscope that can only be used for a single procedure and cannot be reprocessed. As such, HCPCS code C1601 only describes devices that cannot be reprocessed.

j. Transitional Pass-Through Payments and Offsets for Designated Devices

Certain designated new devices are assigned to APCs and identified by the I/OCE as eligible for payment based on the reasonable cost of the new device reduced by the amount included in the APC for the procedure that reflects the packaged payment for device(s) used in the procedure. The I/OCE will determine the proper payment amount for these APCs as well as the coinsurance and any applicable deductible. All related payment calculations will be returned on the same APC line and identified as a designated new device. Please refer to the most current publication of the OPPS HCPCS device offset amounts (Addendum P) associated with the OPPS payment system. OPPS rulemaking is accessible on the CMS website at: https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices. Addendum P has a separate device intensive tab that includes HCPCS with "device offset" amounts. For the device offset amounts of HCPCS codes that are not device-intensive, please refer to the tab in Addendum P for "HCPCS Offsets."

k. Alternative Pathway for Devices That Have a Food and Drug Administration (FDA) Breakthrough Designation

For devices that have received FDA marketing authorization and a Breakthrough Device designation from the FDA, CMS provides an alternative pathway to qualify for device pass-through payment status, under which devices would not be evaluated in terms of the current substantial clinical improvement criterion for the purposes of determining device pass-through payment status. The devices would still need to meet the other criteria for pass-through status. This applies to devices that receive pass-through payment status effective on or after January 1, 2020. For information on the device criteria to qualify for pass-through status under the OPPS, refer to this CMS website, specifically at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/passthrough_payment.

l. Expiring Pass-through Status for Three Device Category HCPCS Codes Effective January 1, 2026

As specified in section 1833(t)(6)(B) of the Social Security Act, under the OPPS, categories of devices are eligible for transitional pass-through payments for at least two, but not more than three years. For the January 2026 update, the pass-through status period for three device categories, specifically, HCPCS codes C1826, C1827 and C1747, will expire on December 31, 2025. We note these device category HCPCS codes will remain active; however, its payment will be included in the primary service. Refer to Table 5C, attachment A and Table 6 for the long descriptor associated with HCPCS codes C1826, C1827 and C1747.

As a reminder, for OPPS billing, because charges related to packaged services are used for outlier and future rate setting, hospitals are advised to report the device category HCPCS codes on the claim whenever they are provided in the Hospital Outpatient Department (HOPD) setting. It is extremely important that hospitals report all HCPCS codes consistent with their descriptors, CPT and/or CMS instructions and correct coding principles, as well as all charges for all services they furnish, whether payment for the services is made separately or is packaged.

For the entire list of current and historical device category codes created since August 1, 2000, which is the implementation date of the hospital OPPS, refer to Table 6. We note this list can also be found in Chapter 4 of the Medicare Claims Processing Manual (Pub.100-04), specifically, Section 60.4.2 (Complete List of Device Pass-through Category Codes).

4. Changes to the Inpatient Only List (IPO) for CY 2026

The Medicare IPO list includes procedures that are typically only provided in the inpatient setting and therefore are not paid under the OPPS. We are phasing out the IPO list over the course of a three-year period beginning in CY 2026. For CY 2026, CMS is removing 285 mostly musculoskeletal services from the IPO list. These changes are included in Table 7, attachment A.

5. New Technology APC Assignment for Implantation of Peritoneal Ascites Pump System

CMS is assigning CPT codes 0870T and 0871T that describe the implantation and replacement procedure of a peritoneal ascites pump system to New Technology APCs. The other associated codes with this procedure have been assigned to clinical APCs. Table 8, attachment A, lists the short descriptors, official long descriptors, status indicators, and APC assignments for CPT codes 0870T through 0875T, etc. For information on OPPS status indicators, please refer to OPPS Addendum D1 of the CY 2026 OPPS/ASC final rule for the latest definitions. These codes, along with their short descriptors, status indicators, and payment rates, are also listed in the January 2026 Update of the OPPS Addendum B.

6. Add-on Payment for Technetium-99m (Tc-99m) Produced by Non-Highly Enriched Uranium (non-HEU) Sources

The $10 add-on payment for Tc-99m when the Tc-99m is produced without the use of HEU ended effective December 31, 2025. Therefore, CMS has terminated HCPCS code Q9969 (Tc-99m from non-highly enriched uranium source, full cost recovery add-on, per study dose) effective December 31, 2025.

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

Effective January 1, 2026, CMS has implemented a new add-on payment of $10 per dose for radiopharmaceuticals that use Tc-99m derived from domestically produced Mo-99. CMS established 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 percent of the Mo-99 used in the Tc-99m generator that produced the dose of Tc-99m must have been domestically produced.

Table 9, attachment A, lists the short descriptor, official long descriptor, status indicator, and APC assignment for HCPCS code C9176. For information on OPPS status indicators, please refer to OPPS Addendum D1 of the CY 2026 OPPS/ASC final rule for the latest definitions. The HCPCS code, along with its short descriptor, status indicator, and payment rate, is also listed in the January 2026 Update of the OPPS Addendum B.

8. Drugs, Biologicals, and Radiopharmaceuticals

a. New CY 2026 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals Receiving Pass-Through Status Effective January 1, 2026

Six (6) new HCPCS codes have been created for reporting drugs and biologicals in the hospital outpatient setting, where there have not previously been specific codes available starting on January 1, 2026. These drugs and biologicals will receive drug pass-through status starting January 1, 2026. These HCPCS codes are listed in Table 10, attachment A.

b. Existing HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals Starting Pass-Through Status as of January 1, 2026

There are two (2) existing HCPCS codes for certain drugs, biologicals, and radiopharmaceuticals in the outpatient setting that will have their pass-through status start on January 1, 2026. These codes are listed in Table 11, attachment A. Therefore, effective January 1, 2026, the status indicator for these codes is changing to Status Indicator = "G".

c. Existing HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals with Pass-Through Status Ending on December 31, 2025

There are four (4) HCPCS codes for certain drugs, biologicals, and radiopharmaceuticals in the outpatient setting that will have their pass-through status end on December 31, 2025. These codes are listed in Table 12, attachment A. Therefore, effective January 1, 2026, the status indicator for these codes is changing from "G" to "K". For more information on OPPS status indicators, refer to OPPS Addendum D1 of the CY 2026 OPPS/ASC final rule for the latest definition. These codes, along with their short descriptors and status indicators are also listed in the January 2026 Update of the OPPS Addendum B.

d. Newly Established HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals as of January 1, 2026

Twenty-five (25) new drug, biological, and radiopharmaceutical HCPCS codes will be established on January 1, 2026. These HCPCS codes are listed in Table 13, attachment A.

e. HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals Deleted as of December 31, 2025

Fifty-seven (57) drug, biological, and radiopharmaceutical HCPCS codes will be deleted on December 31, 2025. These HCPCS codes are listed in Table 14, attachment A.

f. HCPCS Codes for Drug, Biological, and Radiopharmaceutical Changing Payment Status Indicators Effective January 1, 2026

One hundred and twenty-nine (129) drug, biological and radiopharmaceutical HCPCS codes will be changing their payment status indicators on January 1, 2026. The HCPCS codes and their status indicators are listed in Table 15, attachment A. These changes would be made in the January 2026 I/OCE Update effective January 1, 2026.

g. HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals with Descriptor Changes as of January 1, 2026

One (1) drug, biological, and radiopharmaceutical HCPCS codes have had a substantial descriptor change as of January 1, 2026. This HCPCS code is listed in Table 16, attachment A
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h. Drugs and Biologicals with Payments Based on Average Sales Price (ASP)

For CY 2026, payment for the majority of nonpass-through drugs, biologicals, and therapeutic radiopharmaceuticals is made at a single rate of ASP + 6 percent (or ASP plus 6 or 8 percent of the reference product for biosimilars). In CY 2026, a single payment of ASP plus 6 percent for pass-through drugs, biologicals, and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items (or ASP plus 6 or 8 percent of the reference product for biosimilars). Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. Effective January 1, 2026, payment rates for many drugs and biologicals have changed from the values published in the CY 2026 OPPS/ASC final rule with comment period as a result of the new ASP calculations based on sales price submissions from the third quarter of CY 2025. In cases where adjustments to payment rates are necessary, changes to the payment rates will be incorporated in the January 2026 Fiscal Intermediary Standard System (FISS) release. CMS is not publishing the updated payment rates in this Change Request implementing the January 2026 update of the OPPS. However, the updated payment rates effective January 1, 2026, can be found in the January 2026 update of the OPPS Addendum A and Addendum B on the CMS website at https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient

i. Drugs and Biologicals Based on ASP Methodology with Restated Payment Rates

Some drugs and biologicals paid based on ASP methodology will have payment rates that are corrected retroactively. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payments rates will be accessible on the CMS website on the first date of the quarter at https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/restated-drug-biological-payment-rates
Providers may resubmit claims that were affected by adjustments to a previous quarter's payment files.

j. Drug/Biologic Invoice Pricing

Starting for dates of service on and after January 1, 2026, CMS has implemented the use of value code "92" for providers to report invoice pricing for certain drugs/biologicals with OPPS Status Indicator (SI) "E2" where no pricing is available but other applicable requirements are met, and the claim includes one of the revenue categories "0343", "0344", "0636", or "089X."

Value Code "92" was approved by the National Uniform Billing Committee (NUBC) for use by providers when federal regulations require for separate payment, invoice pricing for drug/biological services. Drug/biological lines that contain services with an OPPS SI of "E2" and one of the revenue categories "0343", "0344", "0636", or "089X" may qualify for invoice pricing under Medicare. In recent years there has been an increasing number of drug and biological HCPCS codes for which Average Sale Price (ASP), Wholesale Acquisition Cost (WAC), Average Wholesale Price (AWP), and Mean Unit Cost (MUC) information is not available. These are often HCPCS codes for new drugs or biologicals that have been approved for marketing, but for which the manufacturer does not have sales data, and WAC, AWP, and MUC information is not available. As a result, we are unable to assign a payable status indicator to these drugs or biologicals due to a lack of payment data.

Thus for CY 2026 we have updated our system to allow the use of the provider invoice amount to set a payment rate for a separately payable drug, biological, or radiopharmaceutical until its payment amount becomes available and CMS provides a payment rate in Addendum B. HCPCS code(s) with missing payment rate in Addendum B for a separately payable drug, biological, or radiopharmaceutical will indicate that CMS does not have pricing information (specifically, that ASP, WAC, AWP, and MUC information is not available to determine a payment rate) for a product, and would then calculate the payment for the product based on provider invoices, if the applicable Per-Day Cost (PDC) has been met. If all requirements

are met, Reason Code W7013 will be bypassed, and invoice payment policy will be applied. If a drug/biological line does not meet these requirements, that service line will continue to have reason code W7013 applied.

Additionally, in rare instances where more than one invoice priced drug is reported on a claim, a provider shall indicate the total amount of all invoiced drugs in value code 92 and then report in remarks the invoice amount for each individually invoiced priced HCPCS in remarks.

Example:
2 drugs on claim are invoiced priced
Value Code 92 = 11000.00
Remarks states:
J???? – Invoice amount $9999.99
J#### - Invoice amount $1000.01

9. Changes for Skin Substitutes

a. New Skin Substitute APCs and Their Payment Rates

For CY 2026, CMS finalized our proposals to unpackage skin substitute products from the application services, establish several new APCs. APC 6000 (PMA Skin Substitute Products) APC 6001 (510(k) Skin Substitute Products) and APC 6002 (361 HCT/P Skin Substitute Products)), and assign the skin substitute products to the new APCs based on relevant product characteristics, rather than based on stated prices for provision of these products when they are used during a covered application procedure paid under the OPPS (described by CPT codes 15271-15278). Secondly, CMS finalized the proposal to align skin substitute categorization for payment purposes consistent with their FDA regulatory status for 361 Human Cells, Tissues, and Cellular and Tissue-Based Products (HCT/P) and the device types: Pre-Market Approvals (PMAs) and 510(k)s. For CY 2026, CMS will use a single payment rate of $127.14/cm2 for APCs 6000 through 6002. Table 17, attachment A lists APC titles and their payment rates. They are also listed in the January 2026 Update of the OPPS Addendum A on the CMS website.

Individual HCPCS code APC assignments are listed in the January 2026 Update of the OPPS Addendum B on the CMS website.

b. New OPPS Skin Substitute Status Indicator "S1"

We have created a new status indicator, "S1," for sheet-form skin substitute products to allow for separate payment under the OPPS. We are assigning status indicator "S1" to all skin substitute products assigned to APCs 6000 through 6002. Table 18, attachment A, lists the definition of status indicator "S1". For more information on OPPS status indicators, refer to OPPS Addendum D1 of the Calendar Year 2026 OPPS/ASC final rule for the latest definition.

c. New Unlisted Skin Substitute Product HCPCS Codes

Effective January 1, 2026, we are creating three new unlisted codes to describe skin substitute products that are FDA authorized or cleared but have not yet received a specific individual HCPCS or CPT code: HCPCS codes Q4431 (Unlisted PMA skin substitute product), Q4432 (Unlisted 510(k) skin substitute product), and Q4433 (Unlisted 361 HCT/P skin substitute product). The unlisted HCPCS codes are assigned to the appropriate APCs based on the product's FDA approval or clearance. Specifically, HCPCS code Q4431 is assigned to APC 6000 (PMA Skin Substitute Products); Q4432 is assigned to APC 6001 (Unlisted 510(k) Skin Substitute Products); and HCPCS Code Q4433 is assigned to APC 6002 (Unlisted 361 HCT/P Skin Substitute Products). Table 19, attachment A, lists new unlisted skin substitute product HCPCS codes along with their long descriptors, APC assignments and payment rates. These codes, along with their short descriptors, status indicators, and payment rates, are also listed in the January 2026 Update of the OPPS Addendum B on the CMS website.

d. Deletion of Certain Previous Skin Substitute Application HCPCS Codes

To effectuate 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. Specifically, effective December 31, 2025, we deleted HCPCS codes C5271 through C5278. Application CPT codes 15271 through 15278 remain to describe skin substitute application procedures. CPT add-on application codes 15272, 15274, 15276, and 15278 will continue to be packaged in the outpatient hospital setting. Table 20, attachment A, lists deleted HCPCS skin substitute application codes.

10. Payment for Drug Administration Services at Excepted Provider-Based Departments (PBDs)

In the CY 2026 OPPS/ASC final rule we finalized a policy to use our authority under section 1833(t)(2)(F) of the Act to apply an amount equal to the site-specific Physician Fee Schedule (PFS) payment rate for nonexcepted items and services furnished by a nonexcepted 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 Act (departments that bill the modifier "PO" on claim lines).

11. Payment for Radiation Therapy Services Furnished at Nonexcepted Off-Campus PBDs: Revision of CPT Codes 44702, 44707, 44712 & Deletion of HCPCs Codes G6001-G6017

The PFS Relativity Adjuster is not applied to radiation therapy services (radiation treatment delivery and related imaging guidance services) furnished by nonexcepted off-campus PBDs. Due to section 1848(c)(2)(K) of the Social Security Act, which required maintenance of the CY 2016 coding and payment inputs for these services for CY 2017 and CY 2018 under the PFS, when the section 603 requirements were implemented in 2017, we instructed nonexcepted off-campus PBDs to bill PFS G-codes G6001 through G6017 for these services and append modifier "PN" to each applicable claim line for nonexcepted items and services so that they were paid the technical component rate for the code under the MPFS.

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

Consequently, effective January 1, 2026, we are deleting existing radiation therapy G-codes (G6001 through G6017) that describe imaging guidance for radiation treatment (G6001, G6002, G6017) and radiation treatment delivery (G6003-G6015) because CPT codes 77402, 77407, and 77412 will be used to report these services instead.

Effective January 1, 2026, nonexcepted 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.

12. Payment Adjustment for Certain Cancer Hospitals Beginning CY 2026

For certain cancer hospitals that receive 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, for CY 2018 and subsequent calendar years, the target Payment-to-Cost Ratio (PCR) that should be used in the calculation of the interim monthly payments and at final cost report settlement is reduced by 0.01. For CY 2026, the target PCR, after including the reduction required by Section 16002(b), is 0.87.

13. HCPCS Codes, Status Indicator, APC Assignments and Payment Limitations for Qualifying Non-Opioid Treatments for Pain Relief Starting January 1, 2026.

Section 4135 of the Consolidated Appropriations Act (CAA), 2023 established the eligibility criteria for temporary additional payments for certain non-opioid treatments for pain relief. CMS has evaluated

applicable non-opioid treatments against the statutory eligibility criteria and determined that the products in table 21, attachment A, 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 Act states that the separate payment amount specified in clause (ii), shall not exceed the estimated average of 18 percent 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. The finalized payment limitation amount for each product can be found in table 22, attachment A, and will be updated annually.

14. Changes to OPPS Pricer Logic

a. Rural Sole Community Hospitals (SCH) and Essential Access Community Hospitals (EACHs) will continue to receive a 7.1 percent payment increase for most services in CY 2026.
The rural SCH and EACH payment adjustment excludes drugs, biologicals, items and services paid at charges reduced to cost, and items paid under the pass-through payment policy in accordance with section 1833(t)(13)(B) of the Act, as added by section 411 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).

b. New OPPS payment rates and copayment amounts will be effective January 1, 2026. All copayment amounts will be limited to a maximum of 40 percent of the APC payment rate. Copayment amounts for each service cannot exceed the CY 2026 inpatient deductible of $1, 736. For most OPPS services, copayments are set at 20 percent of the APC payment rate.

c. For hospital outlier payments under OPPS, there will be no change in the multiple threshold of 1.75 for 2026. This threshold of 1.75 is multiplied by the total line-item APC payment to determine eligibility for outlier payments. This factor also is used to determine the outlier payment, which is 50 percent of estimated cost less 1.75 times the APC payment amount. The payment formula is (cost-(APC payment x 1.75))/2.

d. The fixed-dollar threshold for OPPS outlier payments decreases in CY 2026 relative to CY 2025. The estimated cost of a service must be greater than the APC payment amount plus $6,225 to qualify for outlier payments.

e. For outliers for CMHCs (bill type 76x), there will be no change in the multiple threshold of3.4 for 2026. This threshold of 3.4 is multiplied by the total line-item APC payment for the assigned PHP or IOP APC (5851 through 5854) to determine eligibility for outlier payments. This multiple amount is also used to determine the outlier payment, which is 50 percent of estimated costs less 3.4 times the APC payment amount. The payment formula is (cost-(APC payment x 3.4))/2.

f. Continuing our established policy for CY 2026, the OPPS Pricer will apply a reduced update ratio of 0.9805 to the payment and copayment for hospitals that fail to meet their hospital outpatient quality data reporting requirements or that fail to meet CMS validation edits. The reduced payment amount will be used to calculate outlier payments.

g. Effective January 1, 2026, we apply a reduction to OPPS payments and copayments for non-drug items and services for providers that are not excepted from the 340B remedy offset due to being new providers. These payments and copayments for non-drug items and services are calculated by applying a ratio of 0.9951.

h. Effective January 1, 2026, CMS is adopting the Fiscal Year (FY) 2026 Inpatient Prospective Payment System (IPPS) post-reclassification wage index values, as published in the FY 2026 IPPS final rule, with application of the CY 2026 out-commuting adjustment authorized by Section 505 of the MMA to non-IPPS (non-Inpatient Prospective Payment System) hospitals as implemented through the Pricer logic.

i. Effective January 1, 2026, payment rates associated with OPPS status indicators K1 and H1 for the Qualifying Non-Opioid Treatments for Pain Relief Policy will have their payment rates capped accordingly (listed in Table 21, attachment A).

Qualifying non-opioid treatments for pain relief will be evaluated for approval throughout CY 2026. Payment for qualifying products will be effectuated through the OPPS CR and quarterly update process.

15. Update the Outpatient Provider Specific File (OPSF)
Effective January 1, 2026, contractors shall maintain the accuracy of the provider records in the Outpatient Provider Specific File (OPSF) as changes occur in data element values.

a. Updating the OPSF for the Supplemental Wage Index and Supplemental Wage Index Flag Fields and Transitional Exception Policy

In CY 2026, the Supplemental Wage Index and Supplemental Wage Index Flag fields will be used to implement the cap on wage index decrease policy. The Pricer requires the hospital's applicable CY 2025 OPPS wage index in the Supplemental Wage Index field in order to properly apply all wage index policies and determine the hospital's CY 2026 OPPS wage index. Therefore, for CY 2026, in order to accurately pay claims for providers paid through the 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 shall ensure that no 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 otherwise instructed by CMS, 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.
There generally are several types of assignments for the supplemental wage index that would apply under the OPPS. In all of the cases below, the Supplemental Wage Index field would be "1" and the effective date of such changes included for the steps outlined below would be January 1, 2026.

1. If the MAC receives approval from the CMS Central Office to assign an OPPS provider a special wage index in CY 2025 and the use of either "1" or "2" in the Special Payment Indicator field, MACs shall do the following:·

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

2. If the MAC did not email CMS during CY 2025 for a provider's CY 2025 wage index:

i. For IPPS hospitals that are also paid under the OPPS

For these hospitals, as described in detail in the instructions in MAC Implementation File 5 at https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2026-ipps-final-rule-home-page
the 2025 wage index should be obtained from the Table 2 associated with the FY 2026 IPPS final rule (or Correction Notice, if applicable). In other instances in which there is an IPPS value derived through the steps outlined in the "MAC Implementation File 5" instructions document, that same FY 2025 wage index value entered into the Supplemental Wage index for the IPSF shall also be entered into the Supplemental Wage Index Field and would apply into the OPPS on a calendar year basis.

In this case MACs shall do the following:

- 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 a "1" in the Supplemental Wage Index Flag field.
    - Ensure that the Special Wage Index and Special Payment Indicator fields are blank.
    - Establish the record with an effective date of January 1, 2026.

If a Special Wage Index value for CY 2026 would apply due to the transitional exception (from Table 2 or

through the steps outlined in MAC Implementation File 5), in addition to the steps above:

- Enter the same value of "1" or "2" from the table into the Special Payment Indicator field.
    - Enter the same value for the Special Wage Index from the table into the Special Wage Index field.

ii. For Non-IPPS hospitals, CMHCs, and other OPPS providers

We have made the Supplemental Wage Index assignments (based on the CY 2025 OPPS wage index) and Special Wage Index assignments (for the transitional exception policy) for non-IPPS hospitals, CMHCs, and other OPPS providers available on the CMS website at https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/annual-policy-files under "*Annual Policy Files*."

In this case, MACs shall do the following:

- The CY 2025 Wage index from the Excel file available online shall be entered into the Supplemental Wage Index field.
    - Enter a "1" in the Supplemental Wage Index Flag field.
    - Ensure that the Special Wage Index and Special Payment Indicator fields are blank.
    - Establish the record with an effective date of January 1, 2026.

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 Excel file available online into the Special Wage Index field.

b. Updating the OPSF for Expiration of Transitional Outpatient Payments (TOPs)

Cancer and children's hospitals are held harmless under section 1833(t)(7)(D)(ii) of the Social Security Act and continue to receive hold harmless TOPs permanently. For CY 2026, cancer hospitals will continue to receive an additional payment adjustment.

c. Updating the OPSF for the Hospital Outpatient Quality Reporting (HOQR) Program Requirements

Effective for OPPS services furnished on or after January 1, 2009, subsection (d) hospitals that have failed to submit timely hospital outpatient quality data as required in Section 1833(t)(17)(A) of the Act will receive payment under the OPPS that reflects a 2 percentage point reduction from the annual OPPS update for failure to meet the HOQR program requirements. This reduction will not apply to hospitals not required to submit quality data or hospitals that are not paid under the OPPS.

For January 1, 2026, contractors shall maintain the accuracy of the provider records in the OPSF by updating the Hospital Quality Indicator field. CMS will release a Technical Direction Letter that lists Subsection (d) hospitals that are subject to and fail to meet the HOQR program requirements. Once this list is released, A/B MACs will update the OPSF by removing the '1', (that is, ensure that the Hospital Quality Indicator field is blank) for all hospitals identified on the list and will ensure that the OPSF Hospital Quality Indicator field contains '1' for all hospitals that are not on the list. CMS notes that if these hospitals are later determined to have met the HOQR program requirements, A/B MACs shall update the OPSF. For greater detail regarding updating the OPSF for the HOQR program requirements, see Transmittal 368, CR 6072, issued on August 15, 2008.

d. Updating the OPSF for Cost to Charge Ratios (CCR)

As stated in publication 100-04, Medicare Claims Processing Manual, chapter 4, section 50.1, contractors 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 and, when applicable, device department cost-to-charge ratios. The file of OPPS hospital upper limit CCRs and the file of Statewide CCRs are located on the CMS website at https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/annual-policy-files under "*Annual Policy Files*."

e. Updating the "County Code" Field

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

f. Updating the "Wage Index Location Core-Based Statistical Areas (CBSA)" Field

We note that under historical and current 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 OPPS on a calendar year basis. Therefore, MACs shall ensure that wage index reclassifications applied under the FY 2026 IPPS are also reflected in the OPSF on a CY 2026 OPPS basis.

g. Updating the "Payment Core-Based Statistical Areas (CBSA)" Field

In the prior layout of the OPSF, there were only two CBSA related fields: the "Actual Geographic Location CBSA" and the "Wage Index Location CBSA." These fields are used to wage adjust OPPS payment through the Pricer if there is not an assigned Special Wage Index (as has been used historically to assign the wage index for hospitals receiving the outmigration adjustment).

In Transmittal 3750, dated April 19, 2017, for Change Request 9926, we created an additional field for the "Payment CBSA," similar to the IPPS, to allow for consistency between the data in the two systems and identify when hospitals receive dual reclassifications. In the case of dual reclassifications, similar to the IPPS, the "Payment CBSA" field will be used to note the Urban to Rural Reclassification Under Section 1886(d)(8)(E) of the Act (§ 412.103). This "Payment CBSA" field is not used for wage adjustment purposes, but to identify when the 412.103 reclassification applies, because rural status is considered for rural sole community hospital adjustment eligibility. We further note that whereas the IPPS Pricer allows the Payment CBSA, even when applied as the sole CBSA field (without a Wage Index CBSA), to be used for wage adjusting payment, that field is not used for wage adjustment the OPPS.

3. Wage Index Policies in the CY 2026 OPPS Final Rule

In the FY 2026 IPPS and CY 2026 OPPS final rules, we finalized the following changes to the wage index: discontinued the log wage index hospital policy, continued to apply a 5 percent cap for CY 2026 on any wage index values that decreased relative to CY 2025, and implemented a transitional exception policy for hospitals that benefitted from the CY 2024 low wage index hospital policy.

16. Coverage Determinations

As a reminder, the fact that a drug, device, procedure, or service is assigned a HCPCS code and a payment rate under the OPPS does not imply coverage by the Medicare program but indicates only how the product, procedure, or service may be paid if covered by the program. MACs determine whether a drug, device,

procedure, or other service meets all program requirements for coverage. For example, MACs determine that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

III. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
14361.1	Medicare contractors shall access the OPPS Pricer via the Cloud to pay 2026 payment rates on claims with statement from dates on or after January 1, 2026.	X		X						PCS
14361.2	Medicare contractors shall adjust, as appropriate, claims brought to their attention with any retroactive changes that were received prior to implementation of the January 2026 OPPS PRICER.	X		X						PCS
14361.3	The Shared System Maintainer (SSM) shall update the 2026 Per-Day Cost (PDC) threshold annual amount on the PARM PRMDRUGC: • DRUG PACKAGING AMT = $140.00 • DIAG RADIOPHARM AMT = $655.00					X				
14361.4	As specified in Chapter 4, Section 50.1, of the Claims Processing Manual, Medicare contractors shall maintain the accuracy of the data and update the OPSF file as changes occur in data element values. For CY 2025, this includes all changes to the OPSF identified in Section 15 of this CR.	X		X						

IV. PROVIDER EDUCATION

Medicare Learning Network® (MLN): CMS will develop and release national provider education content and market it through the MLN Connects® newsletter shortly after we issue the CR. MACs shall link to relevant information on your website and follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 for distributing the newsletter to providers. When you follow this manual section, you don't need to separately

track and report MLN content releases. You may supplement with your local educational content after we release the newsletter.

Impacted Contractors: A/B MAC Part A, A/B MAC Part HHH

V. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

VI. CONTACTS

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VII. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 1

Medicare Claims Processing Manual

Chapter 4 - Part B Hospital

(Including Inpatient Hospital Part B and OPPS)

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(Rev. 13573; Issued: 01-28-26)

20.6.11 - Modifier PO

(Rev. 13573; Issued: 01-28-26; Effective: 01-01-26; Implementation: 01-05-26)

PO: Excepted service provided at an off-campus, outpatient, provider-based department of a hospital

As described in the CY 2015 OPPS/ASC final rule (79 FR 66910 through 66914), CMS established HCPCS modifier PO to describe excepted service provided at an off-campus, outpatient, provider-based department of a hospital. This modifier should be reported with every HCPCS code for all outpatient hospital items and services furnished in an excepted off-campus provider-based department of a hospital. See 42 CFR 413.65(a)(2) for a definition of "campus".

This modifier should not be reported for remote locations of a hospital (defined at 42 CFR 413.65(a)(2)), satellite facilities of a hospital (defined at 42 CFR 412.22(h)), or for services furnished in an emergency department.

Note that reporting of this modifier was voluntary for CY 2015, but is required beginning January 1, 2016.

We note that, beginning in CY 2019, we finalized a policy to pay for clinic visits (G0463) billed at excepted off-campus provider-based departments (departments that bill modifier "PO" on their claim lines) at the PFS-equivalent amount. We phased-in this policy in over a two-year period. Specifically, half of the total 60-percent payment reduction, a 30-percent reduction, was applied in CY 2019. Consequently, these departments were paid 70 percent of the OPPS rate (100 percent of the OPPS rate minus the 30-percent payment reduction that applies in CY 2019) for the clinic visit. In CY 2020, the two-year phase-in was completed. The PFS-equivalent rate for CY 2020 and subsequent years is 40 percent of the proposed OPPS payment (that is, 60 percent less than the proposed OPPS rate). *Additionally, beginning in CY 2026 HCPCs codes in the drug administration APCs (5691-5694) billed at excepted off-campus provider-based departments (departments that bill modifier "PO" on their claim lines) will be paid at the PFS-equivalent amount.*

Off-campus provider-based departments should not report both the PO and PN modifiers on the same claim line. However, if services reported on a claim reflect items and services furnished from both an excepted and a nonexcepted off-campus PBD of the hospital, the PO modifier should be used on the excepted claim lines and the PN modifier should be used on the nonexcepted claim lines.

Neither the PO nor the PN modifier is to be reported by the following hospital departments:

- A dedicated emergency department as defined in existing regulations at 42 CFR 489.24(b);
- A PBD that is "on the campus," or within 250 yards, of the hospital or a remote location of the hospital as defined under 42 CFR 413.65.

180.7 - Inpatient *O*nly Services

(Rev. 13573; Issued: 01-28-26; Effective: 01-01-26; Implementation: 01-05-26)

Section 1833(t)(1)(B)(i) of the Act allows CMS to define the services for which payment under the OPPS is appropriate and the Secretary has determined that the services designated to be "inpatient only" services are not appropriate to be furnished in a hospital outpatient department. "Inpatient only" services are generally, but not always, surgical services that require inpatient care because of the nature of the procedure, the typical underlying physical condition of patients who require the service, or the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged. An example of an "inpatient only" service is CPT code 33513, "Coronary artery bypass, vein only; four coronary venous grafts." The designation of services to be "inpatient only" is open to public comment each year as part of the annual rulemaking process. Procedures removed from the "inpatient only" list may be appropriately

furnished in either the inpatient or outpatient settings and such procedures continue to be payable when furnished in the inpatient setting.

There is no payment under the OPPS for services that CMS designates to be "inpatient only" services. These services have an OPPS status indicator of "C" in the OPPS Addendum B and are listed together in Addendum E of each year's OPPS/ASC final rule. For the most current Addendum B and for Addendum E published with the OPPS notices and regulations, see http://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/HospitalOutpatientPPS/index.html.

Excluding the handful of exceptions discussed below, CMS does not pay for an "inpatient only" service furnished to a person who is registered in the hospital as an outpatient and reports the service on the outpatient hospital bill type (TOB 13X). CMS also does not pay for all other services on the same day as the "inpatient only" procedure.

There are two exceptions to the policy of not paying for outpatient services furnished on the same day with an "inpatient only" service that would be paid under the OPPS if the inpatient service had not been furnished:

Exception 1: If the "inpatient only" service is defined in CPT to be a "separate procedure" and the other services billed with the "inpatient only" service contain a procedure that can be paid under the OPPS and that has an OPPS SI=T on the same date as the "inpatient only" procedure or OPPS SI = J1 on the same claim as the "inpatient only" procedure, then the "inpatient only" service is denied but CMS makes payment for the separate procedure and any remaining payable OPPS services. The list of "separate procedures" is available with the Integrated Outpatient Code Editor (I/OCE) documentation. See http://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/.

Exception 2: If an "inpatient only" service is furnished but the patient expires before inpatient admission or transfer to another hospital and the hospital reports the "inpatient only" service with modifier "CA", then CMS makes a single payment for all services reported on the claim, including the "inpatient only" procedure, through one unit of APC 5881, (Ancillary outpatient services when the patient dies.) Hospitals should report modifier CA on only one procedure.

As of January 1, 202*1*, procedures that have been removed from the *I*npatient *O*nly (IPO) list are exempt from certain medical review activities related to compliance with the 2-midnight rule, which states that generally services are considered appropriate for inpatient hospital admission and payment under Medicare Part A when the physician expects the patient to require a stay that crosses at least 2 midnights and admits the patient to the hospital based upon that expectation.

Specifically, procedures that have been removed from the IPO list are not eligible for referral to Recovery Audit Contractors (RACs) for noncompliance with the 2-midnight rule following their removal from the IPO list. These procedures will not be considered by the *Medicare review contractors* in determining whether a provider exhibits persistent noncompliance with the 2-midnight rule for purposes of referral to the RAC nor will these procedures be reviewed by RACs for "patient status" *until it is determined that the procedure is more commonly performed in the outpatient setting*.

During the exemption period, *Medicare review contractors* will have the opportunity to review claims for procedures that have been recently removed from the IPO list in order to provide education for practitioners and providers regarding compliance with the 2-midnight rule, but claims identified as noncompliant with the 2-midnight rule will not be denied with respect to the site-of-service under Medicare Part A.

Attachment A − Tables for the Policy Section

Table 1. ─ Old and New Long Descriptors for CPT Code 90480, Effective January 1, 2026

CPT Code	October 2025 Long Descriptor	January 2026 Long Descriptor
90480	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]) vaccine, single dose	Immunization administration by intramuscular injection, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine; first or only component of each vaccine administered

Table 2. ─ Old and New APC Titles for APC 9398, Effective January 1, 2026

APC	October 2025 APC Title	January 2026 APC Title
9398	Covid-19 Vaccine Admin Dose 2 of 2, Single Dose Product or Additional Dose	Covid-19 Vaccine Administration

Table 3. ─ New Covid-19 Add-On CPT Code 90481

CPT Code	Long Descriptor	OPPS SI
90481	Immunization administration by intramuscular injection, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine; each additional component administered (List separately in addition to code for primary procedure)	E1

Table 4. ─ PLA Coding Changes Effective January 1, 2026

CPT Code	Long Descriptor	OPPS SI
0600U	Infectious disease (wound infection), identification of 65 organisms and 30 antibiotic resistance genes, wound swab, real-time PCR, reported as positive or negative for each organism	Q4
0601U	Infectious disease (periprosthetic joint infection), analysis of 11 biomarkers (alpha defensins 1–3, Creactive protein, microbial antigens for Staphylococcus [SPA, SPB], Enterococcus, Candida, and C. acnes, total nucleated cell count, percent neutrophils, RBC count, and absorbance at 280 nm) using immunoassays, hematology, clinical chemistry, synovial fluid, and diagnostic algorithm reported as a probability score	Q4
0602U	Endocrinology (diabetes), insulin (INS) gene methylation using digital droplet PCR, insulin, and Cpeptide immunoassay, serum, Hemoglobin A1c immunoassay, whole blood, algorithm reported as diabetes-risk score	Q4

0603U	Drug assay, presumptive, 77 drugs or metabolites, urine, liquid chromatography with andem mass spectrometry (LC-MS/MS), results reported as positive or negative	Q4
0604U	Allergy and immunology (chronic recurrent angioedema), 4 bradykinin peptides, liquid chromatography and tandem mass spectrometry (LC-MS/ MS), whole blood, quantitative	Q4
0605U	Allergy and immunology (hereditary alpha tryptasemia), DNA, analysis of TPSAB1 gene copy number variation using digital PCR, whole blood, results reported with genotypespecific interpretation of alpha-tryptase copy number and algorithmic classification as normal or abnormal	A
0606U	Hematology (red cell membrane disorders), RBCs, osmotic gradient ektacytometry, whole blood, quantitative	Q4
0607U	Reproductive medicine (endometrial microbiome assessment), real-time PCR analysis for 31 bacterial DNA targets from endometrial biopsy, reported with quantified levels of bacterial presence and targeted treatment recommendations	A
0608U	Reproductive medicine (endometrial microbiome assessment), real-time PCR analysis for 10 bacterial DNA targets from endometrial biopsy, reported with quantified levels of bacterial presence and targeted treatment recommendations	A
0609U	Oncology (prostate), immunoassay for total prostate-specific antigen (PSA) and free PSA, serum or plasma, combined with clinical features, algorithm reported as a probability score for clinically significant prostate cancer	Q4
0610U	Infectious disease (antimicrobial susceptibility), phenotypic antimicrobial susceptibility testing of positive blood culture using microfluidic sensor technology to quantify bacterial growth response to multiple antibiotic types, reporting categorical susceptibility (susceptible, susceptible dose dependent, intermediate, resistant), minimum inhibitory concentration, and interpretive comments	Q4
0611U	Oncology (liver), analysis of over 1,000 methylated regions, cell-free DNA from plasma, algorithm reported as a quantitative result	A
0612U	Oncology (liver), analysis of over 1,000 methylated regions, cell-free DNA from plasma, algorithm reported as a quantitative result	A

0613U	Oncology (urothelial carcinoma), DNA methylation and mutation analysis of 6 biomarkers (TWIST1, OTX1, ONECUT2, FGFR3, HRAS, TERT promoter region), methylation-specific PCR and targeted next-generation sequencing, urine, algorithm reported as a probability index for bladder cancer and upper tract urothelial carcinoma	A

Table 5A. -- Device Pass-Through Category HCPCS Codes

HCPCS Code	Long Descriptor	SI	APC
C1607	Neurostimulator, integrated (implantable), rechargeable with all implantable and external components including charging system	H	2086
C1608	Prosthesis, total, dual mobility, first carpometacarpal joint (implantable)	H	2087

(1) HCPCS Code C1607

Device category HCPCS code C1607 should always be billed with the following CPT codes:

HCPCS Code	Long Descriptor	SI	APC	CY 2026 Device Offset Amount
0908T	Open implantation of integrated neurostimulation system, vagus nerve, including analysis and programming, when performed	J1	5465	$25,904.96
0909T	Replacement of integrated neurostimulation system, vagus nerve, including analysis and programming, when performed	J1	5465	$25,904.96

(2) HCPCS Code C1608

Device category HCPCS code C1608 should always be billed with the following CPT codes:

HCPCS Code	Long Descriptor	SI	APC	CY 2026 Device Offset Amount
1003T	Arthroplasty, first carpometacarpal joint, with distal trapezial and proximal first metacarpal prosthetic replacement (eg, first carpometacarpal total joint)	J1	5115	$5,895.98

Table 5B. -- Device Pass-Through Category HCPCS Code C1741

HCPCS Code	Long Descriptor	SI	APC
C1741	Anchor/screw for bone fixation, absorbable, metallic (implantable)	H	2077

Device category HCPCS code C1741 should always be billed with the following CPT codes:

HCPCS Code	Long Descriptor	SI	APC	CY 2026 Device Offset Amount
27766	Open treatment of medial malleolus fracture, includes internal fixation, when performed	J1	5114	$1,592.39
27769	Open treatment of posterior malleolus fracture, includes internal fixation, when performed	J1	5114	$2,530.19
27784	Open treatment of proximal fibula or shaft fracture, includes internal fixation, when performed	J1	5114	$2,676.97
27792	Open treatment of distal fibular fracture (lateral malleolus), includes internal fixation, when performed	J1	5114	$2,778.53
27814	Open treatment of bimalleolar ankle fracture (eg, lateral and medial malleoli, or lateral and posterior malleoli, or medial and posterior malleoli), includes internal fixation, when performed	J1	5114	$2,761.48
27822	Open treatment of trimalleolar ankle fracture, includes internal fixation, when performed, medial and/or lateral malleolus; without fixation of posterior lip	J1	5114	$2,731.83
27823	Open treatment of trimalleolar ankle fracture, includes internal fixation, when performed, medial and/or lateral malleolus; with fixation of posterior lip	J1	5114	$2,688.83
27826	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of fibula only	J1	5114	$2,401.94
27827	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of tibia only	J1	5115	$5,115.54
27828	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of both tibia and fibula	J1	5115	$5,266.38
27829	Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed	J1	5114	$2,870.46

27832	Open treatment of proximal tibiofibular joint dislocation, includes internal fixation, when performed, or with excision of proximal fibula	J1	5114	$1,927.48

Device category HCPCS code C1735 should always be billed with the following CPT codes:

HCPCS Code	Long Descriptor	SI	APC	CY 2026 Device Offset Amount
0338T	Transcatheter renal sympathetic denervation, percutaneous approach including arterial puncture, selective catheter placement(s) renal artery(ies), fluoroscopy, contrast injection(s), intraprocedural roadmapping and radiological supervision and interpretation, including pressure gradient measurements, flush aortogram and diagnostic renal angiography when performed; unilateral	J1	5192	$0.00
0339T	Transcatheter renal sympathetic denervation, percutaneous approach including arterial puncture, selective catheter placement(s) renal artery(ies), fluoroscopy, contrast injection(s), intraprocedural roadmapping and radiological supervision and interpretation, including pressure gradient measurements, flush aortogram and diagnostic renal angiography when performed; bilateral	J1	5192	$0.00

Device category HCPCS code C1736 should always be billed with the following CPT codes:

HCPCS Code	Long Descriptor	SI	APC	CY 2026 Device Offset Amount
0338T	Transcatheter renal sympathetic denervation, percutaneous approach including arterial puncture, selective catheter placement(s) renal artery(ies), fluoroscopy, contrast injection(s), intraprocedural roadmapping and radiological supervision and interpretation, including pressure gradient measurements, flush aortogram and diagnostic renal angiography when performed; unilateral	J1	5192	$0.00
0339T	Transcatheter renal sympathetic denervation, percutaneous approach including arterial puncture, selective catheter placement(s) renal artery(ies), fluoroscopy, contrast injection(s), intraprocedural roadmapping and radiological supervision and interpretation, including pressure gradient measurements, flush aortogram and diagnostic renal angiography when performed; bilateral	J1	5192	$0.00

Device category HCPCS code C9610 should always be billed with the following CPT codes:

HCPCS Code	Long Descriptor	SI	APC	CY 2026 Device Offset Amount
92920	Percutaneous transluminal coronary angioplasty; single major coronary artery or branch	J1	5192	$0.00
92924	Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; single major coronary artery or branch	J1	5193	$0.00
92928	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch	J1	5193	$0.00
92933	Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch	J1	5194	$0.00
92937	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel	J1	5193	$0.00

92943	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; single vessel	J1	5193	$0.00
C9600	Percutaneous transcatheter placement of drug eluting intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch	J1	5193	$0.00
C9602	Percutaneous transluminal coronary atherectomy, with drug eluting intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch	J1	5194	$0.00
C9604	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of drug-eluting intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel	J1	5193	$0.00
C9607	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of drug-eluting intracoronary stent, atherectomy and angioplasty; single vessel	J1	5194	$0.00
0913T	Percutaneous transcatheter therapeutic drug delivery by intracoronary drug delivery balloon (eg, drug-coated, drug-eluting), including mechanical dilation by nondrug-delivery balloon angioplasty, endoluminal imaging using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) when performed, imaging supervision, interpretation, and report, single major coronary artery or branch	J1	5193	$0.00
92930	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed, single major coronary artery and/or its branch(es); 2 or more distinct coronary lesions with 2 or more coronary stents deployed in 2 or more coronary segments, or a bifurcation lesion requiring angioplasty and/or stenting in both the main artery and the side branch	J1	5194	0.00

92945	Percutaneous transluminal revascularization of chronic total occlusion, single coronary artery, coronary artery branch, or coronary artery bypass graft, and/or subtended major coronary artery branches of the bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; combined antegrade and retrograde approaches	J1	5193	0.00

Device category HCPCS code C1737 should always be billed with the following CPT codes:

HCPCS Code	Long Descriptor	SI	APC	CY 2026 Device Offset Amount
27279	Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device	J1	5116	$0.00
22612	Arthrodesis, posterior or posterolateral technique, single interspace; lumbar (with lateral transverse technique, when performed)	J1	5116	$0.00
22630	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace, lumbar;	J1	5117	$0.00
22633	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace, lumbar;	J1	5117	$0.00
27280	Arthrodesis, sacroiliac joint, open, includes obtaining bone graft, including instrumentation, when performed	J1	5116	$0.00

Device category HCPCS code C1602 should always be billed with the following CPT codes:

HCPCS Code	Long Descriptor	SI	APC	CY 2026 Device Offset Amount
21510	Incision, deep, with opening of bone cortex (eg, for osteomyelitis or bone abscess), thorax	J1	5113	$1.34
23035	Incision, bone cortex (eg, osteomyelitis or bone abscess), shoulder area	J1	5112	$0.00
23170	Sequestrectomy (eg, for osteomyelitis or bone abscess), clavicle	J1	5113	$1,558.11
23172	Sequestrectomy (eg, for osteomyelitis or bone abscess), scapula	J1	5113	$1,242.21
23174	Sequestrectomy (eg, for osteomyelitis or bone abscess), humeral head to surgical neck	J1	5114	$178.66
23180	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), clavicle	J1	5114	$0.00

23182	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), scapula	J1	5114	$0.00
23184	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), proximal humerus	J1	5114	$1,066.79
23935	Incision, deep, with opening of bone cortex (eg, for osteomyelitis or bone abscess), humerus or elbow	J1	5113	$87.92
24134	Sequestrectomy (eg, for osteomyelitis or bone abscess), shaft or distal humerus	J1	5114	$0.00
24136	Sequestrectomy (eg, for osteomyelitis or bone abscess), radial head or neck	J1	5113	$0.00
24138	Sequestrectomy (eg, for osteomyelitis or bone abscess), olecranon process	J1	5114	$0.00
24140	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), humerus	J1	5113	$186.20
24145	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), radial head or neck	J1	5114	$174.21
24147	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), olecranon process	J1	5113	$68.86
25035	Incision, deep, bone cortex, forearm and/or wrist (eg, osteomyelitis or bone abscess)	J1	5114	$30.39
25150	Partial excision (craterization, saucerization, or diaphysectomy) of bone (eg, for osteomyelitis); ulna	J1	5113	$6.35
25151	Partial excision (craterization, saucerization, or diaphysectomy) of bone (eg, for osteomyelitis); radius	J1	5113	$0.00
26230	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis); metacarpal	J1	5113	$14.71
26992	Incision, bone cortex, pelvis and/or hip joint (eg, osteomyelitis or bone abscess)	J1	5113	$0.00
27070	Partial excision, wing of ilium, symphysis pubis, or greater trochanter of femur, (craterization, saucerization) (eg, osteomyelitis or bone abscess); superficial	J1	5113	$2,412.88
27071	Partial excision, wing of ilium, symphysis pubis, or greater trochanter of femur, (craterization, saucerization) (eg, osteomyelitis or bone abscess); deep (subfascial or intramuscular)	J1	5113	$0.00
27303	Incision, deep, with opening of bone cortex, femur or knee (eg, osteomyelitis or bone abscess)	J1	5113	$1,036.29
27360	Partial excision (craterization, saucerization, or diaphysectomy) bone, femur, proximal tibia and/or fibula (eg, osteomyelitis or bone abscess)	J1	5113	$89.25
27607	Incision (eg, osteomyelitis or bone abscess), leg or ankle	J1	5113	$458.31

27640	Partial excision (craterization, saucerization, or diaphysectomy), bone (eg, osteomyelitis); tibia	J1	5113	$264.76
27641	Partial excision (craterization, saucerization, or diaphysectomy), bone (eg, osteomyelitis); fibula	J1	5113	$152.77
28005	Incision, bone cortex (eg, osteomyelitis or bone abscess), foot	J1	5113	$253.72
28120	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); talus or calcaneus	J1	5113	$342.98
28122	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); tarsal or metatarsal bone, except talus or calcaneus	J1	5113	$144.41
25145	Sequestrectomy (eg, for osteomyelitis or bone abscess), forearm and/or wrist	J1	5113	$279.13
26236	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis); distal phalanx of finger	J1	5112	$1.48
28124	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); phalanx of toe	J1	5113	$51.48
11012	Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin, subcutaneous tissue, muscle fascia, muscle, and bone	J1	5073	$62.02

Device category HCPCS code C1601 should always be billed with the following CPT codes:

HCPCS Code	Long Descriptor	SI	APC	CY 2026 Device Offset Amount
31615	Tracheobronchoscopy through established tracheostomy incision	T	5162	$0.17
31622	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)	J1	5153	$10.00
31623	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with brushing or protected brushings	J1	5153	$6.00
31624	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial alveolar lavage	J1	5153	$4.55
31625	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple sites	J1	5153	$15.64
31626	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of fiducial markers, single or multiple	J1	5155	$755.64

31628	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe	J1	5154	$79.61
31629	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i)	J1	5154	$87.99
31630	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with tracheal/bronchial dilation or closed reduction of fracture	J1	5154	$647.17
31631	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of tracheal stent(s) (includes tracheal/bronchial dilation as required)	J1	5155	$1,994.37
31634	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, with assessment of air leak, with administration of occlusive substance (eg, fibrin glue), if performed	J1	5155	$1,582.67
31635	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of foreign body	J1	5153	$25.28
31636	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of bronchial stent(s) (includes tracheal/bronchial dilation as required), initial bronchus	J1	5155	$3,248.97
31638	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with revision of tracheal or bronchial stent inserted at previous session (includes tracheal/bronchial dilation as required)	J1	5155	$896.24
31640	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with excision of tumor	J1	5154	$253.69
31641	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with destruction of tumor or relief of stenosis by any method other than excision (eg, laser therapy, cryotherapy)	J1	5154	$372.53
31643	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of catheter(s) for intracavitary radioelement application	J1	5153	$0.00
31645	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with therapeutic aspiration of tracheobronchial tree, initial	J1	5153	$28.73
31646	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with therapeutic aspiration of tracheobronchial tree, subsequent, same hospital stay	T	5152	$0.00
31647	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with	J1	5155	$3,816.42

	balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), initial lobe			
31648	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), initial lobe	J1	5154	$139.03
31652	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (ebus) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]), one or two mediastinal and/or hilar lymph node stations or structures	J1	5154	$46.47
31653	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (ebus) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]), 3 or more mediastinal and/or hilar lymph node stations or structures	J1	5154	$46.09
31660	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 1 lobe	J1	5155	$4,097.62
31661	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 2 or more lobes	J1	5155	$4,061.57
31785	Excision of tracheal tumor or carcinoma; cervical	J1	5165	$23.59
31627	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with computer-assisted, image-guided navigation (list separately in addition to code for primary procedure[s])	N	NA	$0.00
31632	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), each additional lobe (list separately in addition to code for primary procedure)	N	NA	$0.00
31633	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s), each additional lobe (list separately in addition to code for primary procedure)	N	NA	$0.00
31637	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; each additional major bronchus stented (list separately in addition to code for primary procedure)	N	NA	$0.00
31649	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), each additional lobe (list separately in addition to code for primary procedure)	Q2	5153	$0.00

31651	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), each additional lobe (list separately in addition to code for primary procedure[s])	N	NA	$0.00
31654	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transendoscopic endobronchial ultrasound (ebus) during bronchoscopic diagnostic or therapeutic intervention(s) for peripheral lesion(s) (list separately in addition to code for primary procedure[s])	N	NA	$0.00

Table 5C. -- Expiring Pass-through Status for Three Device Category HCPCS Codes Effective January 1, 2026

HCPCS Code	Long Descriptor	Device Pass-through Status Expiration Date
C1826	Generator, neurostimulator (implantable), includes closed feedback loop leads and all implantable components, with rechargeable battery and charging system	12/31/2025
C1827	Generator, neurostimulator (implantable), non-rechargeable, with implantable stimulation lead and external paired stimulation controller	12/31/2025
C1747	Endoscope, single-use (i.e. disposable), urinary tract, imaging/illumination device (insertable)	12/31/2025

Table 6. -- List of Device Category HCPCS Codes and Definitions Used for Present and Previous Pass-Through Payment *

	HCPCS Codes	Category Long Descriptor	Date First Populated	Pass-Through Expiration Date***
1.	C1883	Adaptor/extension, pacing lead or neurostimulator lead (implantable)	08/01/2000	12/31/2002
2.	C1765	Adhesion barrier	10/01/00 – 3/31/2001; 07/01/2001	12/31/2003
3.	C1713	Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)	08/01/2000	12/31/2002
4.	L8690	Auditory osseointegrated device, includes all internal and external components	01/01/2007	12/31/2008
5.	C1832	Autograft suspension, including cell processing and application, and all system components	01/01/2022	12/31/2024
6.	C1715	Brachytherapy needle	08/01/2000	12/31/2002
7.	C1716	Brachytherapy source, non-stranded, Gold-198, per source	10/01/2000	12/31/2002
8.	C1717	Brachytherapy source, non-stranded, high dose rate Iridium-192, per source	01/01/2001	12/31/2002
9.	C1718	Brachytherapy source, Iodine 125, per source	08/01/2000	12/31/2002

10.	C1719	Brachytherapy source, non-stranded, non-high dose rate Iridium-192, per source	10/01/2000	12/31/2002
11.	C1720	Brachytherapy source, Palladium 103, per source	08/01/2000	12/31/2002
12.	C2616	Brachytherapy source, non-stranded, Yttrium-90, per source	01/01/2001	12/31/2002
13.	C2632	Brachytherapy solution, iodine – 125, per mCi	01/01/2003	12/31/2004
14.	C1721	Cardioverter-defibrillator, dual chamber (implantable)	08/01/2000	12/31/2002
15.	C1882	Cardioverter-defibrillator, other than single or dual chamber (implantable)	08/01/2000	12/31/2002
16.	C1722	Cardioverter-defibrillator, single chamber (implantable)	08/01/2000	12/31/2002
17.	C1888	Catheter, ablation, non-cardiac, endovascular (implantable)	07/01/2002	12/31/2004
18.	C1726	Catheter, balloon dilatation, non-vascular	08/01/2000	12/31/2002
19.	C1727	Catheter, balloon tissue dissector, non-vascular (insertable)	08/01/2000	12/31/2002
20.	C1728	Catheter, brachytherapy seed administration	01/01/2001	12/31/2002
21.	C1729	Catheter, drainage	10/01/2000	12/31/2002
22.	C1730	Catheter, electrophysiology, diagnostic, other than 3D mapping (19 or fewer electrodes)	08/01/2000	12/31/2002
23.	C1731	Catheter, electrophysiology, diagnostic, other than 3d mapping (20 or more electrodes)	08/01/2000	12/31/2002
24.	C1732	Catheter, electrophysiology, diagnostic/ablation, 3D or vector mapping	08/01/2000	12/31/2002
25.	C1733	Catheter, electrophysiology, diagnostic/ablation, other than 3D or vector mapping, other than cool-tip	08/01/2000	12/31/2002
26.	C2630	Catheter, electrophysiology, diagnostic/ablation, other than 3D or vector mapping, cool-tip	10/01/2000	12/31/2002
27.	C1886	Catheter, extravascular tissue ablation, any modality (insertable)	01/01/2012	12/31/2013
28.	C1887	Catheter, guiding (may include infusion/perfusion capability)	08/01/2000	12/31/2002
29.	C1750	Catheter, hemodialysis/peritoneal, long-term	08/01/2000	12/31/2002
30.	C1752	Catheter, hemodialysis/peritonea l, short-term	08/01/2000	12/31/2002
31.	C1751	Catheter, infusion, inserted peripherally, centrally or midline (other than hemodialysis)	08/01/2000	12/31/2002
32.	C1759	Catheter, intracardiac echocardiography	08/01/2000	12/31/2002
33.	C1754	Catheter, intradiscal	10/01/2000	12/31/2002
34.	C1755	Catheter, intraspinal	08/01/2000	12/31/2002
35.	C1753	Catheter, intravascular ultrasound	08/01/2000	12/31/2002
36.	C2628	Catheter, occlusion	10/01/2000	12/31/2002
37.	C1756	Catheter, pacing, transesophageal	10/01/2000	12/31/2002
38.	C2627	Catheter, suprapubic/cystoscopic	10/01/2000	12/31/2002
39.	C1757	Catheter, thrombectomy/embolectomy	08/01/2000	12/31/2002
40.	C2623	Catheter, transluminal angioplasty, drug-coated, non-laser	04/01/2015	12/31/2017
41.	C1885	Catheter, transluminal angioplasty, laser	10/01/2000	12/31/2002
42.	C1725	Catheter, transluminal angioplasty, non-laser (may include guidance, infusion/perfusion capability)	08/01/2000	12/31/2002
43.	C1714	Catheter, transluminal atherectomy, directional	08/01/2000	12/31/2002
44.	C1724	Catheter, transluminal atherectomy, rotational	08/01/2000	12/31/2002
45.	C1761	Catheter, transluminal intravascular lithotripsy, coronary	07/01/2021	06/30/2024
46.	C1760	Closure device, vascular (implantable/insertable)	08/01/2000	12/31/2002

47.	L8614	Cochlear implant system	08/01/2000	12/31/2002
48.	C1762	Connective tissue, human (includes fascia lata)	08/01/2000	12/31/2002
49.	C1763	Connective tissue, non-human (includes synthetic)	10/01/2000	12/31/2002
50.	C1881	Dialysis access system (implantable)	08/01/2000	12/31/2002
51.	C1884	Embolization protective system	01/01/2003	12/31/2004
52.	C1749	Endoscope, retrograde imaging/illumination colonoscope device (implantable)	10/01/2010	12/31/2012
53.	C1748	Endoscope, single-use (i.e. disposable), Upper GI, imaging/illumination device (insertable)	07/01/2020	06/30/2023
54.	C1764	Event recorder, cardiac (implantable)	08/01/2000	12/31/2002
55.	C1822	Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system	01/01/2016	12/31/2017
56.	C1767	Generator, neurostimulator (implantable), non-rechargeable	08/01/2000	12/31/2002
57.	C1820	Generator, neurostimulator (implantable), with rechargeable battery and charging system	01/01/2006	12/31/2007
58.	C1825	Generator, neurostimulator (implantable), non-rechargeable with carotid sinus baroreceptor stimulation lead(s)	01/01/2021	12/31/2023
59.	C1823	Generator, neurostimulator (implantable), nonrechargeable , with transvenous sensing and stimulation leads	01/01/2019	12/31/2022
60.	C1768	Graft, vascular	01/01/2001	12/31/2002
61.	C1769	Guide wire	08/01/2000	12/31/2002
62.	C1052	Hemostatic agent, gastrointestinal, topical	01/01/2021	12/31/2023
63.	C1770	Imaging coil, magnetic resonance (insertable)	01/01/2001	12/31/2002
64.	C2624	Implantable wireless pulmonary artery pressure sensor with delivery catheter, including all system components	01/01/2015	12/31/2016
65.	C1891	Infusion pump, non-programmable, permanent (implantable)	08/01/2000	12/31/2002
66.	C2626	Infusion pump, non-programmable, temporary (implantable)	01/01/2001	12/31/2002
67.	C1772	Infusion pump, programmable (implantable)	10/01/2000	12/31/2002
68.	C1818	Integrated keratoprosthesis	07/01/2003	12/31/2005
69.	C1821	Interspinous process distraction device (implantable)	01/01/2007	12/31/2008
70.	C1062	Intravertebral body fracture augmentation with implant (e.g., metal, polymer)	01/01/2021	12/31/2023
71.	C1893	Introducer/sheath, guiding, intracardiac electrophysiological, fixed-curve, other than peel-away	10/01/2000	12/31/2002
72.	C1892	Introducer/sheath, guiding, intracardiac electrophysiological, fixed-curve, peel-away	01/01/2001	12/31/2002
73.	C1766	Introducer/sheath, guiding, intracardiac electrophysiologica l, steerable, other than peel-away	01/01/2001	12/31/2002
74.	C1894	Introducer/sheath, other than guiding, other than intracardiac electrophysiological, non-laser	08/01/2000	12/31/2002
75.	C2629	Introducer/sheath, other than guiding, other than intracardiac electrophysiological, laser	01/01/2001	12/31/2002
76.	C1776	Joint device (implantable)	10/01/2000	12/31/2002
77.	C1895	Lead, cardioverter-defibrillator, endocardial dual coil (implantable)	08/01/2000	12/31/2002

78.	C1777	Lead, cardioverter-defibrillator, endocardial single coil (implantable)	08/01/2000	12/31/2002
79.	C1896	Lead, cardioverter-defibrillator, other than endocardial single or dual coil (implantable)	08/01/2000	12/31/2002
80.	C1900	Lead, left ventricular coronary venous system	07/01/2002	12/31/2004
81.	C1778	Lead, neurostimulator (implantable)	08/01/2000	12/31/2002
82.	C1897	Lead, neurostimulator test kit (implantable)	08/01/2000	12/31/2002
83.	C1898	Lead, pacemaker, other than transvenous VDD single pass	08/01/2000	12/31/2002
84.	C1779	Lead, pacemaker, transvenous VDD single pass	08/01/2000	12/31/2002
85.	C1899	Lead, pacemaker/cardioverter-defibrillator combination (implantable)	01/01/2001	12/31/2002
86.	C1780	Lens, intraocular (new technology)	08/01/2000	12/31/2002
87.	C1840	Lens, intraocular (telescopic)	10/01/2011	12/31/2013
88.	C2613	Lung biopsy plug with delivery system	07/01/2015	12/31/2017
89.	C1878	Material for vocal cord medialization, synthetic (implantable)	10/01/2000	12/31/2002
90.	C1781	Mesh (implantable)	08/01/2000	12/31/2002
91.	C1833	Monitor, cardiac, including intracardiac lead and all system components (implantable)	01/01/2022	12/31/2024
92.	C1782	Morcellator	08/01/2000	12/31/2002
93.	C1784	Ocular device, intraoperative, detached retina	01/01/2001	12/31/2002
94.	C1783	Ocular implant, aqueous drainage assist device	07/01/2002	12/31/2004
95.	C2619	Pacemaker, dual chamber, non rate-responsive (implantable)	08/01/2000	12/31/2002
96.	C1785	Pacemaker, dual chamber, rate-responsive (implantable)	08/01/2000	12/31/2002
97.	C2621	Pacemaker, other than single or dual chamber (implantable)	01/01/2001	12/31/2002
98.	C2620	Pacemaker, single chamber, non rate-responsive (implantable)	08/01/2000	12/31/2002
99.	C1786	Pacemaker, single chamber, rate-responsive (implantable)	08/01/2000	12/31/2002
100.	C1787	Patient programmer, neurostimulator	08/01/2000	12/31/2002
101.	C1831	Interbody cage, anterior, lateral or posterior, personalized (implantable)	10/01/2021	09/30/2024
102.	C1788	Port, indwelling (implantable)	08/01/2000	12/31/2002
103.	C1830	Powered bone marrow biopsy needle	10/01/2011	12/31/2013
104.	C2618	Probe, cryoablation	04/01/2001	12/31/2003
105.	C2614	Probe, percutaneous lumbar discectomy	01/01/2003	12/31/2004
106.	C1789	Prosthesis, breast (implantable)	10/01/2000	12/31/2002
107.	C1813	Prosthesis, penile, inflatable	08/01/2000	12/31/2002
108.	C2622	Prosthesis, penile, non-inflatable	10/01/2001	12/31/2002
109.	C1815	Prosthesis, urinary sphincter (implantable)	10/01/2000	12/31/2002
110.	C1816	Receiver and/or transmitter, neurostimulator (implantable)	08/01/2000	12/31/2002
111.	C1771	Repair device, urinary, incontinence, with sling graft	10/01/2000	12/31/2002
112.	C2631	Repair device, urinary, incontinence, without sling graft	08/01/2000	12/31/2002
113.	C1841	Retinal prosthesis, includes all internal and external components	10/01/2013	12/31/2015
114.	C1814	Retinal tamponade device, silicone oil	04/01/2003	12/31/2005
115.	C1773	Retrieval device, insertable	01/01/2001	12/31/2002
116.	C2615	Sealant, pulmonary, liquid (implantable)	01/01/2001	12/31/2002

117.	C1817	Septal defect implant system, intracardiac	08/01/2000	12/31/2002
118.	C1874	Stent, coated/covered, with delivery system	08/01/2000	12/31/2002
119.	C1875	Stent, coated/covered, without delivery system	08/01/2000	12/31/2002
120.	C1876	Stent, non-coated/non-covered, with delivery system	08/01/2000	12/31/2002
121.	C1877	Stent, non-coated/non-covered, without delivery system	08/01/2000	12/31/2002
122.	C2625	Stent, non-coronary, temporary, with delivery system	10/01/2000	12/31/2002
123.	C2617	Stent, non-coronary, temporary, without delivery system	10/01/2000	12/31/2002
124.	C1819	Tissue localization excision device	01/01/2004	12/31/2005
125.	C1879	Tissue marker (implantable)	08/01/2000	12/31/2002
126.	C1880	Vena cava filter	01/01/2001	12/31/2002
127.	C1826	Generator, neurostimulator (implantable), includes closed feedback loop leads and all implantable components, with rechargeable battery and charging system	01/01/2023	12/31/2025
128.	C1827	Generator, neurostimulator (implantable), non-rechargeable, with implantable stimulation lead and external paired stimulation controller	01/01/2023	12/31/2025
129.	C1747	Endoscope, single-use (i.e. disposable), urinary tract, imaging/illumination device (insertable)	01/01/2023	12/31/2025
130.	C1824^	Generator, cardiac contractility modulation (implantable)	01/01/2020	12/31/2023
131.	C1982^	Catheter, pressure-generating, one-way valve, intermittently occlusive	01/01/2020	12/31/2023
132.	C1839^	Iris prosthesis	01/01/2020	12/31/2023
133.	C1734^	Orthopedic/device/drug matrix for opposing bone-to-bone or soft tissue-to bone (implantable)	01/01/2020	12/31/2023
134.	C2596^	Probe, image-guided, robotic, waterjet ablation	01/01/2020	12/31/2023
135.	**C1600**	**Catheter, transluminal intravascular lesion preparation device, bladed, sheathed (insertable)**	**01/01/2024**	**12/31/2026**
136.	**C1601**	**Endoscope, single-use (i.e. disposable), pulmonary, imaging/illumination device (insertable)**	**01/01/2024**	**12/31/2026**
137.	**C1602**	**Orthopedic/device/drug matrix/absorbable bone void filler, antimicrobial-eluting (implantable)**	**01/01/2024**	**12/31/2026**
138.	**C1603**	**Retrieval device, insertable, laser (used to retrieve intravascular inferior vena cava filter)**	**01/01/2024**	**12/31/2026**
139.	**C1604**	**Graft, transmural transvenous arterial bypass (implantable), with all delivery system components**	**01/01/2024**	**12/31/2026**
140.	**C1605**	**Pacemaker, leadless, dual chamber (right atrial and right ventricular implantable components), rate-responsive, including all necessary components for implantation**	**07/01/2024**	**06/30/2027**
141.	**C1606**	**Adapter, single-use (i.e. disposable), for attaching ultrasound system to upper gastrointestinal endoscope**	**07/01/2024**	**06/30/2027**
142.	**C8000**	**Support device, extravascular, for arteriovenous fistula (implantable)**	**10/01/2024**	**09/30/2027**
143.	**C1735**	**Catheter(s), intravascular for renal denervation, radiofrequency, including all single use system components**	**01/01/2025**	**12/31/2027**
144.	**C1736**	**Catheter(s), intravascular for renal denervation, ultrasound, including all single use system components**	**01/01/2025**	**12/31/2027**
145.	**C1737**	**Joint fusion and fixation device(s), sacroiliac and pelvis, including all system components (implantable)**	**01/01/2025**	**12/31/2027**

146.	**C1738**	**Powered, single-use (i.e. disposable) endoscopic ultrasound-guided biopsy device**	**01/01/2025**	**12/31/2027**
147.	**C1739**	**Tissue marker, uniquely detectable and identifiable with probe/sensor, any method (implantable), with delivery system**	**01/01/2025**	**12/31/2027**
148.	**C9610**	**Catheter, transluminal drug delivery with or without angioplasty, coronary, non-laser (insertable)**	**01/01/2025**	**12/31/2027**
149.	***C1740***	***Leadless electrode, transmitter, battery (all implantable), for sequential left ventricular pacing***	***10/01/2025***	***09/30/2028***
150.	***C1741***	***Anchor/screw for bone fixation, absorbable, metallic (implantable)***	***10/01/2025***	***09/30/2028***
151.	***C1742***	***Pressure monitoring system, compartmental intramuscular (implantable), continuous, including all components (e.g., introducer, sensor), excludes mobile (wireless) software application***	***10/01/2025***	***09/30/2028***
152.	***C1607***	***Neurostimulator, integrated (implantable), rechargeable with all implantable and external components including charging system***	***01/01/2026***	***12/31/2028***
153.	***C1608***	***Prosthesis, total, dual mobility, first carpometacarpal joint (implantable)***	***01/01/2026***	***12/31/2028***

Bold codes are still actively receiving pass-through payment.

Italicized codes have received preliminary approval for pass-through payment.

^ Sec. 4141. Extension of Pass-Through Status Under the Medicare Program for Certain Devices Impacted by COVID-19 of the Consolidated Appropriations Act, 2023 has extended pass-through status for a 1-year period beginning on January 1, 2023.

* Although the pass-through payment status for device category codes has expired, these codes are still active and hospitals are still required to report the device category C-codes (except the brachytherapy source codes, which are separately paid under the OPPS) on claims when such devices are used in conjunction with procedures billed and paid under the OPPS.

Table 7. ─ Procedures Removed from the IPO List for CY 2026

HCPCS Code	Long Descriptor	Final CY 2026 SI	Final CY 2026 APC
00192	Anesthesia for procedures on facial bones or skull; radical surgery (including prognathism)	N	N/A
00474	Anesthesia for partial rib resection; radical procedures (eg, pectus excavatum)	N	N/A
00604	Anesthesia for procedures on cervical spine and cord; procedures with patient in the sitting position	N	N/A
00904	Anesthesia for; radical perineal procedure	N	N/A
0095T	Removal of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, cervical (list separately in addition to code for primary procedure)	N	N/A
0098T	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, cervical (list separately in addition to code for primary procedure)	N	N/A
01140	Anesthesia for interpelviabdominal (hindquarter) amputation	N	N/A

HCPCS Code	Long Descriptor	Final CY 2026 SI	Final CY 2026 APC
01150	Anesthesia for radical procedures for tumor of pelvis, except hindquarter amputation	N	N/A
01212	Anesthesia for open procedures involving hip joint; hip disarticulation	N	N/A
01232	Anesthesia for open procedures involving upper two-thirds of femur; amputation	N	N/A
01234	Anesthesia for open procedures involving upper two-thirds of femur; radical resection	N	N/A
01274	Anesthesia for procedures involving arteries of upper leg, including bypass graft; femoral artery embolectomy	N	N/A
01404	Anesthesia for open or surgical arthroscopic procedures on knee joint; disarticulation at knee	N	N/A
01634	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; shoulder disarticulation	N	N/A
01636	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; interthoracoscapular (forequarter) amputation	N	N/A
0164T	Removal of total disc arthroplasty, (artificial disc), anterior approach, each additional interspace, lumbar (list separately in addition to code for primary procedure)	N	N/A
0165T	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, lumbar (list separately in addition to code for primary procedure)	N	N/A
01756	Anesthesia for open or surgical arthroscopic procedures of the elbow; radical procedures	N	N/A
0202T	Posterior vertebral joint(s) arthroplasty (eg, facet joint[s] replacement), including facetectomy, laminectomy, foraminotomy, and vertebral column fixation, injection of bone cement, when performed, including fluoroscopy, single level, lumbar spine	J1	5115
0219T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; cervical	J1	5115
0220T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; thoracic	J1	5115
0656T	Anterior lumbar or thoracolumbar vertebral body tethering; up to 7 vertebral segments	J1	5116
0657T	Anterior lumbar or thoracolumbar vertebral body tethering; 8 or more vertebral segments	J1	5116
0790T	Revision (eg, augmentation, division of tether), replacement, or removal of thoracolumbar or lumbar vertebral body tethering, including thoracoscopy, when performed	J1	5116
20661	Application of halo, including removal; cranial	Q1	5112

HCPCS Code	Long Descriptor	Final CY 2026 SI	Final CY 2026 APC
20664	Application of halo, including removal, cranial, 6 or more pins placed, for thin skull osteology (eg, pediatric patients, hydrocephalus, osteogenesis imperfecta)	Q1	5112
20802	Removal of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, cervical (list separately in addition to code for primary procedure)	J1	5116
20805	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, cervical (list separately in addition to code for primary procedure)	J1	5116
20808	Replantation, hand (includes hand through metacarpophalangeal joints), complete amputation	J1	5116
20816	Replantation, digit, excluding thumb (includes metacarpophalangeal joint to insertion of flexor sublimis tendon), complete amputation	J1	5112
20824	Replantation, thumb (includes carpometacarpal joint to mp joint), complete amputation	J1	5112
20827	Replantation, thumb (includes distal tip to mp joint), complete amputation	J1	5112
20838	Replantation, foot, complete amputation	J1	5116
20955	Bone graft with microvascular anastomosis; fibula	J1	5114
20956	Bone graft with microvascular anastomosis; iliac crest	J1	5114
20957	Bone graft with microvascular anastomosis; metatarsal	J1	5114
20962	Bone graft with microvascular anastomosis; other than fibula, iliac crest, or metatarsal	J1	5114
20969	Free osteocutaneous flap with microvascular anastomosis; other than iliac crest, metatarsal, or great toe	J1	5114
20970	Free osteocutaneous flap with microvascular anastomosis; iliac crest	J1	5114
21045	Excision of malignant tumor of mandible; radical resection	J1	5165
21145	Reconstruction midface, lefort i; single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)	J1	5165
21146	Reconstruction midface, lefort i; 2 pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted unilateral alveolar cleft)	J1	5165
21147	Reconstruction midface, lefort i; 3 or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted bilateral alveolar cleft or multiple osteotomies)	J1	5165
21151	Reconstruction midface, lefort ii; any direction, requiring bone grafts (includes obtaining autografts)	J1	5165
21154	Reconstruction midface, lefort iii (extracranial), any type, requiring bone grafts (includes obtaining autografts); without lefort i	J1	5165

HCPCS Code	Long Descriptor	Final CY 2026 SI	Final CY 2026 APC
21155	Reconstruction midface, lefort iii (extracranial), any type, requiring bone grafts (includes obtaining autografts); with lefort i	J1	5165
21159	Reconstruction midface, lefort iii (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); without lefort i	J1	5165
21160	Reconstruction midface, lefort iii (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); with lefort i	J1	5165
21179	Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material)	J1	5165
21180	Reconstruction, entire or majority of forehead and/or supraorbital rims; with autograft (includes obtaining grafts)	J1	5165
21182	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (eg, fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting less than 40 sq cm	J1	5165
21183	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (eg, fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting greater than 40 sq cm but less than 80 sq cm	J1	5165
21184	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (eg, fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting greater than 80 sq cm	J1	5165
21188	Reconstruction midface, osteotomies (other than lefort type) and bone grafts (includes obtaining autografts)	J1	5165
21247	Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts) (eg, for hemifacial microsomia)	J1	5165
21268	Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; combined intra- and extracranial approach	J1	5165
21343	Open treatment of depressed frontal sinus fracture	J1	5165
21344	Open treatment of complicated (eg, comminuted or involving posterior wall) frontal sinus fracture, via coronal or multiple approaches	J1	5165
21348	Open treatment of nasomaxillary complex fracture (lefort ii type); with bone grafting (includes obtaining graft)	J1	5165
21423	Open treatment of palatal or maxillary fracture (lefort i type); complicated (comminuted or involving cranial nerve foramina), multiple approaches	J1	5165
21431	Closed treatment of craniofacial separation (lefort iii type) using interdental wire fixation of denture or splint	J1	5165
21432	Open treatment of craniofacial separation (lefort iii type); with wiring and/or internal fixation	J1	5165

HCPCS Code	Long Descriptor	Final CY 2026 SI	Final CY 2026 APC
21433	Open treatment of craniofacial separation (lefort iii type); complicated (eg, comminuted or involving cranial nerve foramina), multiple surgical approaches	J1	5165
21435	Open treatment of craniofacial separation (lefort iii type); complicated, utilizing internal and/or external fixation techniques (eg, head cap, halo device, and/or intermaxillary fixation)	J1	5165
21436	Open treatment of craniofacial separation (lefort iii type); complicated, multiple surgical approaches, internal fixation, with bone grafting (includes obtaining graft)	J1	5165
21510	Incision, deep, with opening of bone cortex (eg, for osteomyelitis or bone abscess), thorax	J1	5113
21602	Excision of chest wall tumor involving rib(s), with plastic reconstruction; without mediastinal lymphadenectomy	J1	5114
21603	Excision of chest wall tumor involving rib(s), with plastic reconstruction; with mediastinal lymphadenectomy	J1	5114
21615	Excision first and/or cervical rib;	J1	5114
21616	Excision first and/or cervical rib; with sympathectomy	J1	5114
21620	Ostectomy of sternum, partial	J1	5113
21627	Sternal debridement	J1	5113
21630	Radical resection of sternum	J1	5114
21705	Division of scalenus anticus; with resection of cervical rib	J1	5114
21740	Reconstructive repair of pectus excavatum or carinatum; open	J1	5114
21750	Closure of median sternotomy separation with or without debridement (separate procedure)	J1	5114
21825	Open treatment of sternum fracture with or without skeletal fixation	J1	5114
22010	Incision and drainage, open, of deep abscess (subfascial), posterior spine; cervical, thoracic, or cervicothoracic	J1	5114
22015	Incision and drainage, open, of deep abscess (subfascial), posterior spine; lumbar, sacral, or lumbosacral	J1	5114
22110	Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; cervical	J1	5114
22112	Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; thoracic	J1	5114
22114	Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; lumbar	J1	5114
22116	Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; each additional vertebral segment (list separately in addition to code for primary procedure)	N	N/A

HCPCS Code	Long Descriptor	Final CY 2026 SI	Final CY 2026 APC
22206	Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (eg, pedicle/vertebral body subtraction); thoracic	J1	5114
22207	Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (eg, pedicle/vertebral body subtraction); lumbar	J1	5114
22208	Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (eg, pedicle/vertebral body subtraction); each additional vertebral segment (list separately in addition to code for primary procedure)	N	N/A
22210	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; cervical	J1	5114
22212	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; thoracic	J1	5114
22214	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; lumbar	J1	5114
22216	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; each additional vertebral segment (list separately in addition to primary procedure)	N	N/A
22220	Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; cervical	J1	5114
22222	Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; thoracic	J1	5114
22224	Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; lumbar	J1	5114
22226	Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; each additional vertebral segment (list separately in addition to code for primary procedure)	N	N/A
22318	Open treatment and/or reduction of odontoid fracture(s) and or dislocation(s) (including os odontoideum), anterior approach, including placement of internal fixation; without grafting	J1	5115
22319	Open treatment and/or reduction of odontoid fracture(s) and or dislocation(s) (including os odontoideum), anterior approach, including placement of internal fixation; with grafting	J1	5115
22325	Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, 1 fractured vertebra or dislocated segment; lumbar	J1	5115
22326	Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, 1 fractured vertebra or dislocated segment; cervical	J1	5115
22327	Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, 1 fractured vertebra or dislocated segment; thoracic	J1	5115

HCPCS Code	Long Descriptor	Final CY 2026 SI	Final CY 2026 APC
22328	Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, 1 fractured vertebra or dislocated segment; each additional fractured vertebra or dislocated segment (list separately in addition to code for primary procedure)	N	N/A
22532	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic	J1	5115
22533	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar	J1	5116
22534	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic or lumbar, each additional vertebral segment (list separately in addition to code for primary procedure)	N	N/A
22548	Arthrodesis, anterior transoral or extraoral technique, clivus-c1-c2 (atlas-axis), with or without excision of odontoid process	J1	5115
22556	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic	J1	5116
22558	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar	J1	5117
22586	Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft when performed, l5-s1 interspace	J1	5116
22590	Arthrodesis, posterior technique, craniocervical (occiput-c2)	J1	5115
22595	Arthrodesis, posterior technique, atlas-axis (c1-c2)	J1	5115
22600	Arthrodesis, posterior or posterolateral technique, single level; cervical below c2 segment	J1	5116
22610	Arthrodesis, posterior or posterolateral technique, single level; thoracic (with lateral transverse technique, when performed)	J1	5116
22800	Arthrodesis, posterior, for spinal deformity, with or without cast; up to 6 vertebral segments	J1	5116
22802	Arthrodesis, posterior, for spinal deformity, with or without cast; 7 to 12 vertebral segments	J1	5116
22804	Arthrodesis, posterior, for spinal deformity, with or without cast; 13 or more vertebral segments	J1	5116
22808	Arthrodesis, anterior, for spinal deformity, with or without cast; 2 to 3 vertebral segments	J1	5116
22810	Arthrodesis, anterior, for spinal deformity, with or without cast; 4 to 7 vertebral segments	J1	5116
22812	Arthrodesis, anterior, for spinal deformity, with or without cast; 8 or more vertebral segments	J1	5116

HCPCS Code	Long Descriptor	Final CY 2026 SI	Final CY 2026 APC
22818	Kyphectomy, circumferential exposure of spine and resection of vertebral segment(s) (including body and posterior elements); single or 2 segments	J1	5116
22819	Kyphectomy, circumferential exposure of spine and resection of vertebral segment(s) (including body and posterior elements); 3 or more segments	J1	5116
22830	Exploration of spinal fusion	J1	5114
22836	Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; up to 7 vertebral segments	J1	5116
22837	Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; 8 or more vertebral segments	J1	5116
22838	Revision (eg, augmentation, division of tether), replacement, or removal of thoracic vertebral body tethering, including thoracoscopy, when performed	J1	5116
22841	Internal spinal fixation by wiring of spinous processes (list separately in addition to code for primary procedure)	N	N/A
22843	Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 7 to 12 vertebral segments (list separately in addition to code for primary procedure)	N	N/A
22844	Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 13 or more vertebral segments (list separately in addition to code for primary procedure)	N	N/A
22846	Anterior instrumentation; 4 to 7 vertebral segments (list separately in addition to code for primary procedure)	N	N/A
22847	Anterior instrumentation; 8 or more vertebral segments (list separately in addition to code for primary procedure)	N	N/A
22849	Reinsertion of spinal fixation device	J1	5115
22850	Removal of posterior nonsegmental instrumentation (eg, harrington rod)	J1	5114
22852	Removal of posterior segmental instrumentation	J1	5114
22855	Removal of anterior instrumentation	J1	5114
22857	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression); single interspace, lumbar	J1	5116
22860	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression); second interspace, lumbar (list separately in addition to code for primary procedure)	N	N/A
22861	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical	J1	5116
22862	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar	J1	5116
22864	Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical	J1	5114
22865	Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar	J1	5114

HCPCS Code	Long Descriptor	Final CY 2026 SI	Final CY 2026 APC
23200	Radical resection of tumor; clavicle	J1	5114
23210	Radical resection of tumor; scapula	J1	5114
23220	Radical resection of tumor, proximal humerus	J1	5114
23335	Removal of prosthesis, includes debridement and synovectomy when performed; humeral and glenoid components (eg, total shoulder)	J1	5114
23474	Revision of total shoulder arthroplasty, including allograft when performed; humeral and glenoid component	J1	5115
23900	Interthoracoscapular amputation (forequarter)	J1	5115
23920	Disarticulation of shoulder;	J1	5115
24900	Amputation, arm through humerus; with primary closure	J1	5115
24920	Amputation, arm through humerus; open, circular (guillotine)	J1	5115
24930	Amputation, arm through humerus; re-amputation	J1	5114
24931	Amputation, arm through humerus; with implant	J1	5115
24940	Cineplasty, upper extremity, complete procedure	J1	5115
25900	Amputation, forearm, through radius and ulna;	J1	5114
25905	Amputation, forearm, through radius and ulna; open, circular (guillotine)	J1	5114
25915	Krukenberg procedure	J1	5114
25920	Disarticulation through wrist;	J1	5113
25924	Disarticulation through wrist; re-amputation	J1	5113
25927	Transmetacarpal amputation;	J1	5113
26551	Transfer, toe-to-hand with microvascular anastomosis; great toe wrap-around with bone graft	J1	5114
26553	Transfer, toe-to-hand with microvascular anastomosis; other than great toe, single	J1	5114
26554	Transfer, toe-to-hand with microvascular anastomosis; other than great toe, double	J1	5114
26556	Transfer, free toe joint, with microvascular anastomosis	J1	5114
26992	Incision, bone cortex, pelvis and/or hip joint (eg, osteomyelitis or bone abscess)	J1	5113
27005	Tenotomy, hip flexor(s), open (separate procedure)	J1	5113
27025	Fasciotomy, hip or thigh, any type	J1	5113
27030	Arthrotomy, hip, with drainage (eg, infection)	J1	5114
27036	Capsulectomy or capsulotomy, hip, with or without excision of heterotopic bone, with release of hip flexor muscles (ie, gluteus medius, gluteus minimus, tensor fascia latae, rectus femoris, sartorius, iliopsoas)	J1	5114
27054	Arthrotomy with synovectomy, hip joint	J1	5113
27070	Partial excision, wing of ilium, symphysis pubis, or greater trochanter of femur, (craterization, saucerization) (eg, osteomyelitis or bone abscess); superficial	J1	5113
27071	Partial excision, wing of ilium, symphysis pubis, or greater trochanter of femur, (craterization, saucerization) (eg, osteomyelitis or bone abscess); deep (subfascial or intramuscular)	J1	5113

HCPCS Code	Long Descriptor	Final CY 2026 SI	Final CY 2026 APC
27075	Radical resection of tumor; wing of ilium, 1 pubic or ischial ramus or symphysis pubis	J1	5114
27076	Radical resection of tumor; ilium, including acetabulum, both pubic rami, or ischium and acetabulum	J1	5114
27077	Radical resection of tumor; innominate bone, total	J1	5114
27078	Radical resection of tumor; ischial tuberosity and greater trochanter of femur	J1	5114
27090	Removal of hip prosthesis; (separate procedure)	J1	5114
27091	Removal of hip prosthesis; complicated, including total hip prosthesis, methylmethacrylate with or without insertion of spacer	J1	5115
27120	Acetabuloplasty; (eg, whitman, colonna, haygroves, or cup type)	J1	5115
27122	Acetabuloplasty; resection, femoral head (eg, girdlestone procedure)	J1	5114
27125	Hemiarthroplasty, hip, partial (eg, femoral stem prosthesis, bipolar arthroplasty)	J1	5115
27132	Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or allograft	J1	5115
27134	Revision of total hip arthroplasty; both components, with or without autograft or allograft	J1	5115
27137	Revision of total hip arthroplasty; acetabular component only, with or without autograft or allograft	J1	5115
27138	Revision of total hip arthroplasty; femoral component only, with or without allograft	J1	5115
27140	Osteotomy and transfer of greater trochanter of femur (separate procedure)	J1	5114
27146	Osteotomy, iliac, acetabular or innominate bone;	J1	5114
27147	Osteotomy, iliac, acetabular or innominate bone; with open reduction of hip	J1	5114
27151	Osteotomy, iliac, acetabular or innominate bone; with femoral osteotomy	J1	5114
27156	Osteotomy, iliac, acetabular or innominate bone; with femoral osteotomy and with open reduction of hip	J1	5114
27158	Osteotomy, pelvis, bilateral (eg, congenital malformation)	J1	5114
27161	Osteotomy, femoral neck (separate procedure)	J1	5114
27165	Osteotomy, intertrochanteric or subtrochanteric including internal or external fixation and/or cast	J1	5114
27170	Bone graft, femoral head, neck, intertrochanteric or subtrochanteric area (includes obtaining bone graft)	J1	5114
27175	Treatment of slipped femoral epiphysis; by traction, without reduction	J1	5113
27176	Treatment of slipped femoral epiphysis; by single or multiple pinning, in situ	J1	5113
27177	Open treatment of slipped femoral epiphysis; single or multiple pinning or bone graft (includes obtaining graft)	J1	5113

HCPCS Code	Long Descriptor	Final CY 2026 SI	Final CY 2026 APC
27178	Open treatment of slipped femoral epiphysis; closed manipulation with single or multiple pinning	J1	5113
27181	Open treatment of slipped femoral epiphysis; osteotomy and internal fixation	J1	5114
27185	Epiphyseal arrest by epiphysiodesis or stapling, greater trochanter of femur	J1	5113
27187	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate, femoral neck and proximal femur	J1	5114
27222	Closed treatment of acetabulum (hip socket) fracture(s); with manipulation, with or without skeletal traction	T	5111
27226	Open treatment of posterior or anterior acetabular wall fracture, with internal fixation	J1	5114
27227	Open treatment of acetabular fracture(s) involving anterior or posterior (one) column, or a fracture running transversely across the acetabulum, with internal fixation	J1	5114
27228	Open treatment of acetabular fracture(s) involving anterior and posterior (two) columns, includes t-fracture and both column fracture with complete articular detachment, or single column or transverse fracture with associated acetabular wall fracture, with internal fixation	J1	5114
27232	Closed treatment of femoral fracture, proximal end, neck; with manipulation, with or without skeletal traction	J1	5112
27236	Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement	J1	5114
27240	Closed treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with manipulation, with or without skin or skeletal traction	J1	5112
27244	Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with plate/screw type implant, with or without cerclage	J1	5114
27245	Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with intramedullary implant, with or without interlocking screws and/or cerclage	J1	5114
27248	Open treatment of greater trochanteric fracture, includes internal fixation, when performed	J1	5114
27253	Open treatment of hip dislocation, traumatic, without internal fixation	J1	5113
27254	Open treatment of hip dislocation, traumatic, with acetabular wall and femoral head fracture, with or without internal or external fixation	J1	5114
27258	Open treatment of spontaneous hip dislocation (developmental, including congenital or pathological), replacement of femoral head in acetabulum (including tenotomy, etc);	J1	5113
27259	Open treatment of spontaneous hip dislocation (developmental, including congenital or pathological), replacement of femoral head in acetabulum (including tenotomy, etc); with femoral shaft shortening	J1	5113

HCPCS Code	Long Descriptor	Final CY 2026 SI	Final CY 2026 APC
27268	Closed treatment of femoral fracture, proximal end, head; with manipulation	J1	5112
27269	Open treatment of femoral fracture, proximal end, head, includes internal fixation, when performed	J1	5114
27280	Arthrodesis, sacroiliac joint, open, includes obtaining bone graft, including instrumentation, when performed	J1	5116
27282	Arthrodesis, symphysis pubis (including obtaining graft)	J1	5113
27284	Arthrodesis, hip joint (including obtaining graft);	J1	5115
27286	Arthrodesis, hip joint (including obtaining graft); with subtrochanteric osteotomy	J1	5115
27290	Interpelviabdominal amputation (hindquarter amputation)	J1	5116
27295	Disarticulation of hip	J1	5116
27303	Incision, deep, with opening of bone cortex, femur or knee (eg, osteomyelitis or bone abscess)	J1	5113
27365	Radical resection of tumor, femur or knee	J1	5113
27448	Osteotomy, femur, shaft or supracondylar; without fixation	J1	5114
27450	Osteotomy, femur, shaft or supracondylar; with fixation	J1	5114
27454	Osteotomy, multiple, with realignment on intramedullary rod, femoral shaft (eg, sofield type procedure)	J1	5114
27455	Osteotomy, proximal tibia, including fibular excision or osteotomy (includes correction of genu varus [bowleg] or genu valgus [knock-knee]); before epiphyseal closure	J1	5114
27457	Osteotomy, proximal tibia, including fibular excision or osteotomy (includes correction of genu varus [bowleg] or genu valgus [knock-knee]); after epiphyseal closure	J1	5114
27465	Osteoplasty, femur; shortening (excluding 64876)	J1	5114
27466	Osteoplasty, femur; lengthening	J1	5114
27470	Repair, nonunion or malunion, femur, distal to head and neck; without graft (eg, compression technique)	J1	5114
27472	Repair, nonunion or malunion, femur, distal to head and neck; with iliac or other autogenous bone graft (includes obtaining graft)	J1	5114
27486	Revision of total knee arthroplasty, with or without allograft; 1 component	J1	5115
27487	Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial component	J1	5116
27488	Removal of prosthesis, including total knee prosthesis, methylmethacrylate with or without insertion of spacer, knee	J1	5115
27495	Prophylactic treatment (nailing, pinning, plating, or wiring) with or without methylmethacrylate, femur	J1	5114
27506	Open treatment of femoral shaft fracture, with or without external fixation, with insertion of intramedullary implant, with or without cerclage and/or locking screws	J1	5114
27507	Open treatment of femoral shaft fracture with plate/screws, with or without cerclage	J1	5114

HCPCS Code	Long Descriptor	Final CY 2026 SI	Final CY 2026 APC
27511	Open treatment of femoral supracondylar or transcondylar fracture without intercondylar extension, includes internal fixation, when performed	J1	5115
27513	Open treatment of femoral supracondylar or transcondylar fracture with intercondylar extension, includes internal fixation, when performed	J1	5115
27514	Open treatment of femoral fracture, distal end, medial or lateral condyle, includes internal fixation, when performed	J1	5115
27519	Open treatment of distal femoral epiphyseal separation, includes internal fixation, when performed	J1	5114
27535	Open treatment of tibial fracture, proximal (plateau); unicondylar, includes internal fixation, when performed	J1	5114
27536	Open treatment of tibial fracture, proximal (plateau); bicondylar, with or without internal fixation	J1	5114
27540	Open treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, includes internal fixation, when performed	J1	5114
27556	Open treatment of knee dislocation, includes internal fixation, when performed; without primary ligamentous repair or augmentation/reconstruction	J1	5114
27557	Open treatment of knee dislocation, includes internal fixation, when performed; with primary ligamentous repair	J1	5114
27558	Open treatment of knee dislocation, includes internal fixation, when performed; with primary ligamentous repair, with augmentation/reconstruction	J1	5114
27580	Arthrodesis, knee, any technique	J1	5115
27590	Amputation, thigh, through femur, any level;	J1	5113
27591	Amputation, thigh, through femur, any level; immediate fitting technique including first cast	J1	5113
27592	Amputation, thigh, through femur, any level; open, circular (guillotine)	J1	5113
27596	Amputation, thigh, through femur, any level; re-amputation	J1	5113
27598	Disarticulation at knee	J1	5113
27645	Radical resection of tumor; tibia	J1	5113
27646	Radical resection of tumor; fibula	J1	5113
27703	Arthroplasty, ankle; revision, total ankle	J1	5116
27712	Osteotomy; multiple, with realignment on intramedullary rod (eg, sofield type procedure)	J1	5115
27715	Osteoplasty, tibia and fibula, lengthening or shortening	J1	5115
27724	Repair of nonunion or malunion, tibia; with iliac or other autograft (includes obtaining graft)	J1	5114
27725	Repair of nonunion or malunion, tibia; by synostosis, with fibula, any method	J1	5114
27727	Repair of congenital pseudarthrosis, tibia	J1	5113
27880	Amputation, leg, through tibia and fibula;	J1	5114
27881	Amputation, leg, through tibia and fibula; with immediate fitting technique including application of first cast	J1	5113

HCPCS Code	Long Descriptor	Final CY 2026 SI	Final CY 2026 APC
27882	Amputation, leg, through tibia and fibula; open, circular (guillotine)	J1	5113
27886	Amputation, leg, through tibia and fibula; re-amputation	J1	5113
27888	Amputation, ankle, through malleoli of tibia and fibula (eg, syme, pirogoff type procedures), with plastic closure and resection of nerves	J1	5113
28800	Amputation, foot; midtarsal (eg, chopart type procedure)	J1	5113
35372	Thromboendarterectomy, including patch graft, if performed; deep (profunda) femoral	J1	5184
35800	Exploration for postoperative hemorrhage, thrombosis or infection; neck	J1	5184
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)	J1	5194
37617	Ligation, major artery (eg, post-traumatic, rupture); abdomen	J1	5184
38562	Limited lymphadenectomy for staging (separate procedure); pelvic and para-aortic	J1	5092
43840	Gastrorrhaphy, suture of perforated duodenal or gastric ulcer, wound, or injury	J1	5303
44300	Placement, enterostomy or cecostomy, tube open (eg, for feeding or decompression) (separate procedure)	J1	5302
44314	Revision of ileostomy; complicated (reconstruction in-depth) (separate procedure)	T	5055
44345	Revision of colostomy; complicated (reconstruction in-depth) (separate procedure)	T	5055
44346	Revision of colostomy; with repair of paracolostomy hernia (separate procedure)	T	5055
44602	Suture of small intestine (enterorrhaphy) for perforated ulcer, diverticulum, wound, injury or rupture; single perforation	J1	5303
49010	Exploration, retroperitoneal area with or without biopsy(s) (separate procedure)	J1	5342
49255	Omentectomy, epiploectomy, resection of omentum (separate procedure)	J1	5342
51840	Anterior vesicourethropexy, or urethropexy (eg, marshall-marchetti-krantz, burch); simple	J1	5415
56630	Vulvectomy, radical, partial;	J1	5415
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)	J1	5194
G0412	Open treatment of iliac spine(s), tuberosity avulsion, or iliac wing fracture(s), unilateral or bilateral for pelvic bone fracture patterns which do not disrupt the pelvic ring includes internal fixation, when performed	J1	5114

HCPCS Code	Long Descriptor	Final CY 2026 SI	Final CY 2026 APC
G0414	Open treatment of anterior pelvic bone fracture and/or dislocation for fracture patterns which disrupt the pelvic ring, unilateral or bilateral, includes internal fixation when performed (includes pubic symphysis and/or superior/inferior rami)	J1	5114
G0415	Open treatment of posterior pelvic bone fracture and/or dislocation, for fracture patterns which disrupt the pelvic ring, unilateral or bilateral, includes internal fixation, when performed (includes ilium, sacroiliac joint and/or sacrum)	J1	5113

Table 8. ─ CY 2026 OPPS APC and Status Indicator Assignments for the Implantable Peritoneal Ascites Pump System

CPT Code	Short Descriptor	Long Descriptor	APC	SI
0870T	Imp subq prtl ascts pmp sys	Implantation of subcutaneous peritoneal ascites pump system, percutaneous, including pump-pocket creation, insertion of tunneled indwelling bladder and peritoneal catheters with pump connections, including all imaging and initial programming, when performed	APC 1579 (New Technology - Level 42 ($30,001-$40,000))	S
0871T	Rplcmt subq prtl ascites pmp	Replacement of a subcutaneous peritoneal ascites pump, including reconnection between pump and indwelling bladder and peritoneal catheters, including initial programming and imaging, when performed	APC 1578 (New Technology - Level 41 ($25,001-$30,000))	S
0872T	Rplcmt ndwllg bldr&prtl cath	Replacement of indwelling bladder and peritoneal catheters, including tunneling of catheter(s) and connection with previously implanted peritoneal ascites pump, including imaging and programming, when performed	APC 5341 (Level 1 Abdominal/Peritoneal/Biliary and Related Procedures)	J1
0873T	Revj subq prtl asct pmp sys	Revision of a subcutaneously implanted peritoneal ascites pump system, any component (ascites pump, associated peritoneal catheter, associated bladder	APC 5341 (Level 1 Abdominal/Peritoneal/Biliary and Related Procedures)	J1

		catheter), including imaging and programming, when performed		
0874T	Rmvl pertl ascites pmp sys	Removal of a peritoneal ascites pump system, including implanted peritoneal ascites pump and indwelling bladder and peritoneal catheters	APC 5341 (Level 1 Abdominal/Peritoneal/Biliary and Related Procedures)	J1
0875T	Prgrm subq prtl asct pmp sys	Programming of subcutaneously implanted peritoneal ascites pump system by physician or other qualified health care professional	APC 5741 (Level 1 Electronic Analysis of Devices)	Q1

Table 9. ─ New HCPCS Code for Tc-99m Derived from Domestically Produced Mo-99

CY 2026 HCPCS Code	CY 2026 Long Descriptor	CY 2026 Short Descriptor	CY 2026 OPPS SI	CY 2026 OPPS APC
C9176	Tc-99m from domestically produced non-HEU Mo-99, [minimum 50 percent], full cost recovery add-on, per study dose	Dom nonHEU Tc99m add-on/dose	K	1441

Table 10. ─ New CY 2026 HCPCS Codes Effective January 1, 2026, for Certain Drugs, Biologicals, and Radiopharmaceuticals Receiving Pass-Through Status

CY 2026 HCPCS Code	CY 2026 Long Descriptor	CY 2026 SI	CY 2026 APC
C9307	Injection, linvoseltamab-gcpt, 1 mg	G	0916
C9308	Injection, carboplatin (avyxa), 1 mg	G	0917
J1737	Injection, meloxicam (azurity), 1 mg	G	0898
J9184	Injection, gemcitabine hydrochloride (avyxa), 200 mg	G	0909
J9282	Mitomycin, intravesical instillation, 1 mg	G	0913
Q5160	Injection, bevacizumab-nwgd (jobevne), biosimilar, 10 mg	G	0918

Table 11. – Existing HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals Starting Pass-Through Status as of January 1, 2026

CY 2026 HCPCS Code	CY 2026 Long Descriptor	October 2025 SI	January 2026 SI	January 2026 APC
J9275	Injection, cosibelimab-ipdl, 2 mg	E2	G	0915
Q5158	Injection, denosumab-bnht (bomyntra/conexxence), biosimilar, 1 mg	K	G	0892

Table 12. – HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals with Pass-Through Status Ending Effective December 31, 2025

CY 2026 HCPCS Code	CY 2026 Long Descriptor	October 2026 SI	January 2026 SI	January 2026 APC
J0225	Injection, vutrisiran, 1 mg	G	K	9009
J1932	Injection, lanreotide, (cipla), 1 mg	G	K	9051
J2327	Injection, risankizumab-rzaa, intravenous, 1 mg	G	K	9013
Q5124	Injection, ranibizumab-nuna, biosimilar, (byooviz), 0.1 mg	G	K	9017

Table 13. – Newly Established HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals as of January 1, 2026

New HCPCS Code	Old HCPCS Code	Long Descriptor	SI	APC
C9176		Tc-99m from domestically produced non-HEU Mo-99, [minimum 50 percent], full cost recovery add-on, per study dose	K	1441
C9307		Injection, linvoseltamab-gcpt, 1 mg	G	0916
C9308		Injection, carboplatin (avyxa), 1 mg	G	0917
J0013		Esketamine, nasal spray, 1 mg	E1	
J0162		Injection, epinephrine (fresenius), not therapeutically equivalent to j0165, 0.1 mg	N	
J0654		Injection, liothyronine, 1 mcg	K	0900
J1073		Testosterone pellet, implant, 75 mg	K	0904
J1736		Injection, meloxicam (delova), 1 mg	E2	
J1737		Injection, meloxicam (azurity), 1 mg	G	0898
J1837		Injection, posaconazole, 1 mg	K	0905
J2516		Injection, pentamidine isethionate, 1 mg	N	
J2596		Injection, vasopressin (long grove), not therapeutically equivalent to j2598, 1 unit	N	
J2711		Injection, neostigmine methylsulfate 0.1 mg and glycopyrrolate 0.02 mg	N	
J3291		Injection, tranexamic acid in sodium chloride, 5 mg	E1	

J3376		Injection, vancomycin hcl (hikma), not therapeutically equivalent to j3373, 10 mg	N	
J3379		Injection, valproate sodium, 5 mg	N	
J3387		Injection, elivaldogene autotemcel, per treatment	K	0906
J3389		Topical administration, prademagene zamikeracel, per treatment	K	0908
J7299		Intrauterine copper contraceptive (miudella)	E1	
J7528		Mycophenolate mofetil, for suspension, oral, 100 mg	N	
J9184		Injection, gemcitabine hydrochloride (avyxa), 200 mg	G	0909
J9256	C9305	Injection, nipocalimab-aahu, 3 mg	G	0893
J9282		Mitomycin, intravesical instillation, 1 mg	G	0913
J9326	C9306	Injection, telisotuzumab vedotin-tllv, 1 mg	G	0894
Q5160		Injection, bevacizumab-nwgd (jobevne), biosimilar, 10 mg	G	0918

Table 14. ─ HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals Deleted as of December 31, 2025

CY 2026 HCPCS Code	Long Descriptor	CY 2026 SI	APC
C9089	Bupivacaine, collagen-matrix implant, 1 mg	D	N/A
J0172	Injection, aducanumab-avwa, 2 mg	D	N/A
J0190	Injection, biperiden lactate, per 2 mg	D	N/A
J0200	Injection, alatrofloxacin mesylate, 100 mg	D	N/A
J0205	injection, alglucerase, per 10 units	D	N/A
J0215	injection, alefacept, 0.5 mg	D	N/A
J0288	Injection, amphotericin B cholesteryl sulfate complex, 10 mg	D	N/A
J0350	Injection, anistreplase, per 30 units	D	N/A
J0365	injection, aprotonin, 10,000 kiu	D	N/A
J0380	injection, metaraminol bitartrate, per 10 mg	D	N/A
J0395	Injection, arbutamine hcl, 1 mg	D	N/A
J0710	injection, cephapirin sodium, up to 1 gm	D	N/A
J0715	injection, ceftizoxime sodium, per 500 mg	D	N/A
J0795	injection, corticorelin ovine triflutate, 1 microgram	D	N/A
J0889	Daprodustat, oral, 1 mg, (for esrd on dialysis)	D	N/A
J1267	Injection, doripenem, 10 mg	D	N/A
J1330	injection, ergonovine maleate, up to 0.2 mg	D	N/A
J1443	Injection, ferric pyrophosphate citrate solution (triferic), 0.1 mg of iron	D	N/A
J1444	Injection, ferric pyrophosphate citrate powder, 0.1 mg of iron	D	N/A
J1445	Injection, ferric pyrophosphate citrate solution (triferic avnu), 0.1 mg of iron	D	N/A
J1452	Injection, fomivirsen sodium, intraocular, 1.65 mg	D	N/A
J1457	injection, gallium nitrate, 1 mg	D	N/A
J1562	'Injection, immune globulin (vivaglobin), 100 mg	D	N/A

CY 2026 HCPCS Code	Long Descriptor	CY 2026 SI	APC
J1620	injection, gonadorelin hydrochloride, per 100 mcg	D	N/A
J1655	injection, tinzaparin sodium, 1000 iu	D	N/A
J1710	injection, hydrocortisone sodium phosphate, up to 50 mg	D	N/A
J1945	injection, lepirudin, 50 mg	D	N/A
J2504	injection, pegademase bovine, 25 iu	D	N/A
J2513	injection, pentastarch, 10% solution, 100 ml	D	N/A
J2910	injection, aurothioglucose, up to 50 mg	D	N/A
J2940	injection, somatrem, 1 mg	D	N/A
J2995	injection, streptokinase, per 250,000 iu	D	N/A
J3280	injection, thiethylperazine maleate, up to 10 mg	D	N/A
J3305	injection, trimetrexate glucuronate, per 25 mg	D	N/A
J3310	injection, perphenazine, up to 5 mg	D	N/A
J3320	injection, spectinomycin dihydrochloride, up to 2 gm	D	N/A
J3355	Injection, urofollitropin, 75 IU	D	N/A
J3364	injection, urokinase, 5000 iu vial	D	N/A
J3365	injection, iv, urokinase, 250,000 i.u. vial	D	N/A
J3400	injection, trifluprom azine hcl, up to 20 mg	D	N/A
J7309	Methyl Aminolevulinate (mal) for topical administration,16.8%, 10 mg	D	N/A
J7310	ganciclovir, 4.5 mg, long-acting implant	D	N/A
J7505	muromonab-cd3, parenteral, 5 mg	D	N/A
J7513	daclizumab, parenteral, 25 mg	D	N/A
J8562	Fludarabine phosphate, oral, 10 mg	D	N/A
J8650	Nabilone, oral, 1 mg	D	N/A
J9019	Injection, asparaginase (erwinaze), 1,000 iu	D	N/A
J9020	Injection, asparaginase, 10,000 units, not otherwise specified	D	N/A
J9098	Injection, cytarabine liposome, 10 mg	D	N/A
J9151	Injection, daunorubicin citrate, liposomal formulation, 10 mg	D	N/A
J9165	Injection, diethylstilbestrol diphosphate, 250 mg	D	N/A
J9212	Injection, interferon alfacon-1, recombinant, 1 microgram	D	N/A
J9270	Injection, plicamycin, 2.5 mg	D	N/A
Q0174	thiethylperazine maleate, 10 mg, oral, fda approved prescription anti-emetic, for use as a compl	D	N/A
Q2017	Injection ,teniposide, 50 mg	D	N/A
Q5109	Injection, infliximab-qbtx, biosimilar, (ixifi), 10 mg	D	N/A
Q9969	Tc-99m from non-highly enriched uranium source, full cost recovery add-on, per study dose	D	N/A

Table 15. – HCPCS Codes for Drug, Biological, and Radiopharmaceutical Changing Payment Status Indicators Effective January 1, 2026

CY 2026 HCPCS Code	CY 2026 Long Descriptor	January 2026 SI	January 2026 APC
90385	rho(d) immune globulin (rhig), human, mini-dose, for intramuscular use	K	9063
90476	adenovirus vaccine, type 4, live, for oral use	E1	N/A
90634	hepatitis a vaccine, pediatric/adolescent dosage-3 dose schedule, for intramuscular use	N	N/A
90680	rotavirus vaccine, pentavalent, 3 dose schedule, live, for oral use	N	N/A
90710	measles, mumps, rubella, and varicella vaccine (mmrv), live, for subcutaneous use	E1	N/A
A9507	indium in-111 capromab pendetide, diagnostic, per study dose, up to 10 millicuries	K	0854
A9508	iodine i-131 iobenguane sulfate, diagnostic, per 0.5 millicurie	K	0860
A9532	iodine i-125 serum albumin, diagnostic, per 5 microcuries	K	0861
A9542	indium in-111 ibritumomab tiuxetan, diagnostic, per study dose, up to 5 millicuries	N	N/A
A9551	technetium tc-99m succimer, diagnostic, per study dose, up to 10 millicuries	K	0920
A9553	chromium cr-51 sodium chromate, diagnostic, per study dose, up to 250 microcuries	K	0862
A9554	iodine i-125 sodium iothalamate, diagnostic, per study dose, up to 10 microcuries	K	0863
A9568	technetium tc-99m arcitumomab, diagnostic, per study dose, up to 25 millicuries	E1	N/A
C9047	Injection, caplacizumab-yhdp, 1 mg	K	9199
C9144	Injection, bupivacaine (posimir), 1 mg	E1	N/A
C9293	Injection, glucarpidase, 10 units	K	9293
C9363	Skin substitute, Integra Meshed Bilayer Wound Matrix, per square centimeter	S1	6001
C9488	Injection, conivaptan hydrochloride, 1 mg	E2	N/A
J0122	Injection, eravacycline, 1 mg	K	9325
J0139	Injection, adalimumab, 1 mg	E1	N/A
J0209	Injection, sodium thiosulfate (hope), 100 mg	K	0866
J0220	Injection, alglucosidase alfa, 10 mg, not otherwise classified	E2	N/A
J0225	Injection, vutrisiran, 1 mg	K	9009
J0287	injection, amphotericin b lipid complex, 10 mg	E1	N/A
J0470	injection, dimercaprol, per 100 mg	E2	N/A
J0599	Injection, c-1 esterase inhibitor (human), (haegarda), 10 units	E1	N/A
J0606	Injection, etelcalcetide, 0.1 mg	K	9031
J0630	injection, calcitonin salmon, up to 400 units	E1	N/A
J0652	Injection, levothyroxine sodium (hikma), not therapeutically equivalent to J0650, 10 mcg	N	N/A

CY 2026 HCPCS Code	CY 2026 Long Descriptor	January 2026 SI	January 2026 APC
J0687	Injection, cefazolin sodium (wg critical care), not therapeutically equivalent to j0690, 500 mg	N	N/A
J0688	Injection, cefazolin sodium (hikma), not therapeutically equivalent to j0690, 500 mg	N	N/A
J0691	Injection, lefamulin, 1 mg	E2	N/A
J0720	injection, chloramphenicol sodium succinate, up to 1 gm	K	1831
J0742	Injection, imipenem 4 mg, cilastatin 4 mg and relebactam 2 mg	N	N/A
J0801	Injection, corticotropin (acthar gel), up to 40 units	K	9268
J0802	Injection, corticotropin (ani), up to 40 units	K	9275
J0872	Injection, daptomycin (xellia), unrefrigerated, not therapeutically equivalent to j0878 or j0873, 1 mg	N	N/A
J0873	Injection, daptomycin (xellia), not therapeutically equivalent to j0878 or j0872, 1 mg	N	N/A
J0879	Injection, difelikefalin, 0.1 microgram, (for esrd on dialysis)	N	N/A
J0888	Injection, Epoetin Beta, 1 microgram, (Non-ESRD use)	N	N/A
J0892	Injection, argatroban (accord), not therapeutically equivalent to j0884, 1 mg (for esrd on dialysis)	E2	N/A
J0898	Injection, argatroban (auromedics), not therapeutically equivalent to j0883, 1 mg (for non-esrd use)	N	N/A
J1010	Injection, methylprednisolone acetate, 1 mg	N	N/A
J1105	Dexmedetomidine, oral, 1 mcg	E1	N/A
J1130	Injection, diclofenac sodium, 0.5 mg	E2	N/A
J1320	injection, amitriptyline hcl, up to 20 mg	E2	N/A
J1327	injection, eptifibatide, 5 mg	K	9420
J1427	Injection, viltolarsen, 10 mg	E2	N/A
J1429	Injection, golodirsen, 10 mg	E2	N/A
J1438	Injection, etanercept, 25 mg (code may be used for medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered)	E1	N/A
J1455	injection, foscarnet sodium, per 1000 mg	N	N/A
J1458	injection, galsulfase, per 5 mg	K	9224
J1551	Injection, immune globulin (cutaquig), 100 mg	K	9007
J1556	Injection, immune globulin (Bivigam), 500 mg	K	9130
J1595	injection, glatiramer acetate, 20 mg	E1	N/A
J1596	Injection, glycopyrrolate, 0.1 mg	N	N/A
J1598	Injection, glycopyrrolate (fresenius kabi), not therapeutically equivalent to J1596, 0.1 mg	N	N/A
J1632	Injection, brexanolone, 1mg	E1	N/A
J1729	Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg	E2	N/A
J1744	Injection, icatibant, 1 mg	E1	N/A
J1748	Injection, infliximab-dyyb (zymfentra), 10 mg	K	0919

CY 2026 HCPCS Code	CY 2026 Long Descriptor	January 2026 SI	January 2026 APC
J1811	Insulin (fiasp) for administration through dme (i.e., insulin pump) per 50 units	N	N/A
J1826	Injection, interferon beta-1a, 30 mcg	E1	N/A
J1932	Injection, lanreotide, (cipla), 1 mg	K	9051
J1939	Injection, bumetanide, 0.5 mg	N	N/A
J2002	Injection, lidocaine hcl in 5% dextrose, 1 mg	N	N/A
J2170	injection, mecasermin, 1 mg	E1	N/A
J2183	Injection, meropenem (wg critical care), not therapeutically equivalent to j2185, 100 mg	N	N/A
J2212	Injection, methylnaltrexone, 0.1 mg	E1	N/A
J2327	Injection, risankizumab-rzaa, intravenous, 1 mg	K	9013
J2358	Injection, olanzapine, long-acting, 1mg	N	N/A
J2373	Injection, phenylephrine hydrochloride (immphentiv), 20 micrograms	N	N/A
J2440	injection, papaverine hcl, up to 60 mg	E1	N/A
J2510	injection, penicillin g procaine, aqueous, up to 600,000 units	E2	N/A
J2515	injection, pentobarbital sodium, per 50 mg	K	1854
J2597	injection, desmopressin acetate, per 1 mcg	N	N/A
J2650	injection, prednisolone acetate, up to 1 ml	N	N/A
J2679	Injection, fluphenazine hcl, 1.25 mg	N	N/A
J2770	injection, quinupristin/dalfopristin, 500 mg (150/350)	N	N/A
J2793	Injection, rilonacept, 1 mg	E2	N/A
J2919	Injection, methylprednisolone sodium succinate, 5 mg	N	N/A
J2941	injection, somatropin, 1 mg	E1	N/A
J3030	injection, sumatriptan succinate, 6 mg (code may be used for medicare when drug administered und	E1	N/A
J3031	Injection, fremanezumab-vfrm, 1 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered)	E1	N/A
J3350	Injection, urea, up to 40 g	N	N/A
J3357	Injection, ustekinumab, 1 mg	E1	N/A
J3425	Injection, hydroxocobalamin, intramuscular, 10 mcg	N	N/A
J3485	injection, zidovudine, 10 mg	K	1744
J7191	factor viii (antihemophilic factor (porcine)), per i.u.	K	1464
J7200	Factor ix (antihemophilic factor, recombinant), Rixubus, per i.u.	K	1467
J7212	Factor viia (antihemophilic factor, recombinant)-jncw (sevenfact), 1 microgram	K	9395
J7316	Injection, Ocriplasmin, 0.125mg	E1	N/A
J7328	Hyaluronan or derivative, gelsyn-3, for intra-articular injection, 0.1 mg	K	1862
J7356	Injection, foscarbidopa 0.25 mg/foslevodopa 5 mg	E1	N/A

CY 2026 HCPCS Code	CY 2026 Long Descriptor	January 2026 SI	January 2026 APC
J8560	etoposide; oral, 50 mg	K	0802
J8705	Topotecan, oral, 0.25 mg	K	1238
J9017	Injection, arsenic trioxide, 1 mg	N	N/A
J9030	BCG live intravesical instillation, 1 mg	K	9322
J9051	Injection, bortezomib (maia), not therapeutically equivalent to j9041, 0.1 mg	N	N/A
J9052	Injection, carmustine (accord), not therapeutically equivalent to j9050, 100 mg	E1	N/A
J9150	Injection, daunorubicin, 10 mg	N	N/A
J9185	Injection, fludarabine phosphate, 50 mg	N	N/A
J9218	leuprolide acetate, per 1 mg	E1	N/A
J9225	Histrelin implant (vantas), 50 mg	E2	N/A
J9230	Injection, mechlorethamine hydrochloride, (nitrogen mustard), 10 mg	E2	N/A
J9255	Injection, methotrexate (accord), not therapeutically equivalent to J9260, 50 mg	N	N/A
J9275	Injection, cosibelimab-ipdl, 2 mg	G	0915
J9285	Injection, olaratumab, 10 mg	E2	N/A
J9320	Injection, streptozocin, 1 gram	E2	N/A
J9395	injection, fulvestrant, 25 mg	N	N/A
P9041	infusion, albumin (human), 5%, 50 ml	K	0961
P9047	infusion, albumin (human), 25%, 50 ml	K	0965
Q0180	dolasetron mesylate, 100 mg, oral, fda approved prescription anti-emetic, for use as a complete	E2	N/A
Q2009	Injection, Fosphenytoin, 50 mg phenytoin equivalent	K	9321
Q3027	Injection, Interferon Beta-1a, 1 mcg For Intramuscular Use	E1	N/A
Q5098	Injection, ustekinumab-srlf (imuldosa), biosimilar, 1 mg	E1	N/A
Q5099	Injection, ustekinumab-stba (steqeyma), biosimilar, 1 mg	E1	N/A
Q5105	Injection, epoetin alfa-epbx, biosimilar, (Retacrit) (for esrd on dialysis), 100 units	N	N/A
Q5124	Injection, ranibizumab-nuna, biosimilar, (byooviz), 0.1 mg	K	9017
Q5134	Injection, natalizumab-sztn (tyruko), biosimilar, 1 mg	K	0921
Q5137	Injection, ustekinumab-auub (wezlana), biosimilar, subcutaneous, 1 mg	E1	N/A
Q5140	Injection, adalimumab-fkjp, biosimilar, 1 mg	E1	N/A
Q5141	Injection, adalimumab-aaty, biosimilar, 1 mg	E1	N/A
Q5142	Injection, adalimumab-ryvk biosimilar, 1 mg	E1	N/A
Q5143	Injection, adalimumab-adbm, biosimilar, 1 mg	E1	N/A
Q5144	Injection, adalimumab-aacf (idacio), biosimilar, 1 mg	E1	N/A
Q5145	Injection, adalimumab-afzb (abrilada), biosimilar, 1 mg	E1	N/A

CY 2026 HCPCS Code	CY 2026 Long Descriptor	January 2026 SI	January 2026 APC
Q5158	Injection, denosumab-bnht (bomyntra/conexxence), biosimilar, 1 mg	G	0892
Q9996	Injection, ustekinumab-ttwe (pyzchiva), subcutaneous, 1 mg	E1	N/A

Table 16. – HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals with Substantial Descriptor Changes as of January 1, 2026

CY 2026 HCPCS Code	October 2025 Long Descriptor	January 2026 Long Descriptor
J7322	Hyaluronan or derivative, hymovis, for intra-articular injection, 1 mg	Hyaluronan or derivative, hymovis or hymovis one, for intra-articular injection, 1 mg

Table 17. – New OPPS Skin Substitute APCs Effective January 1, 2026

APC	APC Title	Payment Rate
6000	PMA Skin Substitute Products	$127.14/cm^2
6001	510(k) Skin Substitute Products	$127.14/cm^2
6002	361 HCT/P Skin Substitute Products	$127.14/cm^2

Table 18. – New OPPS Skin Substitute Status Indicator Effective January 1, 2026

Status Indicator	Descriptor	OPPS Payment Status
S1	Skin substitute product paid separately	Paid under OPPS; separate APC payment. Subject to payment based on FDA regulatory pathway.

Table 19. – New Unlisted Skin Substitute Product HCPCS Codes Effective January 1, 2026

HCPCS Code	Long Descriptor	APC	Payment Rate
Q4431	Unlisted PMA skin substitute product, not otherwise specified (list in addition to primary procedure)	APC 6000 (PMA Skin Substitute Products)	$127.14/cm^2
Q4432	Unlisted 510(k) skin substitute product, not otherwise specified (list in addition to primary procedure)	APC 6001 (Unlisted 510(k) Skin Substitute Products)	$127.14/cm^2
Q4433	Unlisted 361 HCT/P skin substitute product, not otherwise specified (list in addition to primary procedure)	APC 6002 (Unlisted 361 HCT/P Skin Substitute Products)	$127.14/cm^2

Table 20. –HCPCS Skin Substitute Application Codes Deleted as of December 31, 2025

HCPCS Code	Long Descriptor	SI
C5271	Application of low cost skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	D
C5272	Application of low cost skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (list separately in addition to code for primary procedure)	D
C5273	Application of low cost skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	D
C5274	Application of low cost skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (list separately in addition to code for primary procedure)	D
C5275	Application of low cost skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	D
C5276	Application of low cost skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (list separately in addition to code for primary procedure)	D
C5277	Application of low cost skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	D
C5278	Application of low cost skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (list separately in addition to code for primary procedure)	D

Table 21. – HCPCS Codes, Status Indicator and APC Assignments for Qualifying Non-Opioid Treatments for Pain Relief Effective January 1, 2026.

HCPCS Code	Long Descriptor	SI Oct 2025	SI Jan 2026	CY 2026 APC
C9804	Elastomeric infusion pump (e.g., ON-Q* Pump with Bolus), including catheter and all disposable system components, non-opioid medical device (must be a	H1	H1	2048

HCPCS Code	Long Descriptor	SI Oct 2025	SI Jan 2026	CY 2026 APC
	qualifying Medicare non-opioid medical device for post-surgical pain relief in accordance with Section 4135 of the CAA, 2023)			
C9806	Rotary peristaltic infusion pump (e.g., ambIT® Pump), including catheter and all disposable system components, non-opioid medical device (must be a qualifying Medicare non-opioid medical device for post-surgical pain relief in accordance with Section 4135 of the CAA, 2023)	H1	H1	2056
C9807	Nerve stimulator, percutaneous, peripheral (e.g., SPRINT Peripheral Nerve Stimulation System), including electrode and all disposable system components, non-opioid medical device (must be a qualifying Medicare non-opioid medical device for post-surgical pain relief in accordance with Section 4135 of the CAA, 2023)	H1	H1	2057
C9808	Nerve cryoablation probe (e.g., cryoICE®, cryoSPHERE™, cryoSPHERE MAX™, cryoICE® cryoSPHERE™, cryoICE® Cryo2), including probe and all disposable system components, non-opioid medical device (must be a qualifying Medicare non-opioid medical device for post-surgical pain relief in accordance with Section 4135 of the CAA, 2023)	H1	H1	2058
C9809	Cryoablation needle (e.g., iovera System), including needle/tip and all disposable system components, non-opioid medical device (must be a qualifying Medicare non-opioid medical device for post-surgical pain relief in accordance with Section 4135 of the CAA, 2023)	H1	H1	2059
C9810	Water circulating motorized cold therapy device (e.g., IceMan) including all system components (e.g. pads, console, disposable parts), non-opioid medical device (must be a qualifying medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of the caa, 2023)	N/A	H1	2060
C9811	Electronic ambulatory infusion pump (e.g. Sapphire pump), including all pump components, including disposable components , non-opioid medical device (must be a qualifying Medicare non-	N/A	H1	2079

HCPCS Code	Long Descriptor	SI Oct 2025	SI Jan 2026	CY 2026 APC
	opioid medical device for post-surgical pain relief in accordance with Section 4135 of the CAA, 2023)			
C9812	Echogenic nerve block needles (e.g. SonoPlex, SonoBlock, SonoTap), non-opioid medical device (must be a qualifying Medicare non-opioid medical device for post-surgical pain relief in accordance with Section 4135 of the CAA, 2023)	N/A	H1	2080
C9813	Perforated continuous infusion catheter set (e.g. InfiltraLong), including all components, non-opioid medical device (must be a qualifying Medicare non-opioid medical device for post-surgical pain relief in accordance with Section 4135 of the CAA, 2023)	N/A	H1	2081
C9814	Continuous anesthesia echogenic conduction catheter set (e.g. SonoLong), non-opioid medical device (must be a qualifying Medicare non-opioid medical device for post-surgical pain relief in accordance with Section 4135 of the CAA, 2023)	N/A	H1	2082
C9815	Linear peristaltic pain management infusion pump (e.g. CADD-Solis ambulatory infusion pump), and all disposable system components, non-opioid medical device (must be a qualifying Medicare non-opioid medical device for post-surgical pain relief in accordance with Section 4135 of the CAA, 2023)	N/A	H1	2083
C9816	Rotary peristaltic infusion pump (e.g., reusable ambIT Pump) including all disposable system components, reusable non-opioid medical device (must be a qualifying Medicare non-opioid medical device for post-surgical pain relief in accordance with Section 4135 of the CAA, 2023)	N/A	H1	2084
C9817	Electronic cryo-pneumatic compression, pain management system (e.g. Game Ready® GRPro 2.1 System), including control unit, anatomically correct wrap(s), and other system component(s), non-opioid medical device (must be a qualifying Medicare non-opioid medical device for post-surgical pain relief in accordance with Section 4135 of the CAA, 2023)	N/A	H1	2085

HCPCS Code	Long Descriptor	SI Oct 2025	SI Jan 2026	CY 2026 APC
J0666	Injection, bupivacaine liposome, 1 mg	K1	K1	0763
J0668	Instillation, bupivacaine and meloxicam, 1 mg/0.03 mg	K1	K1	9440
J1096	Dexamethasone, lacrimal ophthalmic insert, 0.1 mg	K1	K1	9308
J1097	Phenylephrine 10.16 mg/ml and ketorolac 2.88 mg/ml ophthalmic irrigation solution, 1 ml	K1	K1	9324
J1885	Injection, ketorolac tromethamine, per 15 mg	K1	K1	0764

Table 22. ─ HCPCS Codes and Payment Limitations for Qualifying Non-Opioid Treatments for Pain Relief Effective January 1, 2026.

HCPCS Code	CY 2026 Payment Limit
C9804	$2,008.72
C9806	$2,008.72
C9807	$2,525.62
C9808	$1,050.68
C9809	$261.38
C9810	$2146.80
C9811	$1,997.16
C9812	$1,997.16
C9813	$1,997.16
C9814	$1,997.16
C9815	$1,997.16
C9816	$2,008.72
C9817	$1,997.16
J0666	$2,443.20
J0668	$2,411.70
J1096	$419.57
J1097	$414.05
J1885	$1,259.42