

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 13836	Date: June 24, 2026
	Change Request 14522

SUBJECT: July 2026 Update of the Ambulatory Surgical Center (ASC) Payment System

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to provide changes to and billing instructions for various payment policies implemented in the July 2026 ASC payment system update.

EFFECTIVE DATE: July 1, 2026

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: July 6, 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	14/40.8-Payment When a Device is Furnished With No Cost or With Full or Partial Credit Beginning January 1, 2008

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

Pub. 100-04	Transmittal: 13836	Date: June 24, 2026	Change Request: 14522
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I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to provide changes to and billing instructions for various payment policies implemented in the July 2026 ASC payment system update.

II. GENERAL INFORMATION

A. Background: As appropriate, this notification also includes updates to the Healthcare Common Procedure Coding System (HCPCS). This Recurring Update Notification applies to Chapter 14, Section 40 of Publication (Pub.) 100-04. A July 2026 Ambulatory Surgical Center Fee Schedule (ASC FS) File, a July 2026 Ambulatory Surgical Center Drug File, a July 2026 ASC Code Pair file, and a July 2026 Ambulatory Surgical Center Payment Indicator (PI) File will be issued with this transmittal.

B. Policy: 1. OPSS Device Pass-through Devices

a. New Device Category Effective July 1, 2026

Section 1833(t)(6)(B) of the Social Security Act requires that, under the Hospital Outpatient Prospective Payment System (OPSS), 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 also apply this policy in the ASC payment system.

For the July 2026 update, we approved one (1) new device for pass-through status under the OPSS and are establishing the new device category in the ASC payment system. The new HCPCS code, C1609, is effective July 1, 2026. Table 1 includes the HCPCS Code, code descriptors, and ASC PI (see Attachment A: Policy Section Tables).

2. Newly Payable ASC Surgical Procedure and a Revised Long Descriptor for an Existing Surgical Procedure

a. New HCPCS Code Describing Cystourethroscopy with Ureteroscopy and/or Pyeloscopy, With Lithotripsy Utilizing a Suction Enabled Ureteral Access Sheath and Revised HCPCS Code Describing Cystourethroscopy with Ureteroscopy and/or Pyeloscopy, With Lithotripsy Utilizing a Steerable Ureteral Catheter or a Suction-Integrated Ureteroscope Effective July 1, 2026

CMS is establishing a new HCPCS code (C8014) effective July 1, 2026, to describe the cystourethroscopy procedure with ureteroscopy and/or pyeloscopy with lithotripsy utilizing a suction enabled ureteral access sheath. We are also revising the long descriptor for HCPCS code C9761 to include a suction-integrated ureteroscope, in addition to the steerable ureteral catheter. We note that the procedure described by HCPCS

code C8014 is distinguishable from the procedure described by HCPCS code C9761 (*Cystourethroscopy, with ureteroscopy and/or pyeloscopy, with lithotripsy, and ureteral catheterization for steerable vacuum aspiration of the kidney, collecting system, ureter, bladder, and urethra if necessary, with use of steerable ureteral catheter or suction-integrated ureteroscope*) as HCPCS code C8014 utilizes a suction enabled ureteral access sheath versus HCPCS code C9761 utilizes a steerable ureteral catheter or a suction-integrated ureteroscope.

Table 2 includes the HCPCS Code, code descriptors, and ASC PI for the new procedure (see Attachment A: Policy Section Tables).

Table 3 includes the HCPCS Code and a revised code descriptor of the existing procedure. (see Attachment A: Policy Section Tables).

3. Changes in Payment Status and Rates for Existing ASC Surgical Procedures

a. Payment Indicator Change for CPT Code 0996T, Retroactive to January 1, 2026

Effective January 1, 2026, the AMA's CPT Editorial Panel established CPT code 0996T to describe the insertion and scleral fixation of a capsular bag prosthesis which contains a lens prosthesis. The procedure also includes removal of eye fluid. Based on our review, the device associated with this code has not received full FDA approval. In addition, we have not received any claims for this code since its effective date of January 1, 2026.

Because the device associated with this CPT code has not received full FDA approval, we are revising the payment indicator for CPT code 0996T to "E5" (Surgical procedure not valid for Medicare purposes because of coverage, regulation and/or statute; no payment made) retroactive to January 1, 2026.

Table 4 includes the HCPCS Code, code descriptors, and ASC PIs for this procedure (see Attachment A: Policy Section Tables).

b. Payment Indicator Revision for Femtosecond Laser Trabeculotomy (0730T), Effective July 1, 2026

CMS is revising payment indicator for femtosecond laser trabeculotomy (0730T).

Table 5 includes the HCPCS Code, code descriptors, and ASC PIs for this procedure. (see Attachment A: Policy Section Tables).

4. Drugs, Biologicals, and Radiopharmaceuticals

a. Newly Established HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals as of July 1, 2026

Ten (10) new drug, biological, and radiopharmaceutical HCPCS codes are established effective July 1, 2026, and are separately payable under the ASC payment system. These HCPCS codes, as well as the descriptors and ASC PIs, are listed in Table 6 (see Attachment A: Policy Section Tables).

b. Existing HCPCS Codes for Certain Drug, Biological, and Radiopharmaceutical Starting Pass-Through Status as of July 1, 2026

In alignment with OPPS policy, two (2) existing HCPCS code for certain drugs, biologicals, and radiopharmaceuticals will be separately payable effective July 1, 2026. The ASC PI assignments for these HCPCS codes will be changed effective July 1, 2026, to ASC PI=K2. The HCPCS codes along with their ASC PIs is listed in Table 7 (see Attachment A: Policy Section Tables).

c. HCPCS Code for Drug, Biological, and Radiopharmaceutical Changing Payment Status

We are changing the payment indicator for HCPCS code J1741 from PI="N1" to PI="K2". The effective date of this change for HCPCS code J1741 is retroactive to March 11, 2026.

We are changing the payment indicator for HCPCS code Q5156 from PI= "K5" to PI= "K2" and we are changing the payment indicator for HCPCS Code J3403 from PI="B5" to PI="K2". The effective date of these changes is retroactive to April 1, 2026.

We are also changing the payment indicator for HCPCS code J2993 from PI="K2" to PI="Y5" effective July 1, 2026.

These HCPCS codes, as well as the descriptors and ASC PIs, are listed in Table 8 (see Attachment A: Policy Section Tables).

d. HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals with Substantial Descriptor Changes as of July 1, 2026

Three (3) drug, biological, or radiopharmaceutical HCPCS codes have had substantial descriptor changes as of July 1, 2026. Table 9 includes the HCPCS codes and the code descriptors for these items (see Attachment A: Policy Section Tables).

e. 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 plus 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 ASP 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 fourth quarter of CY 2025. Updated payment rates effective July 1, 2026, can be found in the July 2026 update of the ASC Addendum B on the CMS website at <https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-payment-rates-addenda>

f. Drugs and Biologicals Paid 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.

5. Payment Indicator Correction for HCPCS codes A2032 and A2034 Retroactive to January 1, 2026

In accordance with our policy to assign sheet-form skin substitute products to payment indicator “S2” (Skin substitute supply group; paid separately when provided integral to a surgical procedure on the ASC list; payment based on OPPS rate), we are correcting the payment indicators for two HCPCS codes describing sheet-form skin substitute products from payment indicator “N1” (packaged) to payment indicator “S2”. These changes are retroactive to January 1, 2026.

Table 10 includes the HCPCS Codes, code descriptors, and ASC PIs for these items (see Attachment A: Policy Section Tables).

6. HCPCS Codes, Payment Indicator, & Payment Limitations for Qualifying Non-Opioid Treatments for Pain Relief

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 product in Table 11 (see Attachment A: Policy Section Tables) newly meets the statutory definition of a Non-opioid Treatment for Pain Relief and should be paid according to the finalized policy for CY 2026. Specifically, HCPCS code J1741 which may be used to describe the drug Caldolor (Injection, ibuprofen, 100 mg) will receive temporary additional payment under Section 4135 of the CAA, 2023, effective March 11, 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 HCPCS code J1741 is also found in Table 11 (see Attachment A: Policy Section Tables)

In addition, we are making a descriptor change to HCPCS code C9809 (Cryoablation needle (e.g., Iovera System), including needle/tip and all disposable system components, nonopioid 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)), which qualifies as a Non-opioid Treatment for Pain Relief, effective January 1, 2025. We are revising the long descriptor to more specifically describe the cryoneurolysis service. There are no changes to HCPCS code C9809’s status indicator or APC assignments. The finalized descriptor for HCPCS code C9809 is found in Table 12 (see Attachment A: Policy Section Tables).

7. 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 ASC payment system 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. Medicare Administrative Contractors (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								Other
		A/B MAC			D M E M A C	Shared-System Maintainers				
		A	B	H H H		F I S S	M C S	V M S	C W F	
14522.6.1	Contractors and CWF shall add TOS F to HCPCS codes listed in table 10, effective for dates of service on or after January 1, 2026.		X						X	
14522.6.2	Contractors and CWF shall add TOS F to HCPCS code J1741 in table 8 for claims with effective dates on or after March 11, 2026.		X						X	
14522.6.3	Contractors and CWF shall add TOS F to HCPCS codes J3403 and Q5156 in table 8 for claims with effective dates on or after April 1, 2026.		X						X	
14522.7	Medicare contractors shall search for and reprocess claims with dates of service from January 1, 2026, through June 30, 2026, as appropriate, that included procedure in table 4 and HCPCS codes in table 10. Affected claims shall be reprocessed no later than 30 days of implementation of this transmittal.		X							CVM
14522.8	Medicare contractors shall search for, and reprocess claims, if necessary, for the HCPCS codes identified in table 8 for the effective date listed in table 8 through June 30, 2026. Affected claims shall be reprocessed no later than 30 days of implementation of this transmittal.		X							CVM
14522.9	Medicare contractors shall make July 2026 ASCFS fee data for their ASC payment localities available on their websites.		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 B

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:
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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 14 - Ambulatory Surgical Centers

Table of Contents

(Rev.13836.; Issued:06-24-26)

Medicare Claims Processing Manual

Chapter 14 - Ambulatory Surgical Centers

40.8 - Payment When a Device is Furnished With No Cost or With Full or Partial Credit Beginning January 1, 2008

(Rev.13836; Issued: 06-24-26; Effective: 07-01-26; Implementation:07-06-26)

Contractors pay ASCs a reduced amount for certain specified procedures when a specified device is furnished without cost or for which either a partial or full credit is received (e.g., device recall). For specified procedure codes that include payment for a device, ASCs are required to include modifier –FB on the procedure code when a specified device is furnished without cost or for which full credit is received. If the ASC receives a partial credit of 50 percent or more of the cost of a specified device, the ASC is required to include modifier –FC on the procedure code if the procedure is on the list of specified procedures to which the -FC reduction applies. A single procedure code should not be submitted with both modifiers –FB and -FC. The pricing determination related to modifiers –FB and -FC is made prior to the application of multiple procedure payment reductions. Contractors adjust beneficiary coinsurance to reflect the reduced payment amount. Tables listing the procedures and devices to which the payment adjustments apply, and the full and partial adjustment amounts, are available on the CMS Web-site.

In order to report the receipt of a partial credit of 50 percent or more of the cost of a device, ASCs have the option of either: 1) Submitting the claim for the procedure to their Medicare contractor after the procedure's performance but prior to manufacturer acknowledgement of credit for a specified device, and subsequently contacting the contractor regarding a claims adjustment once the credit determination is made; or 2) holding the claim for the procedure until a determination is made by the manufacturer on the partial credit and submitting the claim with modifier –FC appended to the implantation procedure HCPCS code if the partial credit is 50 percent or more of the cost of the device. If choosing the first billing option, to request a claims adjustment once the credit determination is made, ASCs should keep in mind that the initial Medicare payment for the procedure involving the device is conditional and subject to adjustment.

For separately payable pass-through devices (ASC payment indicator = J7), modifier -FB or -FC should not be reported with the associated procedure when the device was received at no cost/full credit or with partial credit. The associated procedure codes do not include payment for separately payable devices; therefore, no –FB or –FC modifier is warranted. If applicable, ASCs should report the amount of the credit along with the invoice price of the separately payable device on the claim. The line-item charge for the separately payable device must reflect the amount of the credit received.

ATTACHMENT A: POLICY SECTION TABLES

Table 1. – New OPDS Device Category Payable in ASCs Effective July 1, 2026

HCPCS Code	Short Descriptor	Long Descriptor	ASC PI
C1609	Vert dev motion-preserv	Vertebral device, motion-preserving, with screw fixation	J7

Table 2. – ASC Payment Indicator Assignment for new HCPCS Code C8014 Effective July 1, 2026

HCPCS Code	Short Descriptor	Long Descriptor	ASC PI
C8014	Cysto, litho, w suct sheath	Cystourethroscopy, with ureteroscopy and/or pyeloscopy, with lithotripsy, including use of a suction enabled ureteral access sheath, with irrigation (if performed)	J8

Table 3. –Revised Long Descriptor for C9761, Effective July 1, 2026

HCPCS Code	Long Descriptor
C9761	Cystourethroscopy, with ureteroscopy and/or pyeloscopy, with lithotripsy, and ureteral catheterization for steerable vacuum aspiration of the kidney, collecting system, ureter, bladder, and urethra if necessary, with use of steerable ureteral catheter or suction-integrated ureteroscope

Table 4. – ASC Payment Indicator Assignments for CPT Code 0996T Effective January 1, 2026

HCPCS Code	Short Descriptor	Long Descriptor	Old ASC PI	New ASC PI
0996T	Ins&sclr fix caps bag prosth	Insertion and scleral fixation of a capsular bag prosthesis containing an intraocular lens prosthesis, with vitrectomy, including removal of crystalline lens or dislocated intraocular lens prosthesis, when performed	G2	E5

Table 5. — ASC Payment Indicator Assignment for CPT Code 0730T Effective July 1, 2026

HCPCS Code	Short Descriptor	Long Descriptor	Old ASC PI	New ASC PI
0730T	Trabeculotomy lsr w/oct gdn	Trabeculotomy by laser, including optical coherence tomography (OCT) guidance	E5	G2

Table 6. — Newly Established HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals as of July 1, 2026

New HCPCS Code	Old HCPCS Code	Long Descriptor	ASC PI
A9574		Injection, ferumoxytol, 1 mg	K2
C9310		Injection, leucovorin calcium (avyxa), 1 mg	K2
J0528		Injection, fosfomycin disodium, 20 mg	K2
J1289		Injection, narsoplimab-wuug, 1 mg	K2
J1577		Injection, immune globulin (qivigy), 100 mg	K2
J2361		Injection, depemokimab-ulaa, 1 mg	K2
J2789		Riboflavin 5'-phosphate, ophthalmic solution (epioxahd/epioxa), up to 2 mL	K2
J9053		Injection, belantamab mafodotin-blmf, 0.1 mg	K2
J9062		Injection, amivantamab 5 mg and hyaluronidase-lpuj	K2
Q5167		Injection, denosumab-qbde (enoby/xtrenbo), biosimilar, 1 mg	K2

Table 7. - Existing HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals Starting Pass-Through Status as of July 1, 2026

CY 2026 HCPCS Code	CY 2026 Long Descriptor	Old ASC PI	New ASC PI
Q5098	Injection, ustekinumab-srlf (imuldosa), biosimilar, 1 mg	Y5	K2
Q5161	Injection, denosumab-kyqq (aukelso/bosaya), biosimilar, 1 mg	K5	K2

Table 8. – HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals with Changes to Payment Indicators

CY 2026 HCPCS Code	Long Descriptor	Old ASC PI	New ASC PI	Effective Date
J1741	Injection, ibuprofen, 100 mg	N1	K2	03/11/2026
J2993	Injection, reteplase, 18.1 mg	K2	Y5	07/01/2026
J3403	Revakinagene, per implant	B5	K2	04/01/2026
Q5156	Injection, tocilizumab-anoh (avtozma), biosimilar, 1 mg	K5	K2	04/01/2026

Table 9. - HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals with Substantial Descriptor Changes as of July 1, 2026

CY 2026 HCPCS Code	April 2026 Long Descriptor	July 2026 Long Descriptor
J1569	Injection, immune globulin, (gammagard liquid), non-lyophilized, (e.g., liquid), 500 mg	Injection, immune globulin, (Gammagard liquid/Gammagard liquid ERC), 500 mg
J2787	Riboflavin 5'-phosphate, ophthalmic solution, up to 3 ml	Riboflavin 5'-phosphate, ophthalmic solution (photrexa viscous/photrexa), up to 3 ml
J3375	Injection, vancomycin hydrochloride (xellia), not therapeutically equivalent to j3373, 10 mg	Injection, vancomycin hydrochloride (tyzavan), not therapeutically equivalent to j3373, 10 mg

Table 10. - Payment Indicator Correction for HCPCS codes A2032 and A2034 Retroactive to January 1, 2026

CY 2026 HCPCS Code	Long Descriptor	Old ASC PI	New ASC PI
A2032	Myriad matrix, per square centimeter (add-on, list separately in addition to primary procedure)	N1	S2
A2034	Foundation drs solo, per square centimeter (add-on, list separately in addition to primary procedure)	N1	S2

Table 11. - HCPCS Code, ASC Payment Indicator and Payment Limitation for Qualifying Non-Opioid Treatment for Pain Relief

HCPCS Code	Long Descriptor	ASC PI	Payment Limitation*	Effective Date
J1741	Injection, ibuprofen, 100 mg	K2	\$1,892.36	March 11, 2026

Table 12. - HCPCS Code and Updated Long Descriptor for Qualifying Non-Opioid Treatment for Pain Relief

HCPCS Code	Long Descriptor	Effective Date
C9809	Cryoneurolysis needle (e.g., iovera System), including needle/tip and all disposable system components, nonopioid 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)	July 1, 2026