

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 13978	Date: September 29, 2026
	Change Request 14589

This Transmittal is no longer sensitive and is being re-communicated. This instruction may now be posted to the Internet.

Transmittal 13913 issued August 12, 2026, is being rescinded and replaced by Transmittal 13978, dated September 29, 2026, to remove and add new language to the policy section. We are also removing business requirement 14589.2 and adding a new business requirement. Also, we are adding provider education, Attachment A - Tables for the Policy Section and manual revisions. All other information remains the same.

SUBJECT: October 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 October 2026 Outpatient Prospective Payment System (OPPS) update. The October 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: October 1, 2026

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

IMPLEMENTATION DATE: October 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/Table of Contents
R	4/20.6.7/Modifier CA
R	4/160.1 / Critical Care Services
N	4/160.2 /Trauma Activation 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 October 2026 OPPS update.

This RUN provides instructions on coding changes and policy updates that are effective October 1, 2026, for the Hospital OPPS. The updates include coding and policy changes for new Proprietary Laboratory Analyses (PLA) codes, new services, pass-through drugs, and other items and services. The October 2026 revisions to I/OCE data files, instructions, and specifications are provided in the forthcoming October 2026 I/OCE CR.

B. Policy: 1. CPT Proprietary Laboratory Analyses (PLA) Coding Changes Effective October 1, 2026

The AMA CPT Editorial Panel established 39 new PLA codes, specifically, CPT codes 0660U through 0698U, effective October 1, 2026.

Table 1, attachment A, lists the long descriptors and status indicators for the codes. The codes have been added to the October 2026 I/OCE with an effective date of October 1, 2026. In addition, the codes, along with their short descriptors and status indicators, are listed in the October 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 Calendar Year 2026 OPPS/ASC final rule for the latest definitions.

2. New Category III CPT Codes Effective October 1, 2026

The AMA releases CPT Category III codes three times a year: in April, for implementation beginning the following July, in July for implementation beginning the following October, and in October, for implementation beginning the following January.

For the October 2026 update, CMS is implementing 58 new CPT Category III codes that the AMA released in early August 2026 for implementation on October 1, 2026. The status indicators and APC assignments for these codes are shown in Table 2, attachment A. The CPT codes listed below have been added to October 2026 I/OCE with an effective date of October 1, 2026. These codes, along with their short descriptors, Status Indicators (SI), and payment rates (where applicable) are also listed in the October 2026 OPSS Addendum B that is posted on the CMS website. For more information on the OPSS SI, refer to OPSS Addendum D1 of the CY 2026 OPSS/ASC final rule for the latest definitions.

3. New Category III CPT Code 1091T to Replace HCPCS Code C8010, Effective October 1, 2026

We established HCPCS code C8010 to describe the Category B IDE clinical study associated with Javelin Medical's carotid implants for permanent placement of common carotid artery filters. Because the AMA created a Category III CPT code 1091T effective October 1, 2026, that describes the same procedure, we are deleting HCPCS code C8010.

Table 3, attachment A, lists the information associated with the clinical study, which is also posted on the CMS approved IDE studies website, specifically, at <https://www.cms.gov/medicare/coverage/investigational-device-exemption-ide-studies/approved>.

Table 4, attachment A, lists the long descriptors, APC assignments, and status indicators for CPT code 1091T and the deleted HCPCS code C8010. The CPT code, along with its short descriptor, status indicator (SI), and payment rate is also listed in the October 2026 OPSS Addendum B that is posted on the CMS website. For information on the OPSS status indicators, refer to OPSS Addendum D1 of the CY 2026 OPSS/ASC final rule for the latest definitions.

4. New HCPCS Code Describing Algorithm-Based Assessment of Likelihood of Autism Spectrum Disorder Effective October 1, 2026

CMS is establishing a new HCPCS code G0685 that is effective October 1, 2026, to describe the algorithm-based assessment of likelihood of autism spectrum disorder from analysis of eye-gaze data or other technology. Table 5, attachment A, lists the official long descriptor, status indicator, and APC assignment for HCPCS code G0685. For information on OPSS status indicators, please refer to OPSS Addendum D1 of the CY 2026 OPSS/ASC final rule for the latest definitions. This code, along with its short descriptor, status indicator, and payment rate, is also listed in the October 2026 update of the OPSS Addendum B.

5. Status Indicator Revision and APC Assignment for CPT Code 1011T Effective October 1, 2026

For the January 2026 Update, the CPT Editorial Panel established CPT code 1011T to describe the service associated with photobiomodulation therapy of the oral cavity during radiation therapy. On November 26, 2025, the MuReva OM™ received De Novo classification from the FDA. Since January 1, 2026, CPT code 1011T had been assigned to status indicator "E1" (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) to indicate that the code is not payable under the OPSS because the device associated with this code had not received FDA approval at the time of assignment. Based on the recent FDA approval, this code is now separately payable under the OPSS.

Table 6, attachment A, lists the long descriptor, APC, and status indicator (SI) for CPT codes 1011T. This code, along with its short descriptor, status indicator, and payment rate, is also listed in the October 2026 OPSS Addendum B that is posted on the CMS website. For information on the OPSS status indicators, refer

to OPPS Addendum D1 of the CY 2026 Outpatient Prospective Payment System (OPPS)/Ambulatory Surgical Center (ASC) final rule for the latest definitions.

6. Descriptor Revisions for HCPCS Codes C1982, C9797, C8004

CMS is revising the long descriptors for HCPCS codes C1982, C9797, and C8004, which describe the vascular embolization or occlusion procedure or the simulation angiogram service with use of a pressure-generating catheter. Table 7, attachment A, lists the official revised long descriptors, status indicators, and APC assignments for HCPCS code C1982, C9797, and C8004. 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 October 2026 Update of the OPPS Addendum B.

7. Updates to the Medicare Claims Processing Manual 100-04, Chapter 4, Section 20.6.7

CMS is updating Section 20.6.7 “Modifier CA” of Chapter 4 of the Medicare Claims Processing Manual 100-04, to read “HCPCS modifier CA is defined as a procedure payable only in the inpatient setting when performed emergently on an outpatient who expires prior to admission or transfer to another hospital.” This change reflects the language regarding modifier “CA” in Section 180.7 of the Medicare Claims Processing Manual, 100-04.

8. Updates to the Medicare Claims Processing Manual 100-04, Chapter 4, Section 160.1 and New Section 160.2

We are revising Section 160.1, “Critical Care Services”, and creating a new Section 160.2, “Trauma Activation Services”, in Chapter 4 of the Medicare Claims Processing Manual 100-04. The purpose of these revisions is to clarify the billing requirements related to Trauma Team Activation.

9. Drugs, Biologicals, and Radiopharmaceuticals

a. New CY 2026 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals Receiving Pass-Through Status Effective October 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 October 1, 2026. These drugs and biologicals will receive drug pass-through status starting October 1, 2026. These HCPCS codes are listed in Table 8, attachment A.

b. Existing HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals with Pass-Through Status Ending on September 30, 2026

There are nine (9) HCPCS codes for certain drugs, biologicals, and radiopharmaceuticals in the outpatient setting that will have their pass-through status end on September 30, 2026. These codes are listed in Table 9, attachment A. Therefore, effective October 1, 2026, the status indicator for these codes is changing from “G” to “K” or “N”. 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. These codes, along with their short descriptors and status indicators, are also listed in the October 2026 Update of the OPPS Addendum B.

c. Newly Established HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals as of October 1, 2026

Twenty-nine (29) new drug, biological, and radiopharmaceutical HCPCS codes will be established on October 1, 2026. These HCPCS codes are listed in Table 10, attachment A.

d. HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals Deleted as of September 30, 2026

Ten (10) drug, biological, and radiopharmaceutical HCPCS codes will be deleted on September 30, 2026. These HCPCS codes are listed in Table 11, attachment A.

e. HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals Changing Payment Status

Twenty-one (21) drug, biological, and radiopharmaceutical HCPCS codes are changing payment status effective October 1, 2026, and are listed in Table 12, attachment A.

We are changing the status indicator for CPT code 90616 from status indicator “E1” to status indicator “L”. The effective date of this change for CPT code 90616 is retroactive to August 5, 2026.

We are changing the status indicator for HCPCS code A9521 from status indicator “E1” to status indicator “K”, in the October 2026 I/OCE Update. The effective date of this change for HCPCS code A9521 is retroactive to May 14, 2026.

We are changing the status indicator for HCPCS code J9161 from status indicator “E2” to status indicator “K” in the October 2026 I/OCE Update. The effective date of this change for HCPCS code J9161 is retroactive to July 1, 2026.

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

Three (3) drug, biological, and radiopharmaceutical HCPCS codes have had substantial descriptor changes as of October 1, 2026. These HCPCS codes are listed in Table 13, attachment A.

g. Updated Drugs and Biologicals Payment Rate

One (1) drug, biological, and radiopharmaceutical HCPCS code’s payment rate was updated on July 20, 2026, for the third quarter of 2026.

We updated HCPCS code Q5161’s payment rate on July 20, 2026. The effective date of the payment rate change is retroactive to July 1, 2026. Contractors shall adjust claims with HCPCS Q5161 received on or after 07/01/2026 and before 07/21/2026 within 30 days of the implementation date. This payment rate is listed in the July 2026 update of the OPPS Addenda A and B.

h. Drugs and Biologicals with Payments Based on Average Sales Price (ASP)

For CY 2026, payment for the majority of non-pass-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 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. In cases where adjustments to payment rates are necessary, changes to the payment rates will be incorporated in the October 2026 Fiscal Intermediary Standard System (FISS) release. CMS is not publishing the updated payment rates in this Change Request implementing the October 2026 update of the OPPS. However, the updated payment rates effective October 1, 2026, can be found in the October 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 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 payment 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.

10. New and Revised Skin Substitute Codes

a. Revised HCPCS Codes for Skin Substitute Products Retroactive to April 1, 2026

CMS is revising the long descriptors for several HCPCS Level II codes describing various skin substitute products retroactive to April 1, 2026. These code descriptors have been revised to include the parenthetical “add-on, list separately in addition to primary procedure.” Table 14, attachment A, lists the revised HCPCS Level II Skin Substitute Product Codes retroactive to April 1, 2026. The status indicators and APC assignments for these codes are not changing.

b. New HCPCS Codes for Skin Substitute Products Effective October 1, 2026

CMS is creating new HCPCS Level II codes describing various skin substitute products effective October 1, 2026. Effective October 1, 2026, the new skin substitute product codes are assigned to either status indicator “S1,” indicating that the skin substitute product is paid separately under the OPPS, and either APC 6001 (510(k) Skin Substitute Products) or APC 6002 (361 HCT/P Skin Substitute Products), or status indicator “N” indicating that they are packaged. Table 15, attachment A, lists new HCPCS Level II codes for the various skin substitute products.

11. HCPCS Code, Status Indicator, APC Assignments & 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 16, attachment A, 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, Stimuplex® needles, will receive temporary additional payment under Section 4135 of the CAA, 2023, effective April 30, 2026. We are making a descriptor change to existing HCPCS code C9812 (Echogenic nerve block needles (e.g. Sonoplex, SonoBlock, SonoTap), 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*)) to effectuate this change. We are updating the long descriptor of HCPCS code C9812 to list Stimuplex® needles among the approved non-opioid devices that can be described by this code. There are no changes to HCPCS code C9812's status indicator or APC assignment. The finalized descriptor for HCPCS code C9812 is found in Table 16, attachment A.

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 C9812 is also found in Table 16, attachment A.

12. 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. 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								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
14589.1	Medicare contractors shall adjust, as appropriate, claims brought to their attention with any retroactive changes that were received prior to implementation of the October 2026 OPPS I/OCE.	X		X						
14589.2	Medicare contractors shall adjust claims with HCPCS Q5161 received on or after 07/01/2026 and before 07/21/2026 within 30 days of the implementation date.	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:
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Section B: All other recommendations and supporting information: N/A

VI. CONTACTS

Pre-Implementation Contact(s): Marina Kushnirova, marina.kushnirova@cms.hhs.gov

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)

Table of Contents
(Rev. 13978; Issued: 09-29-2026)

Transmittals for Chapter 4

160.2 – Trauma Activation Services

20.6.7 - Modifier CA

(Rev. 13978; Issued: 09-29-2026; Effective: 10-01-2026; Implementation: 10-05-2026)

CA: Procedure payable only in the inpatient setting when performed emergently on an outpatient who expires prior to admission

In the CY 2003 OPPS final rule (67 FR 66799), we discussed the creation of the new HCPCS modifier CA to address situations where a procedure on the OPPS inpatient-only list must be performed to resuscitate or stabilize a patient (whose status is that of an outpatient) with an emergent, life-threatening condition, and the patient dies before being admitted as an inpatient. HCPCS modifier CA is defined as a procedure payable only in the inpatient setting when performed emergently on an outpatient who expires prior to admission *or transfer to another hospital*. In section VI of Transmittal A-02-129, issued on January 3, 2003, we instructed hospitals on the use of this modifier. Transmittal A-02-129 is available on the cms.gov website. For a complete description of the history of the policy and the development of the payment methodology for these services, refer to the CY 2004 OPPS final rule (68 FR 63467 through 63468), CY 2005 OPPS Final Rule (69 FR 65841), CY 2007 OPPS final rule (71 FR 68157 through 68158), and CY 2012 OPPS/ASC final rule (76 FR 74153 through 74154).

160.1 - Critical Care Services

(Rev. 13978; Issued: 09-29-2026; Effective: 10-01-2026; Implementation: 10-05-2026)

Hospitals should separately report all HCPCS codes in accordance with correct coding principles, CPT code descriptions, and any additional CMS guidance, when available. Specifically with respect to CPT code 99291 (Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes), hospitals must follow the CPT instructions related to reporting that CPT code. Prior to January 1, 2011, any services that CPT indicates are included in the reporting of CPT code 99291 (including those services that would otherwise be reported by and paid to hospitals using any of the CPT codes specified by CPT) should not be billed separately by the hospital. Instead, hospitals should report charges for any services provided as part of the critical care services. In establishing payment rates for critical care services, and other services, CMS packages the costs of certain items and services separately reported by HCPCS codes into payment for critical care services and other services, according to the standard OPPS methodology for packaging costs.

Beginning January 1, 2011, in accordance with revised CPT guidance, hospitals that report in accordance with the CPT guidelines will begin reporting all of the ancillary services and their associated charges separately when they are provided in conjunction with critical care. CMS will continue to recognize the existing CPT codes for critical care services and will establish payment rates based on historical data, into which the cost of the ancillary services is intrinsically packaged. The I/OCE conditionally packages payment for the ancillary services that are reported on the same date of service as critical care services in order to avoid overpayment. The payment status of the ancillary services does not change when they are not provided in conjunction with critical care services. Hospitals may use HCPCS modifier -59 to indicate when an ancillary procedure or service is distinct or independent from critical care when performed on the same day but in a different encounter.

Beginning January 1, 2007, critical care services will be paid at two levels, depending on the presence or absence of trauma activation. Providers will receive one payment rate for critical care without trauma activation and will receive additional payment when critical care is associated with trauma activation.

When critical care services are provided *with or* without trauma activation, the hospital may bill CPT code 99291, Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes (and 99292, if appropriate).

The CPT code 99291 is defined by CPT as the first 30-74 minutes of critical care. This 30-minute minimum has always applied under the OPPS. The CPT code 99292, Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes, remains a packaged service under the OPPS, so that hospitals do not have the ongoing administrative burden of reporting precisely the time for each critical service provided. As the CPT guidelines indicate, hospitals that provide less than 30 minutes of

critical care should bill for a visit, typically an emergency department visit, at a level consistent with their own internal guidelines.

Under the OPPS, the time that can be reported as critical care is the time spent by a physician and/or hospital staff engaged in active face-to-face critical care of a critically ill or critically injured patient. If the physician and hospital staff or multiple hospital staff members are simultaneously engaged in this active face-to-face care, the time involved can only be counted once.

Hospitals should continue to report 99291 (and 99292 as appropriate) for critical care services furnished **with or** without trauma team activation. CPT 99291 maps to APC **5041** (Critical Care). (CPT 99292 is packaged and not paid separately but should be reported if provided.)

Critical care services are paid in some cases separately and in other cases as part of a composite APC payment. See Section 10.2.1 of this chapter for further details.

Future updates will be issued in a Recurring Update Notification.

160.2 – Trauma Activation Services

(Rev. 13978; Issued: 09-29-2026; Effective: 10-01-2026; Implementation: 10-05-2026)

The National Uniform Billing Committee (NUBC) guidelines specify that only trauma centers/hospitals that are licensed or designated by the state or local government authority, or as verified by the American College of Surgeons, may bill revenue code series 68x (Trauma Response). Different subcategory revenue codes are reported by designated Level 1-4 hospital trauma centers.

*Trauma team activation charges billed with revenue code 068x require notification of key hospital personnel in response to triage information from pre-hospital caregivers in advance of the patient's arrival. Only patients for whom there has been **prehospital notification** based on triage information from prehospital caregivers, who meet either local, state or American College of Surgeons field triage criteria, or are delivered by inter-hospital transfers, and are given the appropriate team response can be billed a trauma activation charge under revenue code series 068x. Medical record documentation should demonstrate time of pre-arrival notification to the hospital and by whom, triage information, time of notification to the hospital personnel (i.e., time the trauma team is activated) and services furnished to the patient.*

If trauma activation occurs under the circumstances described by the NUBC guidelines that would permit reporting a charge under 068x, the hospital may also bill one unit of code G0390, which describes trauma activation associated with hospital critical care services. Revenue code 068x must be reported on the same date of service. The OCE will edit to ensure that G0390 appears with revenue code 068x on the same date of service and that only one unit of G0390 is billed. CMS believes that trauma activation is a one-time occurrence in association with critical care services, and therefore, CMS will only pay for one unit of G0390 per day.

NUBC guidelines state that trauma activation billed under revenue code 068x is not a replacement or a substitute for the emergency room visit fee. See section 160 for emergency department visits and 160.1 for critical care services. When trauma activation occurs and is billed with revenue code 068x, there will be both a 045x and 068x revenue codes billed. Additionally, UB-04 Form Locator (FL) 14 Priority (type) of Admission/Visit Code 5 for "Trauma" would be billed.

Trauma activation revenue code 068x can be billed when the ED visit is not critical care. No additional APC payment will be received. In this instance, hospitals shall continue to report a charge with revenue code 068x without any HCPCS code when trauma team activation occurs. To receive additional payment when critical care services are associated with trauma activation, the hospital must report G0390 in the RC 068x and have the same date of service as CPT code 99291 (or 99292, if appropriate.) HCPCS G0390 maps to APC 05045 (Trauma Response with Critical Care).

Attachment A – Tables for the Policy Section

Table 1. — PLA Coding Changes Effective October 1, 2026

CPT Code	Long Descriptor	OPPS SI
0660U	Human papillomavirus (HPV), genotypes 18, 31, 33, and 35, cell-free DNA (cfDNA), whole blood, multiplex digital droplet PCR (ddPCR), quantitative	Q4
0661U	Human papillomavirus (HPV), genotype 16, cell-free DNA (cfDNA), whole blood, digital droplet PCR (ddPCR), quantitative	Q4
0662U	Transplantation medicine (kidney allograft rejection), mRNA, gene-expression profiling by real-time quantitative PCR of 12 genes (11 content and 1 housekeeping), urine, algorithm reported as a rejection risk score	A
0663U	Obstetrics (fetal platelet antigen noninvasive prenatal test [NIPT]), cell-free DNA (cfDNA) sequence analysis for detection of fetal presence or absence of 1 human platelet antigen or more (HPA-1a, HPA-1b, HPA-3a, HPA-5b, and others) when performed, reported as maternal/fetal incompatibility detected or not detected per selected antigen	E1
0664U	Transplantation medicine (kidney allograft failure), RNA expression transcriptome by next-generation sequencing (NGS), profiling of 13 genes, post-transplant peripheral blood, algorithm reported as a risk score for predicting progressive fibrosis in the kidney allograft	A
0665U	Hepatology (metabolic dysfunction-associated steatohepatitis [MASH]), enzyme-linked immunosorbent assay (ELISA) for YKL40 and quantitative reverse transcription polymerase chain reaction (RT-qPCR) for miR-34a-5p, serum, algorithm reported as a single score for MASH activity and fibrosis	Q4
0666U	Infectious disease (wound infection), DNA, multiplex real-time PCR, wound swab, detection of 27 microbial targets and 28 antibiotic resistance targets, reported as semiquantitative for bacterial and fungal targets, and qualitative for viral- and antibiotic-resistance targets	Q4
0667U	Inborn error of metabolism (primary mitochondrial disease), determination of fibroblast growth factor 21 (FGF21) concentration by enzyme-linked immunosorbent assay (ELISA), serum or plasma, diagnostic quantitative result	Q4
0668U	Oncology (pancreas), DNA, genome sequence with 5-hydroxymethylcytosine (5hmC) enrichment and glycan biomarker analysis, whole blood or plasma, algorithm reported as cancer detected or not detected	A

0669U	Infectious disease (Bartonella species, Borrelia species, and Babesia species), multiplex digital PCR for detection of DNA at the genus level for each species, blood, qualitative reporting of presence or absence of each pathogen at the genus level	Q4
0670U	Rare diseases (constitutional/heritable disorders), whole genome sequence analysis combination of short and long reads for single-nucleotide variants, insertions/deletions and characterized intronic variants, copy number variants, duplications/deletions, mobile element insertions, runs of homozygosity, aneuploidy, and inversions, mitochondrial DNA sequence and deletions, short tandem repeat (STR) genes, methylation status of selected regions, blood, saliva, amniocentesis, chorionic villus sample or tissue, identification and categorization of genetic variant, proband and comparator	A
0671U	Rare diseases (constitutional/heritable disorders), whole genome sequence analysis combination of short and long reads for single-nucleotide variants, insertions/deletions and characterized intronic variants, copy number variants, duplications/deletions, mobile element insertions, runs of homozygosity, aneuploidy, and inversions, mitochondrial DNA sequence and deletions, short tandem repeat (STR) genes, methylation status of selected regions, blood, saliva, amniocentesis, chorionic villus sample or tissue, identification and categorization of genetic variant, proband and 2 comparators	A
0672U	Rare diseases (constitutional/heritable disorders), whole exome and mitochondrial DNA sequence analysis, including small sequence changes, deletions, duplications, short tandem repeat (STR) gene expansions, and variants in nonuniquely mappable regions, blood or saliva, identification and categorization of genetic variants, proband and comparator	A
0673U	Rare diseases (constitutional/heritable disorders), whole exome and mitochondrial DNA sequence analysis, including small sequence changes, deletions, duplications, short tandem repeat (STR) gene expansions, and variants in nonuniquely mappable regions, blood or saliva, identification and categorization of genetic variants, proband and 2 comparators	A
0674U	Rare diseases (constitutional/heritable disorders), whole genome and mitochondrial DNA sequence analysis, including small sequence changes, insertions/deletions, copy number variants, mobile element insertions, runs of homozygosity, aneuploidy, and inversions, short tandem repeat (STR) gene expansions, blood, saliva, or genomic	A

	DNA, identification and categorization of genetic variants, proband and comparator	
0675U	Rare diseases (constitutional/heritable disorders), whole genome and mitochondrial DNA sequence analysis, including small sequence changes, insertions/deletions, copy number variants, duplications/deletions, mobile element insertions, runs of homozygosity, aneuploidy, and inversions, short tandem repeat (STR) gene expansions, blood, saliva, or genomic DNA, identification and categorization of genetic variants proband and 2 comparators	A
0676U	Rare diseases (constitutional/heritable disorders), whole genome sequence analysis, including small sequence changes, copy number variants, deletions, duplications, mobile element insertions, uniparental disomy (UPD), inversions, aneuploidy, mitochondrial genome sequence analysis with heteroplasmy and large deletions, short tandem repeat (STR) gene expansions and maternal cell contamination, fetal sample, identification and categorization of genetic variants, proband and maternal comparator	E1
0677U	Rare diseases (constitutional/heritable disorders), whole genome sequence analysis, including small sequence changes, copy number variants, deletions, duplications, mobile element insertions, uniparental disomy (UPD), inversions, aneuploidy, mitochondrial genome sequence analysis with heteroplasmy and large deletions, short tandem repeat (STR) gene expansions and maternal cell contamination, fetal sample, identification and categorization of genetic variants, proband and 2 comparators	E1
0678U	Oncology (hereditary cancer), genome sequence for 117 genes (single-nucleotide variants, deletions/insertions, and characterized intronic variants), copy number variants, duplications/deletions, mobile element insertions and inversions, blood, saliva, cultured skin fibroblasts (skin biopsy) or extracted genomic DNA, diagnostic, identification and categorization of genetic variants	A
0679U	Oncology (hereditary hematologic cancer), genomic DNA, whole genome sequence (single-nucleotide variants, deletions/insertions, and characterized intronic variants), copy number variants, duplications/deletions, mobile element insertions and inversions, analysis of over 105 genes, genomic DNA isolated from blood, saliva, cultured skin fibroblasts (skin biopsy), identification and categorization of genetic variants	A
0680U	Tobacco use, DNA analysis of 1 methylation marker (cg05575921 [AHRR]), methylation-	A

	sensitive digital PCR, whole blood, algorithm reported as quantitative percentage methylation and estimated average cigarette use per day	
0681U	Tobacco use, DNA analysis of 2 methylation markers (1 content: cg05575921 [AHRR] and 1 normalizing: cg08141395), methylation-sensitive digital PCR, saliva, algorithm reported as quantitative percent methylation and estimated average cigarette use per day	A
0682U	Oncology (lung cancer), DNA analysis of 1 methylation marker (cg05575921), methylation-sensitive digital PCR, whole blood, algorithm results reported as the 20-year-hazard ratio for lung cancer	A
0683U	Oncology (lung cancer), DNA analysis of 2 methylation markers (1 content: cg05575921 and 1 normalizing: cg08141395), methylation-sensitive digital PCR, saliva, algorithm results reported as the 20-year-hazard ratio for lung cancer	A
0684U	Alcohol use disorder, DNA analysis of 4 methylation markers (cg02583484, cg04987734, cg09935388, cg04583842), methylation-sensitive digital PCR, whole blood, algorithm reported as a summed T-score	A
0685U	Alcohol use disorder, DNA analysis of 5 methylation markers (4 content: cg02583484, cg04987734, cg09935388, cg04583842, and 1 normalizing: cg08141395), methylation-sensitive digital PCR, whole blood or saliva, algorithm reported as a summed T-score	A
0686U	Oncology (prostate), mRNA, next-generation sequencing (NGS) gene expression profiling of 22 genes, formalin-fixed paraffin-embedded (FFPE) tissue, algorithm reported as risk score	A
0687U	Comparative analysis using short tandem repeat (STR) markers, patient and comparative specimen, DNA, buccal swab and tissue, reported match or mismatch	E1
0688U	Oncology (colorectal cancer), analysis of minimal residual disease (MRD), next-generation sequencing (NGS), circulating tumor DNA (ctDNA) analysis in whole blood and tumor for baseline assessment to evaluate current MRD status and for comparisons to subsequent MRD assessments	A
0689U	Oncology (colorectal cancer), analysis of minimal residual disease (MRD) using patient-specific assays, reported as amount of circulating tumor DNA (ctDNA) detection and trend over time	A
0690U	Transplantation medicine (allograft rejection), quantification of donor-derived cell-free DNA (cfDNA) using digital PCR analysis of 45 single-nucleotide polymorphisms, plasma, reported as	A

	quantity of donor-derived cfDNA in plasma to determine the probability of allograft rejection	
0691U	Carrier screening (cystic fibrosis, spinal muscular atrophy, beta hemoglobinopathies [including sickle cell disease], alpha thalassemia, and Duchenne muscular dystrophy), genomic sequence analysis panel, 6 genes (CFTR, SMN1, HBB, HBA1, HBA2, DMD)	E1
0692U	Cardiology (peripheral artery disease [PAD]), analysis of 3 proteins (midkine, angiopoietin-1, and kidney injury molecule-1 [KIM-1]), immunoassay, plasma, algorithm reported as a risk score for obstructive PAD	Q4
0693U	Oncology (head and neck), circulating tumor DNA (ctDNA), tumor-informed next-generation sequencing (NGS) analysis for 699 genes of patient-specific somatic variants identified from primary tumor tissue, postoperative lymphatic exudate specimen, algorithm reported as presence or absence of ctDNA	A
0694U	Oncology (monoclonal gammopathy), immunoprecipitation and matrix-assisted laser desorption/ionization time-of-flight (MALDI-TOF) mass spectrometry, identification of intact monoclonal immunoglobulin isotypes (IgG, IgA, IgM, kappa, lambda), and M-protein concentrations in conjunction with turbidimetry, blood, semiquantitative	Q4
0695U	Oncology (central nervous system), low-pass whole genome sequence analysis of cerebrospinal fluid, interrogation for chromosome arm-level and focal losses and gains	A
0696U	Oncology (solid organ), targeted genomic sequence analysis, formalin-fixed paraffin-embedded (FFPE) tumor tissue, RNA analysis, 350 or more genes for RNA alterations (eg, gene rearrangements and splice isoforms)	A
0697U	Obesity, DNA genotyping, analysis of up to 41 genes, buccal swab or blood specimen, patient biometrics, risk-score algorithm to identify a predisposition to up to 4 phenotypes, reported as likelihood to benefit from therapeutics	A
0698U	Neurology (traumatic brain injury), analysis of glial fibrillary acidic protein (GFAP) and ubiquitin carboxy-terminal hydrolase L1 (UCHL1), immunoassay, serum or plasma, individual components reported with the overall result of positive or negative based on threshold comparison	Q4

Table 2. – New Category III CPT Codes Effective October 1, 2026

CPT Code	Long Descriptor	Status Indicator	APC
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1054T	Focused non-shock wave ultrasonic propulsion of residual stone fragment(s) post-lithotripsy, unilateral, including ultrasound guidance, fragment(s) less than or equal to 5 mm	J1	5373
1055T	Intraoperative radiofrequency ablation of lumpectomy cavity, unilateral, including applicator placement and removal (List separately in addition to code for primary procedure)	N	N/A
1056T	Cochlear infusion of pharmacologic agent (ie, gene therapy vector), including mastoidectomy, labyrinthotomy, and repair of fenestrations	J1	5163
1057T	Insertion or replacement of subcutaneous neurostimulator pulse generators, with tunneling of 4 electrode arrays, bilateral supraorbital and occipital nerves, including all interrogation, programming, and imaging guidance, when performed	E1	N/A
1058T	Revision of implanted subcutaneous unilateral supraorbital and occipital neurostimulator system, including all interrogation, programming, and imaging guidance, when performed	E1	N/A
1059T	Removal of implanted subcutaneous unilateral supraorbital and occipital neurostimulator system	E1	N/A
1060T	Electronic analysis of implanted subcutaneous supraorbital-occipital neurostimulator pulse generator (eg, frequency, amplitude, pulse width, leads, electrode configuration); with complex programming by physician or other qualified health care professional	E1	N/A
1061T	Electronic analysis of implanted subcutaneous supraorbital-occipital neurostimulator pulse generator (eg, frequency, amplitude, pulse width, leads, electrode configuration); with simple programming by physician or other qualified health care professional	E1	N/A
1062T	Artificial insemination, transcervical intratubal, unilateral or bilateral, including imaging guidance	T	5412
1063T	Oncology (bladder), augmentative algorithmic analysis of histomorphologic features in digitized slides from formalin-fixed paraffin-embedded (FFPE) bladder cancer tissue (high-grade, non-muscle invasive), with clinicopathologic variables entered by the qualified health care professional; algorithm-derived parameters reported as prognostic of recurrence and progression, including hematoxylin and eosin staining of tissue sections, and digitization of glass microscope slides, when performed	Q4	N/A

1064T	Oncology (bladder), augmentative algorithmic analysis of histomorphologic features in digitized slides from formalin-fixed paraffin-embedded (FFPE) bladder cancer tissue (high-grade, non-muscle invasive), with clinicopathologic variables entered by the qualified health care professional; algorithm-derived parameters reported as predictive of response to Bacillus Calmette-Guérin (BCG) therapy, including hematoxylin and eosin staining of tissue sections, and digitization of glass microscope slides, when performed	Q4	N/A
1065T	Cystourethroscopy, with CO2 cryotherapy spray, in a gaseous bladder environment with pressure monitoring, for treatment of; minor bladder lesion(s) (total lesion[s] diameters less than 0.5 cm)	E1	N/A
1066T	Cystourethroscopy, with CO2 cryotherapy spray, in a gaseous bladder environment with pressure monitoring, for treatment of; small bladder lesion(s) (total lesion[s] diameters greater than or equal to 0.5 cm and less than 2.0 cm)	E1	N/A
1067T	Cystourethroscopy, with CO2 cryotherapy spray, in a gaseous bladder environment with pressure monitoring, for treatment of; medium bladder lesion(s) (total lesion[s] diameters greater than or equal to 2.0 cm and less than 5.0 cm)	E1	N/A
1068T	Cystourethroscopy, with CO2 cryotherapy spray, in a gaseous bladder environment with pressure monitoring, for treatment of; large bladder lesion(s) (total lesion[s] diameters greater than or equal to 5.0 cm)	E1	N/A
1069T	Mechanical extremity (ie, hands and feet) cryocompression; individual glove and boot supplies with initial measurement, fitting, and therapy education	S	5735
1070T	Mechanical extremity (ie, hands and feet) cryocompression; individual glove and boot placement, initiation of cooling pre-chemotherapy and continuing through chemotherapy administration	S	5732
1071T	Mechanical extremity (ie, hands and feet) cryocompression; post-chemotherapy treatment continuation, each 30 minutes (List separately in addition to code for primary procedure)	N	N/A
1072T	Liver allograft, normothermic machine perfusion; each additional hour of monitoring and management (List separately in addition to code for primary procedure)	C	N/A
1073T	Liver allograft, normothermic machine perfusion; decannulation	C	N/A

1074T	Liver allograft, hypothermic oxygenated perfusion; cannulation	C	N/A
1075T	Liver allograft, hypothermic oxygenated perfusion; connection to perfusion device	C	N/A
1076T	Liver allograft, hypothermic oxygenated perfusion; monitoring and management, first 2 hours	C	N/A
1077T	Liver allograft, hypothermic oxygenated perfusion; each additional hour of monitoring and management (List separately in addition to code for primary procedure)	C	N/A
1078T	Liver allograft, hypothermic oxygenated perfusion; decannulation	C	N/A
1079T	3D quantitative transmission water bath volumetric ultrasound tomography, breast, with augmentative algorithmic derivation of breast tissue composition (ie, fibroglandular volume), bilateral, with physician or other qualified health care professional interpretation and report	E1	N/A
1080T	Insertion, intracapsular magnifier, with attachment to previously placed intraocular lens	E1	N/A
1081T	Microvascular anastomosis between a lymph node and a vein, including robot assistance, when performed; initial anastomosis	J1	5092
1082T	Microvascular anastomosis between a lymph node and a vein, including robot assistance, when performed; each additional anastomosis (List separately in addition to code for primary procedure)	N	N/A
1083T	Stereotactic placement of infusion catheter(s), brain, for delivery of therapeutic agent(s), including computerized stereotactic planning and burr hole(s)	E1	N/A
1084T	Implantation of scaffolding allograft to reinforce the suprachoroidal space	J1	5492
1085T	Assistive algorithmic analysis for identification of new lesions and determination of inter-lesion heterogeneity of change in metabolic activity and volume for advanced metastatic cancer, data sets from 2 or more previously acquired positron emission tomography (PET) and/or PET computed tomography (CT) (PET/CT) studies	S	5724
1086T	Intraprocedural estimate of coronary fractional flow derived by augmentative algorithmic analysis of data from real-time coronary angiography, with creation of functional map of coronary circulation, when performed, with review and interpretation (List separately in addition to code for primary procedure)	S	5724
1087T	Estimate of coronary fractional flow derived by augmentative algorithmic analysis of data from previously acquired coronary angiogram,	S	5724

	with creation of functional map of coronary circulation, when performed, with automated result		
1088T	Percutaneous application of high-frequency neuromodulation signals using microneedle electrode array for the treatment of nociceptive or neuropathic pain, including electrode placement and patient training, per day	Q1	5721
1089T	Intraoperative quantitative micro-elastography tissue characterization, including real-time imaging and physician assessment, per breast	E1	N/A
1090T	Attachment and insertion of intraocular lens prosthesis-mounted drug-eluting implant (List separately in addition to code for primary procedure)	E1	N/A
1091T	Placement of permanent common carotid artery filter, percutaneous, bilateral, including ultrasound guidance, when performed	S	1576
1092T	Implantation of acellular scaffold (eg, hyaluronan), knee, single implant; into chondral defect, open	J1	5114
1093T	Implantation of acellular scaffold (eg, hyaluronan), knee, single implant; into a chondral or osteochondral defect, arthroscopic	J1	5113
1094T	Implantation of acellular scaffold (eg, hyaluronan), knee, single implant; each additional acellular scaffold implantation (List separately in addition to code for primary procedure)	N	N/A
1095T	Harvesting and processing of autologous bone marrow aspirate concentrate (BMAC), with application onto scaffold or injection into anatomical recipient site (eg, subchondral bone, joint space, chondral lesion), including imaging guidance, when performed, for therapeutic musculoskeletal treatment, excluding spinal procedures	E1	N/A
1096T	Injection(s) of thermoregulated multiphase suspension to demyelinate nerves innervating the knee joint, including imaging guidance, when performed	E1	N/A
1097T	Oncology (pancreas), augmentative algorithmic analysis of histomorphologic features in digitized slides from formalin-fixed paraffin-embedded pancreatic cancer tissue, algorithm-derived parameters reported as prediction of response to fluorouracil backbone versus gemcitabine backbone chemotherapy, including hematoxylin and eosin staining of tissue sections and digitization of glass microscope slides, when performed	Q4	N/A
1098T	Placement of subretinal prosthesis, including vitrectomy	E1	N/A

1099T	Ablation of incompetent vein(s), extremity, transcutaneous, high intensity–focused ultrasound (HIFU), inclusive of all imaging guidance and monitoring	E1	N/A
1100T	Transcutaneous spinal neuromodulation programming, including history and physical examination, safety screening, selection and external placement of a multichannel spinal electrode pad, baseline spinal motor mapping, creation of individualized stimulation parameter sets for therapeutic activities, and patient and/or caregiver instruction, each 30 minutes	A	N/A
1101T	Transcutaneous spinal neuromodulation application in combination with therapeutic activities, direct (one-on-one) patient contact using dynamic activities to improve functional performance, including individualized external placement of a multichannel spinal electrode pad, optimization of stimulation parameters across multiple channels, and delivery of transcutaneous spinal neuromodulation during functional task performance, each 15 minutes	A	N/A
1102T	Intraoperative molecular assessment for lung tumor tissue, in-vivo (including assessment, when performed following lung resection), using computer-aided fluorescence imaging (List separately in addition to code for primary procedure)	N	N/A
1103T	Intraoperative molecular assessment for ovarian, tubal, or peritoneal tumor tissue, in-vivo (including assessment, when performed following ovarian, tubal, or peritoneal resection), using computer-aided fluorescence imaging (List separately in addition to code for primary procedure)	N	N/A
1104T	Noninvasive cardiopulmonary assessment, including quantitative parameters, respectively predictive of significant epicardial coronary artery disease, pulmonary hypertension, and/or elevated pulmonary capillary wedge pressure, derived by augmentative algorithmic analysis of orthogonal voltage gradient and photoplethysmography signals, with automated report	S	5734
1105T	Personalized neurostimulation pulse rate derived by augmentative algorithmic analysis of data from electroencephalogram (EEG) and electrocardiogram (ECG), including acquisition of EEG and single-lead ECG, with automated report	E1	N/A
1106T	Oncology (breast), augmentative algorithmic analysis of histomorphologic features in digitized hematoxylin and eosin stained slides from formalin-fixed paraffin-embedded	Q4	N/A

	(FFPE) breast cancer tissue, algorithm-derived parameters reported as 5-year and 10-year risks of distant metastasis, including digitization of glass microscope slides and hematoxylin and eosin staining of tissue sections, when performed		
1107T	Oncology (prostate), augmentative algorithmic analysis of histomorphologic features in digitized hematoxylin and eosin stained slide(s) from formalin-fixed paraffin-embedded (FFPE) prostate cancer tissue, algorithm-derived parameters reported as 10-year risk of distant metastasis and prostate cancer specific mortality, including hematoxylin and eosin staining of tissue sections and digitization of glass microscope slides, when performed	Q4	N/A
1108T	Stereotactic intracerebral implantation of therapeutic agent, unilateral, including cranial access and intraoperative imaging guidance, when performed; 1 or more injections along a single trajectory	E1	N/A
1109T	Stereotactic intracerebral implantation of therapeutic agent, unilateral, including cranial access and intraoperative imaging guidance, when performed; 1 or more injections along multiple trajectories	E1	N/A
1110T	Stereotactic intracerebral delivery of therapeutic agent, by controlled infusion, unilateral, including cranial access and intraoperative imaging guidance, when performed; single trajectory	E1	N/A
1111T	Stereotactic intracerebral delivery of therapeutic agent, by controlled infusion, unilateral, including cranial access and intraoperative imaging guidance, when performed; multiple trajectories	E1	N/A

Table 3. – Permanent Placement of Common Carotid Artery Filters Category B Investigational Device Exemption (IDE) Study

Study Title	Sponsor Name	NCT Number	IDE Number	CMS Approval Date	Category
Carotid Implants for PreveNtion of STroke ReCurrEnce From Large Vessel Occlusion in Atrial Fibrillation Patients Treated With Oral Anticoagulation	Javelin Medical	NCT05723926	G220272	07/30/2024	B

Table 4. – New Category III CPT Code 1091T that Describes Permanent Placement of Common Carotid Artery Filters, Effective October 1, 2026

HCPCS Code	Long Descriptor	SI	APC
1091T	Placement of permanent common carotid artery filter, percutaneous, bilateral, including ultrasound guidance, when performed	S	1576
C8010	Percutaneous placement of permanent common carotid embolic protection device, including all system components and imaging guidance; bilateral	D	N/A

Table 5. – New HCPCS Code Describing Algorithm-Based Assessment of Likelihood of Autism Spectrum Disorder Effective October 1, 2026

HCPCS Code	Long Descriptor	SI	APC
G0685	Algorithm-based assessment of likelihood of autism spectrum disorder (asd), derived from validated analysis of eye-gaze data or other technology	S	5734

Table 6. – Status Indicator and APC Assignment for CPT Code 1011T Effective October 1, 2026

CPT Code	Long Descriptor	SI	APC
1011T	Photobiomodulation (PBM) therapy of oral cavity, including placement of an oral device, monitoring of patient tolerance to treatment, and removal of the oral device	Q1	5735

Table 7. – Descriptor Revisions for HCPCS Codes C1982, C9797, C8004

HCPCS Code	Long Descriptor	SI	APC	CY 20206 APC Group Title
C1982	Catheter, pressure-generating, (e.g., one-way valve or occlusion balloon, intermittently or temporarily occluding)	N	N/A	N/A
C9797	Vascular embolization or occlusion procedure with use of a pressure-generating catheter (e.g., one-way valve or occlusion balloon, intermittently or temporarily occluding), inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction	J1	5194	Level 4 Endovascular Procedures
C8004	Simulation angiogram with use of a pressure-generating catheter (e.g., one-way valve or occlusion balloon, intermittently or temporarily occluding), inclusive of all radiological supervision	J1	5193	Level 3 Endovascular Procedures

	and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the angiogram, for subsequent therapeutic radioembolization of tumors			
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Table 8. - New CY 2026 HCPCS Codes Effective October 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
A9613	Piylufolastat f 18 (pylarify truvu), diagnostic, 1 millicurie	G	0962
C9311	Injection, eplontersen, 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)	G	0958
C9312	Injection, trabectedin (apotex), not therapeutically equivalent to J9362, 0.01 mg	G	0959
C9313	Injection, pivekimab sunirine-pvzy, 0.01 mg	G	0960
J9186	Injection, etoposide (avyxa), 1 mg	G	0970
J9191	Injection, fluorouracil (avyxa), 10 mg	G	0971

Table 9. - HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals with Pass-Through Status Ending Effective September 30, 2026

CY 2026 HCPCS Code	CY 2026 Long Descriptor	July 2026 SI	October 2026 SI	October 2026 APC
A9608	Flotufolastat F 18, diagnostic, 1 millicurie	G	K	9254
J0184	Injection, amisulpride, 1 mg	G	N	N/A
J0402	Injection, aripiprazole (abilify asimtufii), 1 mg	G	K	9246
J0577	Injection, buprenorphine extended-release (brixadi), less than or equal to 7 days of therapy	G	K	0732
J0578	Injection, buprenorphine extended release (brixadi), greater than 7 days and up to 28 days of therapy	G	K	0733
J1304	Injection, tofersen, 1 mg	G	K	9262
J2799	Injection, risperidone (uzedy), 1 mg	G	K	9266
J7214	Injection, factor viii/von willebrand factor complex, recombinant (altuviio), per factor viii i.u.	G	K	9277
J9321	Injection, epcoritamab-bysp, 0.16 mg	G	K	9250

Table 10. - Newly Established HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals as of October 1, 2026

New HCPCS Code	Old HCPCS Code	Long Descriptor	SI	APC
A9613		Piflufolastat f 18 (pylarify truvu), diagnostic, 1 millicurie	G	0962
C9311		Injection, eplontersen, 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)	G	0958
C9312		Injection, trabectedin (apotex), not therapeutically equivalent to J9362, 0.01 mg	G	0959
C9313		Injection, pivekimab sunirine-pvzy, 0.01 mg	G	0960
J0014	C9046	Cocaine hydrochloride nasal solution (goprelto), 1 mg	N	N/A
J0643		Injection, leucovorin calcium, not otherwise specified, 1 mg	N	N/A
J0644	C9310	Injection, leucovorin calcium (avyxa), 1 mg	G	0936
J0871		Injection, daptomycin (endo), not therapeutically equivalent to j0878, 1 mg	K	0966
J1757		Injection, tividenofusp alfa-eknm, 1 mg	K	0967
J1818		Injection, pegzilarginase-nbln, 0.05 mg	K	0968
J1946		Injection, furosemide (lasix onyu), 1 mg	E1	N/A
J1947		Injection, furosemide (furoscix), 1 mg	E1	N/A
J1957		Injection, levetiracetam, 5 mg	N	N/A
J1958		Injection, levetiracetam in sodium chloride, 5 mg	N	N/A
J3268	C9462	Injection, delafloxacin, 1 mg	E2	N/A
J3406		Injection, omidubicel-onlyv, per therapeutic dose	K	0969
J7524		Mycophenolate mofetil, oral, 5 mg	N	N/A
J7526		Injection, mycophenolate mofetil, 5 mg	N	N/A
J7529		Mycophenolate mofetil, for suspension, oral, 5 mg	N	N/A
J7530		Mycophenolate mofetil (myhibbin), oral suspension, 5 mg	N	N/A
J7531		Prednisolone sodium phosphate, orally disintegrating tablet, 1 mg	E1	N/A
J9066		Injection, bendamustine hydrochloride (avyxa), 1 mg	E2	N/A
J9186		Injection, etoposide (avyxa), 1 mg	G	0970
J9187		Injection, etoposide, 1 mg	N	N/A
J9191		Injection, fluorouracil (avyxa), 10 mg	G	0971

J9192		Injection, fluorouracil, 10 mg	N	N/A
J9362		Injection, trabectedin, 0.01 mg	K	0972
Q5172		Injection, filgrastim-laha (filkri), biosimilar, 1 microgram	K	0973
Q5173		Injection, denosumab-adet (ponlimsi), biosimilar, 1 mg	E2	N/A

Table 11. — HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals Deleted as of September 30, 2026

CY 2026 HCPCS Code	Long Descriptor	CY 2026 SI	APC
J0640	Injection, leucovorin calcium, per 50 mg	D	N/A
J1941	Injection, furosemide (furoscix), 20 mg	D	N/A
J1953	Injection, levetiracetam, 10 mg	D	N/A
J7514	Mycophenolate mofetil (myhibbin), oral suspension, 100 mg	D	N/A
J7517	Mycophenolate mofetil, oral, 250 mg	D	N/A
J7519	Injection, mycophenolate mofetil, 10 mg	D	N/A
J7528	Mycophenolate mofetil, for suspension, oral, 100 mg	D	N/A
J9181	Injection, etoposide, 10 mg	D	N/A
J9190	Injection, fluorouracil, 500 mg	D	N/A
J9352	Injection, trabectedin, 0.1 mg	D	N/A

Table 12. - HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals Changing Payment Status

CY 2026 HCPCS Code	Long Descriptor	July 2026 SI	July 2026 APC	October 2026 SI	October 2026 APC
90616	Influenza virus vaccine, trivalent (tIRV), mRNA, 37.5 mcg/0.38 mL dosage, for intramuscular use	E1	N/A	L	N/A
A9600	Strontium Sr-89 chloride, therapeutic, per millicurie	K	0701	E1	N/A
J0209	Injection, sodium thiosulfate (hope), 100 mg	K	0866	E1	N/A
J0211	Injection, sodium nitrite 3 mg and sodium thiosulfate 125 mg (nithiodote)	K	0750	E1	N/A
J0565	Injection, bezlotoxumab, 10 mg	K	9490	E1	N/A
J0716	Injection, centruiroides (scorpion) immune f(ab)2, up to 120 milligrams	E1	N/A	K	1431
J0841	Injection, crotalidae immune f(ab')2 (equine), 120 mg	E1	N/A	K	9188
J0891	Injection, argatroban (accord), not therapeutically equivalent to j0883, 1 mg (for non-esrd use)	K	9020	E2	N/A
J2374	Apraclonidine hydrochloride ophthalmic, 1% solution, 0.1 ml	E1	N/A	N	N/A

CY 2026 HCPCS Code	Long Descriptor	July 2026 SI	July 2026 APC	October 2026 SI	October 2026 APC
J7314	Injection, fluocinolone acetonide, intravitreal implant (yutiq), 0.01 mg	K	9328	E1	N/A
J9161	Injection, denileukin diftitox-cxdl, 1 mcg	E2	N/A	K	0978
J9232	Injection, docetaxel (hospira), not therapeutically equivalent to J9171, 1 mg	E2	N/A	K	0977
J9296	Injection, pemetrexed (accord), not therapeutically equivalent to j9305, 10 mg	K	9127	E2	N/A
J9302	Injection, ofatumumab, 10 mg	K	9260	E1	N/A
J9313	Injection, moxetumomab pasudotox-tdfk, 0.01 mg	K	9305	E1	N/A
J9361	Injection, efbemalenograstim alfa-vuxw, 0.5 mg	E2	N/A	K	0980
J9394	Injection, fulvestrant (fresenius kabi) not therapeutically equivalent to j9395, 25 mg	K	9103	E2	N/A
Q5154	Injection, omalizumab-igec (omlyclo), biosimilar, 5 mg	E2	N/A	K	0979
Q5166	Injection, denosumab-desu (osvyrti/jubereq), biosimilar, 1 mg	E2	N/A	K	0974
Q5168	Injection, ranibizumab-leyk (nufymco), biosimilar, 0.1 mg	E2	N/A	K	0975
Q5169	Injection, pegfilgrastim-unne (armlupeg), biosimilar, 0.5 mg	E2	N/A	K	0976

Table 13. - HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals with Substantial Descriptor Changes as of October 1, 2026

CY 2026 HCPCS Code	July 2026 Long Descriptor	October 2026 Long Descriptor
A9595	Piflufolastat f-18, diagnostic, 1 millicurie	Piflufolastat f 18 (pylarify), diagnostic, 1 millicurie
J3300	Injection, triamcinolone acetonide, preservative free, 1 mg	Injection, triamcinolone acetonide (triesence), preservative free, 1 mg
J9033	Injection, bendamustine hydrochloride, 1 mg	Injection, bendamustine hydrochloride, not otherwise specified, 1 mg

Table 14. – Revised HCPCS Level II Skin Substitute Product Codes Retroactive to April 1, 2026

HCPCS Code	Long Descriptor	OPPS Status Indicator	APC
A2040	Microlyte painguard (add-on, list separately in addition to primary procedure), per square centimeter	S1	6001

A2041	Foundation drs+ duo (add-on, list separately in addition to primary procedure), per square centimeter	S1	6001
A2042	Foundation drs+ solo (add-on, list separately in addition to primary procedure), per square centimeter	S1	6001
A2043	Biobrane (add-on, list separately in addition to primary procedure), per square centimeter	S1	6001
A2045	Novashield or novogen wound matrix (add-on, list separately in addition to primary procedure), per square centimeter	S1	6001

Table 15. – New HCPCS Level II Skin Substitute Product Codes Effective October 1, 2026

HCPCS Code	Long Descriptor	OPPS Status Indicator	APC
A2046	Dermisphere hdrt, per square centimeter (add-on, list separately in addition to primary procedure)	S1	6001
A2047	Lacertamatrix, per square centimeter (add-on, list separately in addition to primary procedure)	S1	6001
A2048	Puraply mz, per milligram	N	N/A
A2049	Theracor, per square centimeter (add-on, list separately in addition to primary procedure)	S1	6001
A2050	Fibrillar collagen wound dressing, per milligram	N	N/A
Q4207	Carbon life, per square centimeter (add-on, list separately in addition to primary procedure)	S1	6002
Q4223	Dermabind sl optic, per square centimeter (add-on, list separately in addition to primary procedure)	S1	6002
Q4243	Amchomatrix, per square centimeter (add-on, list separately in addition to primary procedure)	S1	6002

Table 16. – HCPCS Code, Updated Long Descriptor, Status Indicator, and APC Assignment for Qualifying Non-Opioid Treatment for Pain Relief

HCPCS Code	Long Descriptor	SI October 2026	CY 2026 APC	Payment Limitation*	Effective Date
C9812	Echogenic and/or nerve stimulator-guided nerve block needles (e.g. SonoPlex, SonoBlock, SonoTap, Stimuplex),	H1	2080	\$1,997.16	April 30, 2026

	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)				
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*Please note, the payment limitation is not the payment rate of the assigned APC.