

August 4, 2025

**Comments to
Centers for Medicare and Medicaid Services
Advisory Panel on Hospital Outpatient Payment
August 25, 2025**

**Submitted By: Kirsten Tullia
On behalf of AdvaMed, the MedTech Association**

AdvaMed appreciates the opportunity to address the Advisory Panel on Hospital Outpatient Payment (the Panel) and commends the Panel on its efforts to evaluate and improve the APC groups under the hospital outpatient prospective payment system (OPPS) and to ensure Medicare beneficiaries have timely access to new technologies.

AdvaMed member companies develop and produce the medical devices, diagnostic products, and health information systems that are transforming health care through earlier disease detection, less invasive procedures, and more effective treatments. AdvaMed members range from the largest to the smallest medical technology innovators and companies. We are committed to ensuring patient access to lifesaving and life-enhancing devices and other advanced medical technologies in the most appropriate settings.

Our comments today will address the following topics:

- Inpatient Only List
- Reconfiguring APCs
- Comments on Specific APCs

Inpatient Only List

In the CY 2026 OPPS/ASC proposed rule, CMS proposes to eliminate the IPO List over a period of three years, beginning with 285 primarily musculoskeletal procedures for CY 2026. CY 2026. We are concerned about the lack of a data-driven, consistent, and transparent methodology for setting payment rates under the OPPS as these procedures are removed from the IPO List. CMS provided limited information in the proposed rule regarding the process used to assign IPO List procedures to an APC. This is particularly troublesome for the musculoskeletal procedures proposed for removal, as clinical similarity is arguable for multiple procedures assigned to different APCs in the proposed rule, and sufficient hospital outpatient claims data are not available to determine resource similarity. Appropriate APC placement and setting payment amounts that appropriately recognize resource use following IPO List removal is critical to

ensuring Medicare patients retain access to these procedures enabling providers to deliver care in the most appropriate place of treatment for an individual patient.

We urge CMS to provide greater transparency and intent regarding how it plans to evaluate and value procedures that currently require intensive post-operative care, such as those involving ICU-level monitoring, extended recovery times, and/or heightened risk profiles, into the OPPS payment structure. These procedures will likely remain mostly inpatient as they involve multidisciplinary care teams, specialized equipment, and post-operative observation that may not be feasible or safe in outpatient settings.

We are still conducting analyses of the impact of this proposal on specific payment rates for procedures previously only performed in the inpatient setting, however, we generally remain concerned these initial APC placements will underpay for these procedures and result in unintended consequences for site of service patterns that could negatively impact patient outcomes.

AdvaMed therefore recommends the Panel:

- *Recommend CMS, in consultation with all interested stakeholders, establish a data-driven, consistent, and transparent ratesetting methodology for determining adequate and appropriate payment for procedures removed from the IPO List;*
- *Recommend CMS work with and allow stakeholder feedback on the assignment of these procedures to appropriate clinical APCs and New Technology APC groupings; and*
- *Recommend CMS, if the agency proceeds with these removals, monitor any impact shifts in site of service may have on patient outcomes and safety.*

Reconfiguring APCs

Complexity Adjustments

In the CY 2026 OPPS/ASC proposed rule, CMS solicits comment on potential changes to the complexity adjustment methodology to determine APC assignment for qualifying procedure combinations. AdvaMed supports complexity adjustments as an important mechanism to help ensure adequate payment under the comprehensive APC methodology. We supported the changes made to the complexity adjustment criteria as previously finalized in the CY 2019 final rule but believe that the current methodology is not well documented by CMS, nor is it consistently applied for specific procedure combinations.

CMS has requested comment on the complexity adjustment methodology, however AdvaMed remains concerned that CMS does not provide enough information in either its OPPS rules or Claims Accounting document for interested stakeholders to replicate Addendum J. This has been noted as well by various Medicare claims consultants. Additional clarity is needed to understand the results of Addendum J in order to facilitate the ability to provide meaningful feedback to CMS. Therefore, AdvaMed requests that the HOP Panel recommend that CMS provide sufficient detail in the Final CY 2026 OPPS Final Rule and the Claims Accounting document such that Addendum J can be replicated in its entirety.

AdvaMed has previously noted, as part of the evaluation of the complexity adjustment methodology, that it appears CMS does not evaluate the number of claims and total cost of single frequency J1 procedures, J1+J1 procedure code combinations, and J1+N procedure code combinations in the same manner.

Specifically, we ask the Panel to recommend to CMS that the Agency update the complexity adjustment methodology to include the cost of all secondary J1 procedures when evaluating J1+N procedure code combinations. This would be consistent with how CMS evaluates the cost of single frequency J1 procedures and J1+J1 procedure code combinations. However, for reasons not well explained in CMS' Claims Accounting document, CMS does not include the claims or cost of secondary J1 procedures when they appear on these claims, resulting in an inconsistent evaluation of not only the cost of these procedure combinations but also significantly reducing the number of claims that are included for evaluation for a complexity adjustment. We further recommend CMS consider expanding its review of procedure combinations to include clusters of -J1 and add-on codes, and certain select HCPCS device codes, rather than only code pairs, when cost and volume criteria are met. This would better reflect medical practice when multiple procedures or more resource-intensive pairings of -J1 codes with device codes are performed together.

Comments on Specific APCs

Noninvasive Arterial Plaque Analyses

Four new Category III codes, 0710T-0713T, were established in 2022 to report noninvasive arterial plaque analyses. This family of codes was created to describe a new diagnostic imaging tool which analyzes the structural and composition biomarkers of atherosclerotic plaque stability for all arterial vessels, derived from computed tomographic angiography. Within this family of codes, 0712T is reported for quantifying the structure and composition of the vessel wall and assessing lipid-rich necrotic core plaque to assess atherosclerotic plaque stability.

CPT Code 0712T is currently placed in APC 5521, Level 1 Imaging without Contrast, with a payment level of \$88.01 for CY 2025. However, the images assessed under this code are obtained from a CTA and include contrast, so it is inappropriate to continue to place this code in a non-contrast APC. We believe there is a more appropriate APC, specifically, APC 1511. We believe this is a more appropriate APC assignment because a similar code for coronary atherosclerotic plaque analysis, 0625T¹, was placed in APC 1511 with a payment level of \$950.50 for CY 2025 and CMS proposes to maintain this assignment for CY 2026. If CMS continues to assign 0712T to APC 5521, Medicare beneficiaries will not have access to this

¹ In 2021, four Category III codes (0623T-0626T) were established to report automated quantification and characterization of coronary atherosclerotic plaque. Automated quantification and characterization of coronary atherosclerotic plaque is a web-based service in which coronary CTA data are analyzed using computerized algorithms to assess the extent and severity of coronary artery disease (CAD). CPT code 0625T is reported for automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; computerized analysis of data from coronary computed tomographic angiography. These four temporary codes will be deleted in CY 2026 and a new CPT I code will be reported.

essential new technology service in cardiovascular care because the lack of adequate payment to hospitals will discourage its utilization.

We recommend CMS reassign 0712T to APC 1511 to appropriately pay for this new technology while claims data is developed in order to facilitate beneficiary access to appropriate healthcare.

AdvaMed therefore recommends the Panel:

- *Recommend CMS reassign CPT code 0712T to New Tech APC 1511 for CY 2026.*

Radiation Therapy

In 2025, the AMA revised the code set for several forms of external beam radiotherapy. Prior to this revision 3 codes were used to report 2D and 3D radiation delivery (77402, 77407, and 77412) with code selection based on the number of treatment areas, ports and blocks used. For 2025, CPT code 77402 in 2025 resides in APC 5621, Level 1 Radiation Therapy, with a payment rate of \$109.50 and CPT codes 77407 and 77412 reside in APC 5622, Level 2 Radiation Therapy, with a payment rate of \$262.98. Two codes used to report intensity modulated radiation therapy (IMRT) (77385 and 77386) with code selection based on the type of cancer treated (e.g. 77385 for prostate and breast and 77386 for all other sites) reside in APC 5623, Level 3 Radiation Therapy, with a payment rate of \$578.47.

For 2026, the IMRT codes (77385 and 77386) will be retired and two of the codes (77407 and 77412) will be revised and used to report 3D or IMRT delivery based on certain treatment parameters (e.g., number of isocenters or whether active motion management is used). The APCs CMS has proposed for 77407 and 77412 are the same APCs in which 77407 and 77412 have resided prior to this code revision (APC 5622), which has resulted in a reduction in payment for IMRT of over 52% and does not account for the costs associated with 77385 and 77386.

We believe CMS may have not tracked the revisions closely and simply placed the revised codes in the same APCs where they have historically been placed, not accounting for the claims data that had been collected for the IMRT codes. We encourage the HOP Panel to explore placing revised codes 77407 and 77412 in higher paying APCs reflecting the cost data for IMRT. The American Society for Radiation Oncology has proposed APC 5623 for CPT code 77407 and APC 5624 for CPT code 77412. We support this recommendation.

AdvaMed therefore recommends the Panel:

- *Recommend CMS reassign CPT code 77407 to APC 5623 CY 2026; and*
- *Recommend CMS reassign CPT code 77412 to APC 5624 for CY 2026.*

First Carpometacarpal Total Joint Arthroplasty

CPT code 1003T will be effective January 1, 2026 to report arthroplasty of the first carpometacarpal joint (CMC1), with distal trapezial and proximal first metacarpal prosthetic replacement (e.g. total thumb arthroplasty).

In the CY 2026 OPPTS Proposed Rule, CMS proposes to assign 1003T to APC 5114, Level 4 Musculoskeletal Procedures, with a proposed payment level of \$7,533.87. CMS is also proposing a Status Indicator of J1 and Payment Indicator of J8 (device intensive), given this procedure

involves implantation of a complex and costly prosthesis. However, the proposed Device Offset amount is \$2,335.50, which would impose a substantial barrier to adoption and limit Medicare beneficiaries' access due to insufficient facility reimbursement.

While, historically, other hand/wrist surgical procedures are frequently assigned to APC 5114, these procedures are not total joint reconstruction. CPT code 1003T is a total joint reconstruction and more similar to other arthroplasty procedures in APC 5116, Level 6 musculoskeletal procedures, given the implantation of a complex prosthesis involving detailed preparation of multiple bones and a higher cost articulating implant. Specifically, CPT code 1003T is analogous to that of total wrist arthroplasty (CPT code 25446) and distal ulna arthroplasty (CPT code 25442), which are assigned correctly to APC 5116 and also J8.

Assignment to APC 5114 does not reflect the clinical and resource complexity of 1003T. Maintaining this placement would result in inadequate reimbursement, limiting Medicare beneficiary access and discouraging utilization of this essential procedure.

AdvaMed therefore recommends the Panel:

- *Recommend CMS reassign CPT code 1003T to APC 5116 for CY 2026.*

Coronary Therapeutic Services and Procedures

CPT code 92X01 and 92X02 will be effective January 1, 2026. CMS proposed assigning these codes to APC 5193, Level 3 Endovascular Procedures. We recommend both codes be assigned to APC 5194, Level 4 Endovascular Procedures, due to the clinical complexity and resource intensity they represent, which exceeds that of their non-complex equivalents. These procedures are significantly complex and should be grouped accordingly to reflect the higher clinical and operational burden.

AdvaMed therefore recommends the Panel:

- *Recommend CMS reassign CPT codes 92X01 and 92X02 to APC 5194 for CY 2026.*

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