

Calendar Year 2026 Hospital Outpatient Prospective Payment System (HOPPS) Final Rule ACR Detailed Summary

On November 21, 2025, the Centers for Medicare and Medicaid Services (CMS) released the calendar year (CY) 2026 Hospital Outpatient Prospective Payment System (HOPPS) [final rule](#). These finalized changes are effective January 1st, 2026.

Conversion Factor Update – pg. 108

CMS finalized an increase to the conversion factor of 2.6 percent, bringing it up to \$91.415 for CY 2026. This increase is based on the final estimate of the hospital inpatient market basket percentage increase of 3.3 percent for inpatient services paid under the hospital inpatient prospective payment system (IPPS) reduced by a productivity adjustment of 0.7 percentage point. CMS also finalized further adjustment to the conversion factor to ensure that any revisions made to the wage index and rural adjustment are made on a budget neutral basis. CMS finalized to calculate an overall budget neutrality factor of 0.9990 for wage index changes, as adopted on a calendar year basis for the OPSS. CMS finalized the calculation of an additional budget neutrality factor of 0.9955 to account for the finalized policy to cap wage index reductions for hospitals at 5 percent on an annual basis. CMS finalized the proposal to maintain the current rural adjustment policy and therefore sets the budget neutrality factor for the rural adjustment to be 1.0000.

In this final rule, hospitals that fail to meet the reporting requirements of the Hospital Outpatient Quality Reporting (OQR) Program will be subject to a further CF reduction of 2.0 percentage points, resulting in a CF of \$89.632 for CY 2026.

CMS finalized the proposal to use CY 2024 claims data to set CY 2026 OPSS and ASC rates. CMS finalized the proposal to use the most recently available cost report data from the Healthcare Cost Report Information System (HCRIS).

Estimated Impact on Hospitals – pg. 1575

In this final rule, CMS estimates that OPSS expenditures, including beneficiary cost-sharing and estimated changes in enrollment, utilization, and case mix will be approximately \$101 billion, which is approximately \$8 billion higher than estimated CY 2025 OPSS expenditures.

Finalized Ambulatory Payment Classification Group Policies

Imaging Ambulatory Payment Classifications

CMS did not finalize any new changes to the APC structure for imaging codes. The seven payment categories remain. However, CMS has moved codes within these payment categories which will cause changed reimbursement for 2026. CMS is making reassignments to the codes within the series to resolve and/or prevent any violations of the two-times rule.



Finalized CY 2026 Imaging APCs

APC	APC Group Title	SI	CY 2025 Relative Weight	CY 2026 Finalized Relative Weight	CY 2025 Payment Rate	CY 2026 Finalized Payment Rate
5521	Level 1 Imaging without Contrast	S*	0.9874	0.9726	\$88.05	\$88.91
5522	Level 2 Imaging without Contrast	S	1.1926	1.1684	\$106.34	\$106.81
5523	Level 3 Imaging without Contrast	S	2.7108	2.6666	\$241.72	\$243.77
5524	Level 4 Imaging without Contrast	S	6.1490	6.1068	\$548.30	\$558.25
5571	Level 1 Imaging with Contrast	S	1.9964	1.9603	\$178.02	\$179.20
5572	Level 2 Imaging with Contrast	S	4.0051	3.8990	\$357.13	\$356.43
5573	Level 3 Imaging with Contrast	S	8.8602	8.7611	\$790.06	\$800.90

*Procedure or Service, Not Discounted When Multiple; Paid under OPPS; separate APC payment.

Comprehensive APCs – pg. 40

CMS conducted an annual review and finalized no changes in this rule to the current number of 72 C-APCs. Table 4 lists all C-APCs for CY2026, all of which were established in past rules. CMS finalized complexity adjustments for several existing C-APCs.

Finalized APC Placements for Imaging Services

HOPPS Addendums for additional information on APC placements and reimbursement rates can be found [here](#). Addendums A and B can be found under the file name “2026 NFRM OPPS Addenda” under the Related Links section.

CT Lung Cancer Screening

CMS finalized the proposal to place CPT code 71271 for low dose CT lung cancer screening in APC 5522 with payment rate of \$106.81. The finalized placement for code G0296 (visit to determine lung LDCT eligibility) is APC 5822, with a payment rate of \$103.79.

Medical Physics Dose Evaluation

CMS finalized the proposal to place 76145 for medical physics dose evaluation for radiation exposure that exceeds institutional review threshold (including reports) in APC 5723 with payment rate \$381.24 for CY 2026.

Medical 3D Printing Services

CMS finalized the proposal to place code C8001 (3d anatomical segmentation imaging for preoperative planning, data preparation and transmission, obtained from previous diagnostic computed tomographic or magnetic resonance examination of the same anatomy) into APC 5721 with payment rate of \$131.46 for CY 2026.

CMS finalized the APC placement for code 0559T (Anatomic model 3D printed from image data set(s): first individually prepared and processed component of an anatomic structure) into APC 5734 with Q1 status indicator and payment rate of \$135.93. Code 0561T (Anatomic guide 3D printed from image data set(s): first anatomic guide) has also been placed into APC 5734 with Q1 status indicator and payment rate of \$135.93. This is an increase from the proposed rule, where both codes were previously placed into APC 5733 with a Q1 status indicator.

Colorectal Cancer (CRC) Screening Services

CMS finalized the proposal to assign CPT code 74263 for screening CT colonography (CTC)/virtual colonoscopy a status indicator of “S” and APC 5523 (Level 3 Imaging Without Contrast) with a payment rate of \$243.77.

Finalized Payment Adjustments to Cancer Hospitals – pg. 138

The ACA requires an adjustment to cancer hospitals’ outpatient payments to bring each hospital’s payment-to-cost ratio (PCR) up to the level of the PCR for all other hospitals, the target PCR. The changes in additional payments from year to year are budget neutral. The 21st Century Cures Act reduced the target PCR by 1.0 percentage point and excludes the reduction from OPSS budget neutrality. The cancer hospital adjustment is applied at cost report settlement rather than on a claim-by-claim basis.

Table 10 shows the estimated percentage increase in OPSS payments to each cancer hospital for CY 2026, due to the cancer hospital payment adjustment policy.

Table 10: Estimated CY 2026 Hospital-Specific Payment Adjustment for Cancer Hospitals to be Provided at Cost Report Settlement

Provider Number	Hospital Name	Estimated % Increase in OPSS Payments for CY 2026 Due to Payment Adjustment
050146	City of Hope Comprehensive Cancer Center	36.9%
050660	USC Norris Cancer Hospital	36.3%
100079	Sylvester Comprehensive Cancer Center	30.9%
100271	H. Lee Moffitt Cancer Center & Research Institute	16.6%
220162	Dana-Farber Cancer Institute	46.4%
330154	Memorial Sloan-Kettering Cancer Center	40.9%
330354	Roswell Park Cancer Institute	11.9%
360242	James Cancer Hospital & Solove Research Institute	20.9%
390196	Fox Chase Cancer Center	18.2%
450076	M.D. Anderson Cancer Center	48.5%
500138	Seattle Cancer Care Alliance	49.4%

Finalized APC Exceptions to the 2 Times Rule – pg. 189

CMS finalized 27 exceptions to the 2-times rule based on the following criteria: resource homogeneity; clinical homogeneity; hospital outpatient setting utilization; frequency of service (volume); and opportunity for up-coding and code fragments. Table 16, found below, lists the 27 APCs that CMS will exempt from the 2 times rule for 2026 based on CY 2024 available claims data.

Table 16: Final CY 2026 APC Exceptions to the 2 Times Rule

APC	APC Group Title
5012	Clinic Visits and Related Services
5024	Level 4 Type A ED Visits
5052	Level 2 Skin Procedures
5054	Level 4 Skin Procedures
5071	Level 1 Excision/ Biopsy/Incision and Drainage
5301	Level 1 Upper GI Procedures
5502	Level 2 Extraocular, Repair, and Plastic Eye Procedures
5521	Level 1 Imaging without Contrast
5522	Level 2 Imaging without Contrast
5523	Level 3 Imaging without Contrast
5524	Level 4 Imaging without Contrast
5572	Level 2 Imaging with Contrast
5611	Level 1 Therapeutic Radiation Treatment Preparation
5612	Level 2 Therapeutic Radiation Treatment Preparation
5627	Level 7 Radiation Therapy
5671	Level 1 Pathology
5674	Level 4 Pathology
5691	Level 1 Drug Administration
5692	Level 2 Drug Administration
5722	Level 2 Diagnostic Tests and Related Services
5724	Level 4 Diagnostic Tests and Related Services
5731	Level 1 Minor Procedures
5734	Level 4 Minor Procedures
5791	Pulmonary Treatment
5821	Level 1 Health and Behavior Services
5822	Level 2 Health and Behavior Services
5823	Level 3 Health and Behavior Services

Changes to New-Technology APCs

Cardiac Positron Emission Tomography (PET)/Computed Tomography (CT) Studies – pg. 211

For CY 2026, the OPPS payment rates for the service described by CPT codes 78431, 78432, and 78433 were based on available CY 2024 claims data.

In the proposed rule, CPT code 78431 had over 30,000 single frequency claims in CY 2024 with a geometric mean of approximately \$2200, which falls within the cost band for the currently assigned APC 1522. Based on updated claims data, CPT code 78431 has an updated geometric mean cost of approximately \$2,182. Because the geometric mean cost of CPT code 78431 is still within the range for APC 1522, the proposed APC assignment for CPT code 78431 for CY 2026, CMS finalized the proposed APC assignment of CPT code 78431 without modification.

In the proposed rule, CPT code 78432 had only 31 single frequency claims available. There were three additional single frequency claims for CY 2024 processed for CPT code 78432 since the proposed rule, bringing the total number of single frequency claims to 34 for CPT code 78432 for CY 2024. Since the updated arithmetic mean cost for CPT code 78432 is outside of the cost band for APC 1519 (New Technology - Level 19, CMS did not finalize the proposal to assign CPT code 78432 to APC 1519 for CY 2026. Based on the updated statistical methodologies, CMS assigned CPT code 78432 to APC 1517 for CY 2026 (New Technology - Level 17 with a payment rate of \$1,550.50.

In the proposed rule, CPT code 78433 had over 1400 single frequency claims in CY 2024. The geometric mean was approximately \$2037, which is an amount above the cost band for APC 1521 (New Technology - Level 21) to which it had been previously assigned. Therefore, CMS had proposed to reassign code 78433 to APC 1522 (New Technology - Level 22) for CY 2026. Based on updated claims data, CPT code 78433 has an updated geometric mean cost of approximately \$2004. Because the geometric mean cost of CPT code 78433 is still within the range for APC 1522, the proposed APC assignment for CPT code 78433 for CY 2026, CMS finalized the proposed APC assignment of CPT code 78433 without modification.

Table 21: Proposed and Final CY 2026 OPPS New Technology APC and Payment Rates for Cardiac PET/CT CPT Codes 78431, 78432, and 78433

CPT Code	Long Descriptor	Proposed CY 2026 APC	Proposed CY 2026 Payment Rate	Final CY 2026 APC	Final CY 2026 Payment Rate
78431	Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); multiple studies at rest and stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan	1522	\$2250.50	1522	\$2250.50

78432	Myocardial imaging, positron emission tomography (PET), combined perfusion with metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), dual radiotracer (eg, myocardial viability)	1519	\$1750.50	1517	\$1550.50
78433	Myocardial imaging, positron emission tomography (PET), combined perfusion with metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), dual radiotracer (eg, myocardial viability); with concurrently acquired computed tomography transmission scan	1522	\$2250.50	1522	\$2250.50

Non-Cardiac Contrast Enhanced Ultrasound (CEUS), CPT Codes 76978 and 76979 – pg. 316

CPT codes 76978 and 76979 describe non-cardiac contrast enhanced ultrasounds. CPT code 76978 describes ultrasound, targeted dynamic microbubble sonographic contrast characterization (non-cardiac) for the initial lesion, while CPT code 76979 describes each additional lesion with a separate injection and is packaged with the primary procedure code per OPSS policy.

For CY 2026, CMS proposed to assign both codes to APC 5571 (Level 1 Imaging with Contrast) with payment rate of \$179.20. CPT code 76978 had a geometric mean cost of around \$287 based on 710 single frequency claims and CPT code 76979 was packaged with a primary procedure. CMS stated in the final rule that they agreed with the commenters' request for APC reassignment due to the proposed APC not accurately reflecting the resource costs associated with these specialized procedures.

After reviewing the clinical characteristics and resource costs associated with CPT codes 76978, CMS reassigned CPT 76978 from APC 5571 (Level 1 Imaging with Contrast) to APC 5572 (Level 2 Imaging with Contrast) for CY 2026, increasing the payment rate to \$356.43. This reassignment better reflects the complexity and resource intensity of non-cardiac contrast enhanced ultrasound procedures. CPT code 76978 will be assigned status indicator "S" (separately payable) under APC 5572, while CPT code 76979 will maintain status indicator "N" (packaged) and will continue to be packaged with the primary procedure code 76978 under the new APC assignment.

This change recognizes the specialized nature of contrast-enhanced ultrasound technology and ensures appropriate payment for these services, and these changes are effective on January 1.

Table 60: Proposed and Final CY 2026 APC and Status Indicator Assignments for CPT codes 76978 and 76979

CPT Code	Long Descriptor	Proposed CY 2026 SI	Proposed CY 2026 APC	Final CY 2026 SI	Final CY 2026 APC
76978	Ultrasound, targeted dynamic microbubble sonographic contrast characterization (non-cardiac); initial lesion	S	5571 (Level 1 Imaging with Contrast)	S	5572 (Level 2 Imaging with Contrast)
76979	Ultrasound, targeted dynamic microbubble sonographic contrast characterization (non-cardiac); each additional lesion with separate injection (List separately in addition to code for primary procedure).	N	N/A*	N	N/A*

*CPT Code 76969 has a status indicator of “N” which designates the service as packaged and will continue to be packaged with the primary procedure code 76979 under the new APC assignment.

Brachytherapy

Universal Low Volume APC Policy for Clinical and Brachytherapy APCs – pg. 39

Beginning with the CY 2022 HOPPS final rule, CMS adopted and implemented a universal Low Volume APC policy for CY 2022 and subsequent calendar. This policy is applied when a clinical or brachytherapy APC has fewer than 100 single claims that can be used for ratesetting. Under the low volume APC payment adjustment policy, CMS determines the APC cost as the greatest of the geometric mean cost, arithmetic mean cost, or median cost based on up to 4 years of claims data. For CY 2026, CMS finalized the proposal to designate six brachytherapy APCs as low volume APCs as well as five clinical APCs. Table 42 in the rule lists the final low volume APCs using comprehensive (OPPS) ratesetting methodology for CY 2026.

Finalized Low Volume Brachytherapy APCs for CY 2026

APC	APC Description	CY 2024 Claims Available for Rate Setting	Final CY 2026 APC Payment Rate
2632	Iodine I-125 sodium iodide	1	\$396.32
2635	Brachytx, non-str, HA, P-103	9	\$106.75



2636	Brachy linear, non-str, P-103	0*	\$89.40
2642	Brachytx, stranded, C-131	49	\$119.11
2643	Brachytx, non-stranded, c-131	88	\$99.80
2647	Brachytx, NS, Non-HDRIr-192	3	\$908.70

*For this final rule, there are no CY 2024 claims that contain the HCPCS code assigned to APC 2636 that are available for CY 2026 OPPS/ASC ratesetting.

OPPS Payment for Software as a Service

Atherosclerosis Imaging-Quantitative Computer Tomography (AI-QCT) – pg. 219

Atherosclerosis Imaging-Quantitative Computer Tomography (AI-QCT) is a Software as a Service (SaaS) that assesses the extent of coronary artery disease severity. The AMA CPT Editorial Panel is creating a new Category I CPT code for AI-QCT, which is currently described by CPT 75577 (formerly placeholder code 75XX6). Since CPT placeholder code 75XX6 will not be effective until January 1, 2026, CMS will not have claims data available for ratesetting for this code until the CY 2028 rulemaking cycle. However, as CPT code 0625T will still be in use until December 31, 2025, CMS proposed to determine the payment rate for CPT placeholder code 75XX6 using the available CY 2024 claims data for CPT code 0625T.

For CY 2024, the geometric mean cost of around \$496 based on 22 claims may better reflect the cost of the procedure described by CPT code 0625T, but there are not enough claims to be confident about the result. Due to these issues, CMS is not confident that the results of the 4-year lookback period accurately reflect the actual costs of CPT code 0625T. Therefore, CMS finalized the proposal to use their authority under section 1833(t)(2)(E) to assign CPT placeholder code 75XX6 to APC 1511 (New Technology - Level 11) with a payment rate of \$950.50 for CY 2026, which based on the information currently available, best reflects the cost of the service as described by the New Technology APC application.

Quantitative Magnetic Resonance for Analysis of Tissue Composition – pg. 233

LiverMultiScan is a SaaS that is intended to aid the diagnosis and management of chronic liver disease, the most prevalent of which is Non-alcoholic Fatty Liver Disease (NAFLD). In the proposed rule, CMS identified 107 claims for code 0648T and 104 claims for 0649T for CY2024. The geometric mean cost for CPT code 0648T is \$253.68 and is \$162.96 for CPT code 0649T. Since the CY 2026 OPPS/ASC proposed rule was published, CPT code 0648T has an updated geometric mean cost of around \$269 based on 114 single frequency claims, and CPT code 0649T has an updated geometric mean cost of around \$158 based on 111 single frequency claims.

After consideration of the public comments, CMS finalized the proposal without modification. CMS will use their equitable adjustment authority under section 1833(t)(2)(E) of the Act to continue to assign CPT codes 0648T and 0649T to New Technology APC 1511 (New Technology—Level 11 (\$901–\$1,000) with a payment rate of \$950.50 for CY 2026.

Lung Cancer Prediction (LCP) – pg. 237

CPT codes 0721T and 0722T describe quantitative computed tomography tissue characterization, used in products such as Optellum’s lung cancer prediction (LCP) technology.

In the proposed rule, CMS found 496 combined claims for CPT codes 0721T and 0722T for CY 2024: only 7 claims for CPT code 0721T and 489 claims for 0722T. The geometric mean cost of CPT code 0721T is \$30.24 and the geometric mean cost for CPT code 0722T is \$60.47. Based on the geometric mean cost for CPT code 0722T, which has a significantly greater number of claims than 0721T, CMS would assign both codes to APC 1502 (New Technology – Level 2 with a payment rate of \$75.50. However, assigning these SaaS services based on the geometric costs would significantly impact the payment by decreasing the payment rate by close to 90 percent in 1 year.

Therefore, CMS finalized the proposal to use their authority under section 1833(t)(2)(E) for CY 2026 to continue to assign CPT codes 0721T and 0722T to APC 1508 (New Technology - Level 8) with a payment rate of \$650.50 based on the information provided by the manufacturer in their New Technology APC application, which CMS believes may better reflect the cost of the service at this time than the available claims data.

Quantitative Magnetic Resonance (QMR) for Analysis of Tissue Composition – pg. 240

CPT codes 0697T and 0698T are for services such as CoverScan, a medical image management and processing software package that analyzes MR data and provides quantified metrics of multiple organs such as the heart, lungs, liver, spleen, pancreas, and kidney. In the proposed rule, CMS identified 55 single frequency claims for 0698T and no claims for 0697T in CY 2024. Because the SaaS standalone and add-on services are identical, CMS used available data from the add-on code for ratesetting.

As the 55 single frequency claims for 0698T are below the threshold of 100 claims for a service within a year, CMS would usually apply the universal low volume APC policy. This would have yielded a geometric median cost of approximately \$777. CMS would propose to assign CPT codes 0697T and 0698T to APC 1509 (New Technology – Level 9) with a payment of \$750.50. But, because CMS continues to have the same concerns about payment variability and the possible effects the payment may have on patient access to these SaaS services, CMS finalized the proposal to use their authority under section 1833(t)(2)(E) for CY 2026 to continue to assign CPT codes 0697T and 0698T to APC 1511 (New Technology—Level 11) with a payment of \$950.50 which they believe best reflects the cost of the service at this time.

Quantitative Magnetic Resonance Cholangiopancreatography (QMRCP) – pg. 243

CPT codes 0723T and 0724T describe quantitative magnetic resonance cholangiopancreatography (QMRCP) services that perform quantitative assessment of the biliary tree and gallbladder. For CY 2026, the OPPS payment rates are proposed to be based on available CY 2024 claims data. The updated claims data for the 4-year lookback period for the universal low volume APC policy shows no claims for HCPCS code 0723T and four single claims for 0724T. Because CMS is finalizing the proposal to maintain current New Technology APC assignments for CY 2026 for New Technology APC services with fewer than 10 claims in the 4-year lookback period, CMS is continuing to assign HCPCS code 0723T and 0724T to APC 1511.

Fractional Flow Reserve Derived From Computed Tomography (FFRct) – pg. 292

Fractional Flow Reserve Derived from Computed Tomography (FFRCT), also known by the trade name HeartFlow®, is a noninvasive diagnostic service that allows physicians to measure coronary artery disease in a patient through the use of coronary CT scans. CPT code 75580 is used to report this service.

In the proposed rule, CMS identified 17,813 single frequency claims that were used to calculate the geometric mean cost of \$278.51 in CY 2024. CMS stated that they believed that the geometric mean cost may have been impacted by an outdated automated return-to-provider (RTP) Healthcare Common Procedure Coding System-to-revenue code edit that occurred when the Category I CPT code became effective. The edit prevented providers from reporting the cardiology revenue code (0480), which maps to the cardiology cost center (03140), when billing CPT code 75580. Although the edit was removed, and providers were notified to resubmit any incorrectly returned claims, CMS believed that the outdated edit may have impacted the geometric mean for CPT code 75580.

CMS acknowledged in the final rule that there are several procedural and logistical hurdles associated with changing billing practices and will continue to monitor the claims data. CMS finalized their proposal without modification to continue to assign CPT code 75580 to APC 5724 (Level 4 Diagnostic Tests and Related Services) with a payment amount of \$877.34, as they believe best reflects the cost of the service at this time.

The following table lists the Software as a Service (SaaS) final CY 2025 APCs and final CY 2026 APCs with their corresponding payment rates.

Software as a Service (SaaS) CY 2026 Finalized APC Placements and Payment Rates

CPT Code	Long Descriptor	CY2025 APC	CY2025 Payment Rate	Final CY2026 APC	Final CY2026 Payment Rate
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75577	Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computer tomographic angiography; computerized analysis of data from coronary computed tomographic angiography	1511 – New Tech Level 11	\$950.50	1511 – New Tech Level 11	\$950.50
0648T	Quantitative magnetic resonance for analysis of tissue composition (e.g., fat, iron, water content), including multiparametric data acquisition, data preparation and transmission, interpretation and report, obtained without diagnostic MRI examination of the same anatomy (e.g., organ, gland, tissue, target structure) during the same session	1511 – New Tech Level 11	\$950.50	1511 – New Tech Level 11	\$950.50
0649T	Quantitative magnetic resonance for analysis of tissue composition (e.g., fat, iron, water content), including multiparametric data acquisition, data preparation and transmission, interpretation and report, obtained with diagnostic MRI examination of the same anatomy (e.g., organ, gland, tissue, target structure) (List separately in addition to code for primary procedure)	1511 – New Tech Level 11	\$950.50	1511 – New Tech Level 11	\$950.50
0697T	Quantitative magnetic resonance for analysis of tissue composition (eg, fat, iron, water content), including multiparametric data acquisition, data preparation and transmission, interpretation and report, obtained without diagnostic MRI examination of the same anatomy (eg, organ, gland, tissue, target structure) during the same session; multiple organs	1511 – New Tech Level 11	\$950.50	1511 – New Tech Level 11	\$950.50

0698T	Quantitative magnetic resonance for analysis of tissue composition (eg, fat, iron, water content), including multiparametric data acquisition, data preparation and transmission, interpretation and report, obtained with diagnostic MRI examination of the same anatomy (eg, organ, gland, tissue, target structure); multiple organs (List separately in addition to code for primary procedure)	1511 – New Tech Level 11	\$950.50	1511 – New Tech Level 11	\$950.50
0721T	Quantitative computed tomography (CT) tissue characterization, including interpretation and report, obtained without concurrent CT examination of any structure contained in previously acquired diagnostic imaging	1508 – New Tech Level 8	\$650.50	1508 – New Tech Level 8	\$650.50
0722T	Quantitative computed tomography (CT) tissue characterization, including interpretation and report, obtained with concurrent CT examination of any structure contained in the concurrently acquired diagnostic imaging dataset (List separately in addition to code for primary procedure)	1508 – New Tech Level 8	\$650.50	1508 – New Tech Level 8	\$650.50
0723T	Quantitative magnetic resonance cholangiopancreatography (QMRCP) including data preparation and transmission, interpretation and report, obtained without diagnostic magnetic resonance imaging (MRI) examination of the same anatomy (e.g., organ, gland, tissue, target structure) during the same session	1511 – New Tech Level 11	\$950.50	1511 – New Tech Level 11	\$950.50
0724T	Quantitative magnetic resonance cholangiopancreatography (QMRCP) including data preparation and transmission, interpretation and report, obtained with diagnostic magnetic resonance imaging (MRI) examination of the same anatomy	1511 – New Tech Level 11	\$950.50	1511 – New Tech Level 11	\$950.50

	(e.g., organ, gland, tissue, target structure) (List separately in addition to code for primary procedure)				
0865T	Quantitative magnetic resonance image (MRI) analysis of the brain with comparison to prior magnetic resonance (MR) study(ies), including lesion identification, characterization, and quantification, with brain volume(s) quantification and/or severity score, when performed, data preparation and transmission, interpretation and report, obtained without diagnostic MRI examination of the brain during the same session	5523 – Level 3 Imaging without contrast	\$241.72	5523 – Level 3 Imaging without contrast	\$243.77
0866T	Quantitative magnetic resonance image (MRI) analysis of the brain with comparison to prior magnetic resonance (MR) study(ies), including lesion detection, characterization, and quantification, with brain volume(s) quantification and/or severity score, when performed, data preparation and transmission, interpretation and report, obtained with diagnostic MRI examination of the brain (List separately in addition to code for primary procedure)	5523 – Level 3 Imaging without contrast	\$241.72	5523 – Level 3 Imaging without contrast	\$243.77
0944T	3D contour simulation of target liver lesion(s) and margin(s) for image-guided percutaneous microwave ablation	5523 – Level 3 Imaging without contrast	\$241.72	5523 – Level 3 Imaging without contrast	\$243.77
75580	Noninvasive estimate of coronary fractional flow reserve (FFR) derived from augmentative software analysis of the data set from a coronary computed tomography angiography, with interpretation and report by a physician or other qualified health care professional	5724 – Level 4 Diagnostic Tests & Related Services	\$1,017.39	5724 – Level 4 Diagnostic Tests & Related Services	\$877.34

Comment Solicitation on Payment Policy for Software as a Service (SaaS) – pg. 426

CMS currently does not have a comprehensive Medicare payment policy specific to SaaS that accounts for the unique challenges of paying for these services. For CY 2026, CMS solicited comments from the public on payment policies for these services under the OPPTS, including applicable lessons learned from risk-bearing payment arrangements and input that helps incorporate the underlying value of technologies within medical practice into payment policy. CMS notes the agency similarly sought out comment on this issue under the CY 2026 PFS proposed rule.

Generally, commenters supported a dedicated payment policy for innovative technologies. The comments illustrated the complexity intrinsic to paying for SaaS, and CMS recognizes the need for a payment policy that accounts for that. CMS thanked commenters and will consider the comments for future rulemaking.

Payment for Radiation Therapy Services Furnished at Nonexcepted Off-Campus PBDs – pg. 433

The PFS Relativity Adjuster is not applied to radiation therapy services, including radiation treatment delivery and related imaging guidance services, furnished by nonexcepted off-campus PBDs. Nonexcepted off-campus PBDs were instructed to bill Medicare Physician Fee Schedule G-codes for radiation therapy services and append modifier “PN”. CMS is deleting radiation therapy G-codes (G6001–G6017) effective Jan 1, 2026, because CPT codes 77402, 77407, and 77412 have been revised and may be used to report these services instead.

After consideration of the public comments received, CMS finalized, without modification, the proposal that, effective January 1, 2026, nonexcepted off-campus PBDs use the revised radiation treatment CPT codes described in the CY 2026 PFS proposed rule and append modifier “PN” to each applicable claim line for nonexcepted items and services. The payment amount for these services when billed with the “PN” modifier will be set to reflect the technical component rate for the code under the MPFS.

Payment for Non-Pass-Through Drugs, Biologicals, and Radiopharmaceuticals Policy Packaged Drugs, Biologicals, and Radiopharmaceuticals

CMS currently pays for drugs, biologicals, and radiopharmaceuticals that do not have pass-through payment status in one of two ways: packaged into the payment for the associated service or separate payment (individual APCs). Hospitals do not receive a separate payment for packaged items and may not bill beneficiaries separately for any packaged items; these costs are recognized and paid within the OPPTS payment rate for the associated procedure or service.

Payment Policy for Therapeutic Radiopharmaceuticals – pg. 625

For CY 2026, CMS finalized the proposal to continue paying for therapeutic radiopharmaceuticals at Average Sales Price (ASP) plus 6 percent. For therapeutic radiopharmaceuticals for which ASP

data are unavailable, CMS will determine 2026 payment rates based on arithmetic mean unit cost data derived from hospital claims.

Separate Payment for Diagnostic Radiopharmaceuticals – pg. 85

In the CY 2025 HOPPS final rule, CMS finalized a policy to pay separately for any diagnostic radiopharmaceutical with a per day cost greater than \$630 for 2025. Those at or below this threshold will remain policy packaged.

In the CY 2026 HOPPS PR, CMS proposed increasing the per-day packaging threshold from \$630 to \$655, adjusted for inflation using the Producer Price Index. CMS finalized this policy without modifications.

Average Sales Price (ASP) reporting remains voluntary under HOPPS but is encouraged. CMS solicited public input on barriers and challenges to ASP reporting for radiopharmaceuticals. CMS stated they appreciate the insight from commenters regarding their concerns with CMS continuing to use arithmetic MUC as the payment methodology for diagnostic radiopharmaceuticals. CMS will take these comments into consideration for future rulemaking.

Services That Will Be Paid Only as Inpatient Services

Current Methodology for Identifying Appropriate Changes to the IPO List – pg. 862

Currently, there are 1,731 services on the IPO list. Under CMS’s longstanding policy and current regulations, the IPO list is annually reviewed to identify any services that should be added to, or removed from, the list based on the most recent data and medical evidence available.

The criteria for assessing procedures for removal from the IPO list are:

- Most outpatient departments are equipped to provide the service or procedure to the Medicare population.
- The simplest service or procedure described by the code may be performed in most outpatient departments.
- The service or procedure is related to codes that CMS has already removed from the Inpatient Only list.
- CMS determines that the service or procedure is being performed in numerous hospitals on an outpatient basis.
- CMS determines that the service or procedure can be appropriately and safely performed in an ambulatory surgical center, and is specified as a covered ambulatory surgical procedure, or CMS has proposed to specify it as a covered ambulatory surgical procedure.

CY 2026 Proposal to Eliminate the IPO List – pg. 869

For CY 2026 and subsequent years, CMS proposed to eliminate the IPO list through a 3-year transition, completing the elimination by CY 2029. While CMS agreed with commenters in previous rulemakings that the IPO list was necessary, and that it would be inappropriate for us to establish payment rates for those services under the OPSS (78 FR 75055, 86 FR 63673), CMS has

reconsidered the various comments from interested parties requesting that they eliminate the IPO list, and reevaluated the need for CMS to restrict payment for certain procedures in the hospital outpatient setting.

CMS finalized eliminating the IPO list over the course of the next 3 years, starting with the removal of 285 mostly musculoskeletal-related services, as provided in Table 119 of this final rule, for CY 2026.

CMS also finalized amending § 419.22(n) to state that, effective on January 1, 2026, the Secretary shall eliminate the list of services and procedures designated as requiring inpatient care through a 3-year transition period, with the list eliminated in its entirety by January 1, 2028. The complete list of codes that describe services that are finalized to be paid by Medicare in CY 2026 as inpatient only services is included as Addendum E to this CY 2026 OPPS/ASC final rule.

Impact of Unnecessary Increases in Volume on the OPPS

Expanding the Method to Control Unnecessary Increases in the Volume of Outpatient Services Furnished in Excepted Off-Campus Provider-Based Departments (PBDs) – pg. 904

In the CY 2019 OPPS/ASC final rule with comment period, CMS adopted a method to control unnecessary increases in the volume of the clinic visit service furnished in excepted off-campus provider-based departments (PBDs). CMS implemented this policy in a non-budget neutral manner to ensure that their method for controlling the unnecessary growth in the volume of clinic visits furnished by excepted off-campus PBDs does not simply increase other unnecessary expenditures within the OPPS, thus driving different utilization-distorting decisions.

For CY 2026, CMS finalized the proposal to expand this policy to include drug administration services furnished in excepted off-campus PBDs. Specifically, CMS finalized its proposal to use the agency’s authority under section 1833(t)(2)(F) of the Social Security Act (“the Act”) to apply the Physician Fee Schedule equivalent payment rate for any codes assigned to the drug administration ambulatory payment classifications (APCs) when provided at an off-campus PBD excepted from section 603 of the Bipartisan Budget Act of 2015.

For CY 2026, it is estimated this provision will reduce OPPS spending by \$290 million, with \$220 million of the savings accruing to Medicare, and \$70 million saved by Medicare beneficiaries in the form of reduced beneficiary coinsurance.

Request for Information on Adjusting Payment under the OPPS for Services Predominately Performed in the Ambulatory Surgical Center or Physician Office Settings – pg. 972

While CMS has implemented volume control policies to pay for certain hospital outpatient clinic visits at a rate closer to that under the PFS and proposed to expand this policy to drug administration services, they sought feedback in the CY 2026 OPPS PR for future rulemaking on the development of a more systematic process for identifying ambulatory services at high risk of shifting to the hospital setting based on financial incentives rather than medical necessity and

adjusting payments accordingly. CMS received approximately 43 pieces of correspondence that were submitted in response to the RFI questions. The agency thanks all interested parties for their comments and CMS will take them into consideration for future rulemaking.

Virtual Direct Supervision of Diagnostic Services Furnished to Hospital Outpatients – pg. 977

In the CY 2023 OPPTS/ASC final rule with comment period, CMS extended the end date of the flexibility allowing for the virtual supervision. This allowed for the flexibility allowing for the flexibility of virtual supervision of outpatient diagnostic services through audio/video real-time communications technology from the end of the PHE to the end of the calendar year in which the PHE ends. In the CY 2024 OPPTS/ASC final rule this was once again extended to December 31, 2024. In the CY 2025 HOPPS final rule, CMS again revised the definition of direct supervision at § 410.32(b)(3)(ii) to extend the availability of virtual direct supervision of therapeutic and diagnostic services under the PFS through December 31, 2025.

In addition to desiring uniformity under the PFS and OPPTS in how regulations are applied to similarly situated clinicians and providers, CMS states that the approach used in the PFS final rule strikes the appropriate balance between recognizing that the virtual supervision of diagnostic services has been available and widely utilized since the beginning of the PHE and ensuring quality of care and patient safety.

Consequently, CMS finalized the proposal to revise § 410.27(a)(1)(iv)(B)(1) and § 410.28(e)(2)(iii) to make the availability of the direct supervision of CR, ICR, PR services and diagnostic services via audio-video real-time communications technology (excluding audio-only) permanent, except for diagnostic services that have a global surgery indicator of 010 or 090.

Hospital Price Transparency (HPT) Regulations

Consistent with the President’s Executive Order 14221, “Making America Healthy Again by Empowering Patients with Clear, Accurate, and Actionable Healthcare Pricing Information,” CMS finalized several modifications to the HPT regulations to ensure that hospitals provide meaningful, accurate information about the amount they charge for health care items and services.

Beginning January 1, 2026, hospitals will be required to calculate and encode the median, 10th and 90th percentile allowed amounts as well as the count of allowed amounts in their machine-readable file (MRF) when payer-specific negotiated charges are based on percentages or algorithms.

In addition, CMS finalized the proposal to require hospitals to attest in the MRF that, to the best of its knowledge and belief, the hospital has included all applicable standard charge information and that the information encoded is true, accurate, and complete as of the date in the file. The effective date for the new data elements required in the MRF is January 1, 2026, but CMS delayed the enforcement of those requirements until April 1, 2026.

Hospital Outpatient Quality Reporting (OQR) Program and Rural Emergency Hospital Quality Reporting (REHQR) Program - Request for Information (RFI) on New Measure Concepts

Measure Concepts under Consideration for Future Years in the Hospital OQR, REHQR, and ASCQR Programs – Request for Information (RFI) - pg.1166

In the Cross-Program Measures section of the RFI, CMS finalized a broad expansion of digital quality measures (dQM) in outpatient settings through the implementation of electronic Clinical Quality Measures (eCQMs) in the Hospital Outpatient Quality Reporting (OQR), Rural Emergency Hospital Quality Reporting (REHQR), and Ambulatory Surgical Center Quality Reporting (ASCQR) Programs. These changes are intended to modernize data collection, reduce provider burden, and improve the accuracy and timeliness of quality reporting.

For example, in the Hospital OQR Program, CMS decided that the Emergency Care Access & Timeliness eCQM, which replaces two existing chart-abstracted metrics: OP-18: *Median Time from Emergency Department (ED) Arrival to Departure* and OP-22: *Left Without Being Seen*, will become mandatory.

- Hospital OQR: Voluntary in CY 2027; mandatory in CY 2028.
- REHQR: Voluntary in CY 2027; mandatory in CY 2029.
- REHs may report either this eCQM or the ED Departure measure.

To support these transitions, CMS outlines technical requirements for eCQM reporting that also comply with the Office of the National Coordinator's (ONC) standards and submission of data. CMS also codified its discretion for granting eCQM reporting extensions under the Extraordinary Circumstances policy, which will apply across the three programs.

In addition to these proposals, CMS removed several existing measures to reduce redundancy and reporting burden, including *COVID-19 Vaccination Coverage Among Healthcare Personnel*, *Hospital Commitment to Health Equity (HCHE)*, *Facility Commitment to Health Equity (FCHE)*, *Screening for Social Drivers of Health (SDOH)*, and the *Screen Positive Rate for SDOH*.

These determinations are part of CMS's broader Digital Quality Measurement Strategy, which aims to transition to fully digital, interoperable quality reporting systems to improve data timeliness, accuracy, and usability while reducing the need for manual data abstraction.

Hospital Outpatient Quality Reporting (OQR) Program - pg. 1195

Updates to the Hospital OQR Program include adding a new quality measure and revising existing ones to better reflect current outpatient care practices. It also proposes removing measures deemed topped out, duplicative, or outdated.



For 2026, CMS is adding a new measure: *OP-40 – Excessive Radiation Dose or Inadequate Image Quality for Diagnostic CT in Adults*. This measure aims to enhance patient safety by monitoring radiation exposure and ensuring consistent image quality across all adult diagnostic CT scans.

Simultaneously, CMS will remove *OP-10 – Abdomen CT: Use of Contrast Material*, citing that performance on this measure is consistently high across hospitals, making it no longer helpful for distinguishing quality. Unlike OP-10, which is limited to abdominal imaging, OP-40 applies more broadly and is considered a more comprehensive indicator of imaging quality and safety. CMS is also reversing in its earlier plan to mandate reporting of OP-40: Excessive Radiation Dose or Inadequate Image Quality for Diagnostic CT in Adults; as a result of comments received during the rulemaking process regarding the burden that mandatorily reporting this measure would impose, it has will allow sites to voluntarily report this measure.

Rural Emergency Hospital Quality Reporting (REHQR) Program (p. 1523)

Acknowledging the unique challenges rural emergency hospitals face, CMS described its goal to ensure future REHQR program measures are clinically meaningful, feasible, and present minimal burden, and support data consistency. CMS finalized alignment of REHQR measures with those in the Hospital OQR Program and determined that OP-40 will be available for indefinite voluntary reporting beginning in 2026.

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