

September 12, 2025

Mehmet Oz, MD, MBA  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1834-P  
P.O. Box 8013  
Baltimore, MD 21244-1850

*Submitted electronically via <http://www.regulations.gov>*

Executive Summary: On behalf of over 39,000 orthopaedic surgeons and residents represented by the American Association of Orthopaedic Surgeons (AAOS), we appreciate the opportunity to provide feedback on the CY 2026 Hospital Outpatient Prospective Payment and Ambulatory Surgical Center proposed rule (CMS1834-P).

- **OPPS and ASC Payment Updates:** CMS proposes a 2.4% update to ASC payment rates for facilities that meet the relevant quality reporting requirements. AAOS supports continuation of the hospital market basket methodology for ASC updates on a permanent basis and agrees with excluding the 2% 340B remedy offset from ASC rate-setting. We also support broader use of complexity adjustments to better reflect orthopaedic services.
- **Inpatient Only List & Two-Midnight Rule:** AAOS strongly opposes eliminating the IPO List for all musculoskeletal procedures effective January 1, 2026. While some procedures (e.g., total shoulder and ankle arthroplasty) can safely move outpatient, many trauma and high-complexity procedures lack supporting data. CMS must use peer-reviewed evidence, patient factors, and physician discretion when removing procedures. We also urge clarification that the Two-Midnight exception applies to Medicare Advantage.
- **ASC Covered Procedures List:** AAOS supports clinically driven expansion of the ASC-CPL but urges safeguards to ensure only appropriate patients undergo surgery in ASCs. We also call for inclusion of add-on services, transparency in stakeholder nominations, and alignment of APC policies with the growing complexity of outpatient musculoskeletal procedures.
- **APC Group Policies:** AAOS supports the creation of a new Level 7 MSK APC to account for the higher resource needs of advanced joint replacement and trauma procedures. We note that the addition of more complex procedures to the ASC-CPL should be accompanied by corresponding updates to APC policies to ensure appropriate valuation and alignment of clinical and resource characteristics.
- **Payment for Devices:** AAOS encourages broader and more timely coverage of innovative devices under OPPI and TCET pathways, ensuring patient access to clinically effective technologies.
- **Non-Opioid Pain Relief Policies:** AAOS supports unbundling payment for non-opioid pain management from APCs but remains concerned CMS's interpretation of the NOPAIN Act is too

narrow. We urge CMS to include all FDA-approved non-opioid therapies commonly used in orthopaedic care.

- **Quality Reporting:** AAOS supports cross-program measures, including use of qualified clinical data registries, to reduce burden and improve consistency across programs.
- **RFI on Site-Neutral Payment Reform:** AAOS broadly supports reducing payment differentials across sites of service to promote efficiency and patient choice. However, reforms must be coupled with improvements to the physician fee schedule, regulatory relief, and safeguards for rural access to avoid unintended consequences for physician practices and patient care.

Dear Administrator Oz,

On behalf of over 39,000 orthopaedic surgeons and residents represented by the American Association of Orthopaedic Surgeons (AAOS), and the orthopaedic specialty societies and state societies that have co-signed below, we are pleased to provide comments in response to the proposed rule, Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Overall Hospital Quality Star Ratings; and Hospital Price Transparency, (CMS-1834-P) published in the Federal Register on July 17, 2025.

### **Updates to OPPS and ASC Payment Rates**

In the CY 2026 OPPS/ASC proposed rule, the Centers for Medicare & Medicaid Services (CMS) proposes to update OPPS payment rates for hospitals that meet applicable quality reporting requirements by 2.4%.<sup>1</sup> This increase is based on a projected hospital market basket percentage increase of 3.2%, reduced by a 0.8% productivity adjustment. Similarly, CMS proposes a 2.4% update to ASC payment rates for facilities that meet the relevant quality reporting requirements. This update also reflects the 3.2% projected market basket increase, offset by a 0.8% productivity adjustment. CMS has continued to apply the methodology of using the hospital market basket to update ASC payments since CY 2019 and extended this policy through CY 2025 in last year's final rule. AAOS consistently supported the use of the hospital market basket to determine ASC payment updates and urges CMS to adopt this methodology on a permanent basis to better reflect the costs associated with providing surgical services in ASC settings.

### ***Complexity Adjustments***

AAOS supports CMS taking a more expansive view of code combinations eligible for complexity adjustments, including both broader code pairs and clinically appropriate clusters of three or more codes, to better reflect the complexity and resource needs of certain orthopaedic services.

### **Changes in the Inpatient Only List and 2 Midnight Rule**

The AAOS is gravely concerned that CMS proposes to eliminate the Medicare Inpatient Only (IPO) List starting with all 269 musculoskeletal procedures effective January 1, 2026. This is a complicated clinical and policy decision, and we urge the Agency to consider the associated risks to Medicare beneficiaries before finalizing this drastic proposal.

As we have stated in previous comments, AAOS supports the removal of certain procedures from the IPO List for which there is evidence that they can safely be performed in the outpatient setting, such as

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<sup>1</sup> Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS). (2025, July 17). CY 2026 Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems Proposed Rule <https://www.federalregister.gov/documents/2025/07/17/2025-13360/medicare-and-medicaid-programs-hospital-outpatient-prospective-payment-and-ambulatory-surgical>

total shoulder arthroplasty and total ankle arthroplasty.<sup>2</sup> We agree with CMS that with developments in the practice of medicine, these procedures can safely be done in the outpatient setting. The AAOS believes that determining the appropriate setting of care should be done through the lens of patient safety and peer-reviewed evidence, and that physicians are best qualified for leading this individualized decision-making process with their patients. Importantly, we recommend that CMS clearly state in the regulatory text that removal of a procedure from the IPO List does not disqualify the procedure from being performed in the inpatient setting when clinically appropriate. Likewise, we urge CMS to clarify in the OPSS final rule that Medicare Advantage (MA) plans should also continue to cover these procedures in the inpatient setting when clinically appropriate with limited review or difficulty. Per the Contract Year 2024 Medicare Advantage and Part D Final Rule (CMS-4201-F) MA plan approval of inpatient admissions should be based on whether the complex medical factors documented in the medical record support medical necessity of the inpatient admission, under the two-midnight benchmark or the case-by-case exception.

AAOS is concerned about removal of certain procedures that do not have data to support the appropriateness of their performance in the outpatient setting. Finalizing this policy as proposed will mean that complicated procedures from major trauma, such as pelvic, acetabulum, hip and fragility fractures and amputations that are mostly done with heavy inpatient monitoring, will be paid in the outpatient setting. AAOS experts believe that even with advances in medical practice, such procedures cannot be safely done in the outpatient setting currently. Hence, AAOS asks that CMS set general criteria for procedure selection based upon peer-reviewed clinical evidence, patient factors including age, co-morbidities, social support, and other factors relevant to positive patient outcomes. Specifically, we support the following social factors be considered when determining the best setting for musculoskeletal procedures: “lives alone,” “pain,” “prior hospitalization,” “depression,” “functional status,” “high risk medications,” and “health literacy.”<sup>3</sup> In some cases, a patient may be clinically stable but lack the resources to care for themselves once they go home, especially after a same-day outpatient discharge. This can lead to an increased risk for adverse events or accidents that end in hospital readmission. We ask that CMS consider these criteria when forming guardrails around the performance of procedures in the outpatient setting in order to protect patients and facilitate proper post-surgical recovery. Also, we ask that CMS provide objective empirical data on the safety of such complicated

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<sup>2</sup> 1 Refer to:

1. “Neer Award 2016: Outpatient total shoulder arthroplasty in an ambulatory surgery center is a safe alternative to inpatient total shoulder arthroplasty in a hospital: a matched cohort study,” *Journal of Shoulder and Elbow Surgery*, T. J. Brolin, R. P. Mulligan, F. M. Azar, & T. W. Throckmorton, 26(2), 204-208 (2017).
2. “Ambulatory total shoulder arthroplasty: a comprehensive analysis of current trends, complications, readmissions, and costs,” *The Journal of Bone and Joint Surgery*, J. M. Cancienne, S.F. Brockmeier, L.V. Gulotta, D.M. Dines, & B.C. Werner, 99(8), 629-637 (2017).
3. “Outpatient total shoulder arthroplasty: a population-based study comparing adverse event and readmission rates to inpatient total shoulder arthroplasty,” *Journal of Shoulder and Elbow Surgery*, T.S. Leroux, B.A. Basques, R.M. Frank, J.W. Griffin, G.P. Nicholson, B.J. Cole, ... & Verma, N. N. 25(11), 1780-1786 (2016).

<sup>3</sup> Ohta, B, Mola, A, Rosenfeld, P and Ford, S 2016 Early Discharge Planning and Improved Care Transitions: Pre-Admission Assessment for Readmission Risk in an Elective Orthopedic and Cardiovascular Surgical Population. *International Journal of Integrated Care*, 16(2): 10, pp. 1–10, DOI: <http://dx.doi.org/10.5334/ijic.2260>

procedures that are rarely performed in the outpatient setting prior to allowing their removal from the IPO List.

It is also critical to consider the negative impact on access to treatment that will result from removing musculoskeletal procedures from the IPO List. In the experience of our members, the “option” for the outpatient setting becomes the justification for making it the default location for traditional Medicare, Medicare Advantage, and commercial insurers. This trend is highly problematic for patients with comorbidities and other social factors who should be candidates for inpatient care, but find their procedures tied up by insurance companies. Additionally, patients in rural areas tend to have less access to outpatient care, so eliminating the IPO List could complicate their ability to receive care if insurers curtail coverage of inpatient procedures.

We appreciate that CMS proposes to maintain the indefinite exemption period from the Two-Midnight rule for procedures that are removed from the IPO List. The Two-Midnight rule has long been a source of administrative challenge for our members as certain musculoskeletal procedures have been removed from the IPO List in prior years. By acknowledging the foremost expertise of physicians in determining the most appropriate site of care through this indefinite exemption along with other existing policies related to the Two-Midnight Rule, CMS is taking an important step toward increasing choice and improving quality of care. As with the IPO List, we ask that CMS consider the language used to state that the Two-Midnight exception applies to MA plans as well in the 2026 OPSS Final Rule. We urge CMS to remain focused on using clinically relevant criteria to ensure that the procedures removed from the IPO List are appropriate and safe and we oppose elimination of the IPO List over the next three years, including removing all musculoskeletal procedures from the IPO List on January 1, 2026 or in future years.

### **Proposed Ambulatory Surgical Center (ASC) Covered Procedures List (ASC-CPL) and Related Payment Policies**

AAOS has long supported expanding the ASC-CPL to include musculoskeletal procedures that can be performed safely in the ASC setting, based on patient needs and clinical considerations. We have previously supported the addition of procedures such as total shoulder arthroplasty and total ankle arthroplasty when evidence demonstrates they can be performed safely in the ASC. As stated above, we feel strongly that the IPO List should not be eliminated. However, once it has been determined through rigorous analysis on a procedure-by-procedure basis that a procedure can be safely and effectively performed in an outpatient setting and removed from the IPO List - as was done with the total joint arthroplasty procedures - we believe the choice of outpatient setting in which to perform a procedure must remain a clinical decision between a patient and their surgeon, rooted in patient safety, peer-reviewed evidence, and the physician’s judgment, not dictated by payment or policy constraints.

For CY 2026, CMS proposes to update the ASC-CPL by adding 276 surgery or surgery-like codes not currently on the CY 2025 IPO List and 271 mostly musculoskeletal codes currently on the IPO List if CMS finalizes their removal. CMS also proposes to revise the general standard criteria for adding

procedures to the ASC-CPL by retaining the condition that procedures be separately paid under the OPPS and relocating two existing standards to a new section outlining possible physician considerations in making site-of-service decisions: (1) the procedure is not expected to pose a significant safety risk to a Medicare beneficiary when performed in an ASC; and (2) standard medical practice dictates that the beneficiary would not typically require active medical monitoring and care at midnight following the procedure. Additionally, CMS proposes to relocate five general exclusion criteria to the new section of possible physician considerations: (1) generally result in extensive blood loss, (2) require major or prolonged invasion of body cavities, (3) directly involve major blood vessels, (4) are generally emergent or life-threatening in nature, and (5) commonly require systemic thrombolytic therapy. Surgical procedures meeting the revised criteria would be added to the ASC-CPL through future rulemaking. CMS believes this policy change will allow physicians to exercise their clinical judgement in assessing procedure safety, considering the patient's clinical profile, available surgical backup, and the facility's ability to promptly manage unforeseen complications.

While AAOS supports the intent of these changes insofar as they reinforce the primacy of the physician-patient relationship in determining the appropriate site of care, we caution that CMS must ensure patient safety remains at the forefront of this decision-making. As we have previously stated, it is imperative that only those patients who are strong candidates for the procedure have the option of undergoing surgery in the outpatient setting, including ASCs. Decisions should be guided by patient safety, peer-reviewed evidence-based medicine, and the clinical expertise of the operating physician, with careful consideration of patient complexity and co-morbidities. We urge CMS to ensure that these revisions to the standards and exclusion criteria do not dilute existing safety protections or overly accelerate expansion of the ASC-CPL absent robust clinical evidence.

AAOS does have concerns about access to ASCs and differing population health profiles of ASC patients versus hospital patients. According to research presented in the March 2025 MedPAC Report to Congress, more than 90% of ASCs are for profit and located in urban areas. Their concentration also varies significantly, with 35 ASCs per 100,000 Medicare and Medicare Advantage beneficiaries in Maryland to just 3 per 100,000 in rural locales including Kentucky and Vermont.<sup>2</sup> For those patients who are treated in ASCs, data presented in the March 2019 MedPAC Report reveals that they are by and large a less medically complex population.<sup>3</sup> If CMS moves forward with phasing out the IPO List despite AAOS' concerns, and expanding the ASC-CPL, AAOS advises CMS to account for these differences in population health at different sites of care by risk adjusting the reimbursement to ensure patients can receive care in the setting that is most appropriate.

In addition, we reiterate our longstanding call for transparency in the ASC-CPL recommendation process. Medical specialty societies like ours possess the clinical expertise to recommend procedures that can be safely performed in an ASC, and stakeholder recommendations are critical to an evidence-based, patient-centered expansion of the ASC-CPL. We urge CMS to publish in the proposed rule the full list of procedures nominated by stakeholders for addition to the ASC-CPL, even if CMS does not propose to add them, so that stakeholders have a meaningful opportunity to provide input on these decisions.

### **Proposed OPSS Ambulatory Payment Classification (APC) Group Policies**

AAOS has long maintained that musculoskeletal procedures removed from the IPO List, particularly joint replacement procedures, warrant assignment to a higher APC level due to their complexity and resource demands. In CY 2019, when CMS last proposed major changes to the MSK APCs, AAOS commented that total knee arthroplasty (TKA), and any future arthroplasty procedures removed from the IPO list, should be assigned to the highest APC level available. This applied to all procedures recommended by AAOS through prior OPSS rulemaking, including shoulder, ankle, and hip arthroplasty.

CMS is now proposing to add a new Level 7 Musculoskeletal (MSK) Ambulatory Payment Classification (APC 5117) by splitting the current Level 6 MSK APC (5116). The new level 7 APC would have a geometric mean cost of \$28,285.22, while APC 5116 would have a geometric mean cost of \$18,337.97. CMS notes that several HCPCS codes proposed for removal from the IPO List are currently assigned to APC 5116 and have significant claims volume, supporting creation of the additional Level 7 under the two times rule.

If CMS finalizing the proposal to eliminate the IPO List, despite AAOS' opposition to this proposal, AAOS does support CMS' subsequent proposal to add MSK APC 5117 which is warranted to account for greater preparation required for successful outpatient performance of procedures being removed from the IPO List, including discharge planning, care coordination, and durable medical equipment. Properly aligning APC placement with the complexity of those procedures is essential to maintaining access to high-quality care across all outpatient settings. Finally, we note that the addition of more complex procedures to the ASC-CPL should be accompanied by corresponding updates to APC policies to ensure appropriate valuation and alignment of clinical and resource characteristics.

### **Proposed OPSS Payment for Devices**

AAOS appreciates CMS's efforts to enhance access to innovative technologies for Medicare beneficiaries. We continue to encourage CMS to consider expanding the OPSS payment pathway for devices to encompass a more extensive list, increasing the frequency of Medicare coverage for new technologies that improve patient safety and outcomes. We reiterate our support for innovation and expanded coverage for devices that improve patient safety and outcomes in response to the Transitional Coverage for Emerging Technologies (TCET) coverage pathway.

We are pleased that CMS proposes to maintain the revised device edit policy implementation in CY 2025 which helps ensure claims submitted for device-intensive procedures include a device code and charge. We encourage CMS to finalize this policy in the CY 2026 OPSS Final Rule. Additionally, we support CMS's decision to maintain HCPCS code C9757 for outpatient facility reporting through 2026, and we urge CMS to consider preserving this code indefinitely to ensure continued Medicare beneficiary access to this innovative procedure.

### **Non-opioid Policies for Pain Relief Under OPPI and ASC Payment System**

AAOS supports CMS' proposal to continue its policy, as finalized in CY 2025, to provide temporary additional payments for certain non-opioid treatments for pain relief in the hospital outpatient and ASC settings. As we have stated previously, AAOS is supportive of the utilization of non-opioid pain management where appropriate and commends CMS for taking steps to improve access to these treatments. AAOS encourages CMS to consider a wide range of non-opioid treatments, including but not limited to intravenous acetaminophen, regional nerve blocks, icing wraps, transcutaneous stimulators, and topical analgesics. Additionally, we reiterate our support for incentivizing payment for alternative chronic pain management treatments such as acupuncture, chiropractic services, osteopathic manipulation, cognitive behavioral therapy, and physical therapy, when appropriate, in outpatient settings of care. AAOS continues to seek further clarity on whether the proposed separate payment applies to specific treatments commonly used in orthopedics, such as indwelling nerve catheters and cryoneurolysis (e.g., Iovera).

AAOS remains concerned that CMS is taking an inappropriately narrow approach to implement the NOPAIN Act, which risks limiting access to many safe and effective non-opioid therapies used in orthopaedic care. In particular, we are concerned with CMS' interpretation that in order to qualify for separate payment under the NOPAIN Act, products must have an explicit indication for use in the postsurgical setting. This is evident in the fact that CMS allows separate payment for the use of an injectable version of a non-steroidal anti-inflammatory drug (NSAID) that has the postsurgical indication on its label, but not the tablet form of the same medication, which does not. However, it is common for products to receive a broader label that indicates their ability to treat moderate or severe acute pain. These products often undergo clinical trials studying efficacy in patients experiencing moderate to severe acute pain and are approved with the intention of being used in every setting in which that pain is present, including after surgery. Unfortunately, CMS appears to believe that these products do not qualify for separate payment because their label does not specifically reference a postsurgical application. This approach violates the spirit and intent of the NOPAIN Act, which was to ensure patients could reasonably and easily access all FDA-approved, safe, and effective non-opioid treatment options that are indicated for moderate to severe pain and used in the post-surgical setting.

We urge CMS to broaden its interpretation of the statute and to establish a transparent process for adding new qualifying products. Doing so would increase use of non-opioid pain treatments in the postsurgical setting, decrease rates of opioid addiction occurring post-surgically, and save lives. It would also align well with this Administration's stated goal of addressing the opioid addiction crisis.

### **Cross-Program Proposals for the HOOR, REHRQ, and ASCOR Programs**

AAOS appreciates that CMS is looking to simplify the measure set and use cross-program measures. Specifically, we support the inclusion of the Information Transfer Patient Reported Outcome Performance Measure (PRO-PM) in these programs. We are also supportive of CMS' proposal to have ASCs use qualified clinical data registries to submit this quality data through the Hospital Outpatient Quality Reporting program.

### **Request for Information: Adjusting Payment under the OPSS for Services Predominately Performed in the Ambulatory Surgical Center or Physician Office Settings**

In response to CMS's request for information on site-neutral payment policies, AAOS broadly supports reform initiatives that minimize payment differentials for identical services that can be safely and effectively performed across two or more settings including a hospital outpatient department, ambulatory surgery center or physician office. We believe such reforms can curb inefficiencies, promote patient and physician choice, and stimulate much-needed competition within the healthcare system.

Nonetheless, AAOS strongly urges CMS to couple any such reforms with long-term structural fixes to the physician fee schedule (PFS). We are deeply concerned that hospitals will respond to site-neutral payment cuts through personnel reductions, including employed physicians. Without corresponding improvements to the PFS, it will not be economically feasible for these physicians to start or join independent practices, leaving them vulnerable to consolidation into private equity backed entities or large health insurance conglomerates. Any site-neutral payment reform should also be coupled with relief from regulatory and administrative burdens such as prior authorization, further freeing staff and financial resources for patient care.

Moreover, CMS should incorporate strict guardrails into any site-neutral methodology including regular reevaluation to ensure appropriate and fair payment rates, and preservation of physician discretion in determining the most clinically appropriate site of service.

In summary, AAOS continues to support the goals of slowing consolidation and protecting independent physician practices by reducing site-of-service differentials. However, these changes must be implemented thoughtfully and in tandem with broader reforms, otherwise they risk undermining the very physicians and practices they aim to support.

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Thank you for your time and attention to the concerns of the American Association of Orthopaedic Surgeons (AAOS) on the significant proposals made in the CY 2026 OPSS/ASC proposed rule. AAOS looks forward to working closely with CMS on further improving the payment system, and to enhancing the care of musculoskeletal patients in the United States. Should you have questions on any of the above

comments, please do not hesitate to contact Lori Shoaf, JD, MA, Vice President, AAOS Office of Government Relations at [shoaf@aaos.org](mailto:shoaf@aaos.org).

Sincerely,

A handwritten signature in black ink, appearing to read 'A. Bruggeman', with a stylized flourish at the end.

Adam Bruggeman, MD, MHA, FAAOS, FAOrthoA  
Chair, AAOS Council on Advocacy

This letter has received sign-on from the following orthopaedic societies:

American Osteopathic Academy of Orthopedics (AOAO)  
American Orthopaedic Foot & Ankle Society (AOFAS)  
American Orthopaedic Society for Sports Medicine (AOSSM)  
American Shoulder and Elbow Surgeons (ASES)  
American Society for Surgery of the Hand Professional Organization (ASSH)  
North American Spine Society (NASS)

Florida Orthopaedic Society  
Georgia Orthopaedic Society  
Illinois Association of Orthopedic Surgeons  
Massachusetts Orthopaedic Association  
Minnesota Orthopaedic Society  
Missouri State Orthopaedic Association  
North Dakota Orthopaedic Society  
Ohio Orthopaedic Society  
Oregon Association of Orthopaedic Surgeons  
Pennsylvania Orthopaedic Society  
South Carolina Orthopaedic Association  
Tennessee Orthopaedic Society  
Texas Orthopaedic Association  
West Virginia Orthopaedic Society  
Wisconsin Orthopaedic Society