ASCA
Ambulatory Surgery Center Association

Legislative and Regulatory Update

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Learning Objectives

- Highlight 2026 OPPS/ASC proposed rule developments.
- Examine proposed changes to the ASC Quality Reporting Program.
- Discuss legislation being considered that would impact ASCs.

Primary Areas of Focus

- Medicare Payment Policy
- ASC Quality Reporting Program
- Legislative Update

Medicare Payment Policy

2026 Proposed Payment Update

- **ASC Effective Inflation Update: 2.4%**
  - CMS to use hospital market basket index through 2026 (final year of trial)
  - Hospital Market Basket: 3.2%
  - Multi-factor productivity (MFP) adjustment: 0.8%
- **HOPD Effective Inflation Update: 2.4%**
  - Hospital Market Basket: 3.2%
  - Multi-factor productivity (MFP) adjustment: 0.8%
- **Secondary Rescaling Factor: 0.842**

2025 ASC-CPL Nomination Process

ASCA 2025 ASC-CPL Requests	Final ASC-CPL Additions for 2025
Cardiovascular Codes: • Electrophysiology Studies and Ablations: 93613, 93619, 93620, 93623, 93650, 93653, 93654, 93655, 93656 and 93657 • Peripheral Vascular — Diagnostic: 75630, 75710, 75716 and 75736 • Cardioversion and Transesophageal Echocardiogram: 92960 and 93355 ***Spine Codes:*** • Posterior Lumbar Inter-body Fusion: 22630 • Combined Posterior Lumbar and Posterior Lumbar Inter-body Fusion: 22633	***ADRC Therapy:*** • 0717T, 0718T ***Dental Codes:*** • D7251, D7280, D7320, D7321, D7410, D7411, D7412, D7413, D7414, D7415, D7450, D7451, D7460, D7461, D7471, D7485, D7521, D7530, D7540

2026 ASC-CPL Nomination Process

ASCA 2026 ASC-CPL Requests	Proposed ASC-CPL Additions for 2026
Cardiovascular Codes: • Electrophysiology Studies and Ablations: 93619, 93620, 93624, 93642, 93650, 93653, 93654, 93656 and 93724 • Cardioversion and Transesophageal Echocardiogram: 92960, 93312 and 93318 • Percutaneous Coronary Intervention (PCI): C9602, C9604 and C9607 ***Spine Codes:*** • Posterior Lumbar Inter-body Fusion: 22630 • Combined Posterior Lumbar and Posterior Lumbar Inter-body Fusion: 22633 ***Vascular Code:*** • Vascular Embolization or Occlusion: 37244	**276 Codes currently payable in HOPD** **271 codes moved directly from IPO** **ASCA Recommended Codes Proposed for ASC CPL:** ***Cardiovascular Codes:*** • Electrophysiology Studies and Ablations: 93650, 93653, 93654 and 93656 • Percutaneous Coronary Intervention (PCI): C9602, C9604 and C9607 ***Spine Codes:*** • Posterior Lumbar Interbody Fusion: 22630 • Combined Posterior Lumbar and Posterior Lumbar Interbody Fusion: 22633 ***Vascular Code:*** • Vascular Embolization or Occlusion: 37244

42 CFR 416.166(b) General Standards

Provides that covered surgical procedures are surgical procedures:

- *Specified by the Secretary and published in the Federal Register and/or via the Internet on the CMS website*
- *Are separately payable under the OPPS*
- *Would not be expected to pose a significant safety risk to a Medicare beneficiary when performed in an ASC*
- *And for which standard medical practice dictates that the beneficiary would not typically be expected to require active medical monitoring and care at midnight following the procedure.*

42 CFR 416.166(c) General Exclusion Criteria

Provides that covered surgical procedures do not include those surgical procedures that:

- *Generally result in extensive blood loss*
- *Require major or prolonged invasion of body cavities*
- *Directly involve major blood vessels*
- *Are generally emergent or life-threatening in nature*
- *Commonly require systemic thrombolytic therapy*
- *Are designated as requiring inpatient care under § 419.22(n)*
- *Can only be reported using a CPT unlisted surgical procedure code*
- *Or are otherwise excluded under § 411.15*

Proposed 42 CFR 416.166(b) General Standards

Provides that covered surgical procedures are surgical procedures:

- ~~*Specified by the Secretary and published in the Federal Register and/or via the Internet on the CMS website*~~
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Moved to new physician considerations section:

- *Would not be expected to pose a significant safety risk to a Medicare beneficiary when performed in an ASC*
- *And for which standard medical practice dictates that the beneficiary would not typically be expected to require active medical monitoring and care at midnight following the procedure.*

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Criticisms

Secondary Rescaling Factor: 0.842

- *Driving reductions in reimbursements for top procedure codes*
- *66984 (cataract removal) and 43239 (EGD biopsy) proposed for reductions*

ASC CPL Additions

- *Despite 547 codes proposed for addition, not all of ASCA's recommendations were included:*
  - *Cardioversion and transesophageal echocardiogram codes (92960, 93312 and 93318)*
  - *Electrophysiology studies and ablation codes (93619, 93620, 93624, 93642 and 93724)*

ASC Quality Reporting Program

Final 2025 Changes to ASCQR Program

- CMS adopted:
  - The **Facility Commitment to Health Equity (FCHE)** measure beginning with the CY 2025/CY 2027 payment determination period.
  - The **Screening for Social Drivers of Health (SDOH)** measure beginning with voluntary reporting in the CY 2025 reporting period followed by mandatory reporting beginning with the CY 2026 reporting period/CY 2028 payment determination.
  - The **Screen Positive Rate for Social Drivers of Health (SDOH)** measure beginning with voluntary reporting in the CY 2025 reporting period followed by mandatory reporting beginning with the CY 2026 reporting period/CY 2028 payment determination.
- ASC-20 retained

Proposed 2026 Changes to ASCQR Program

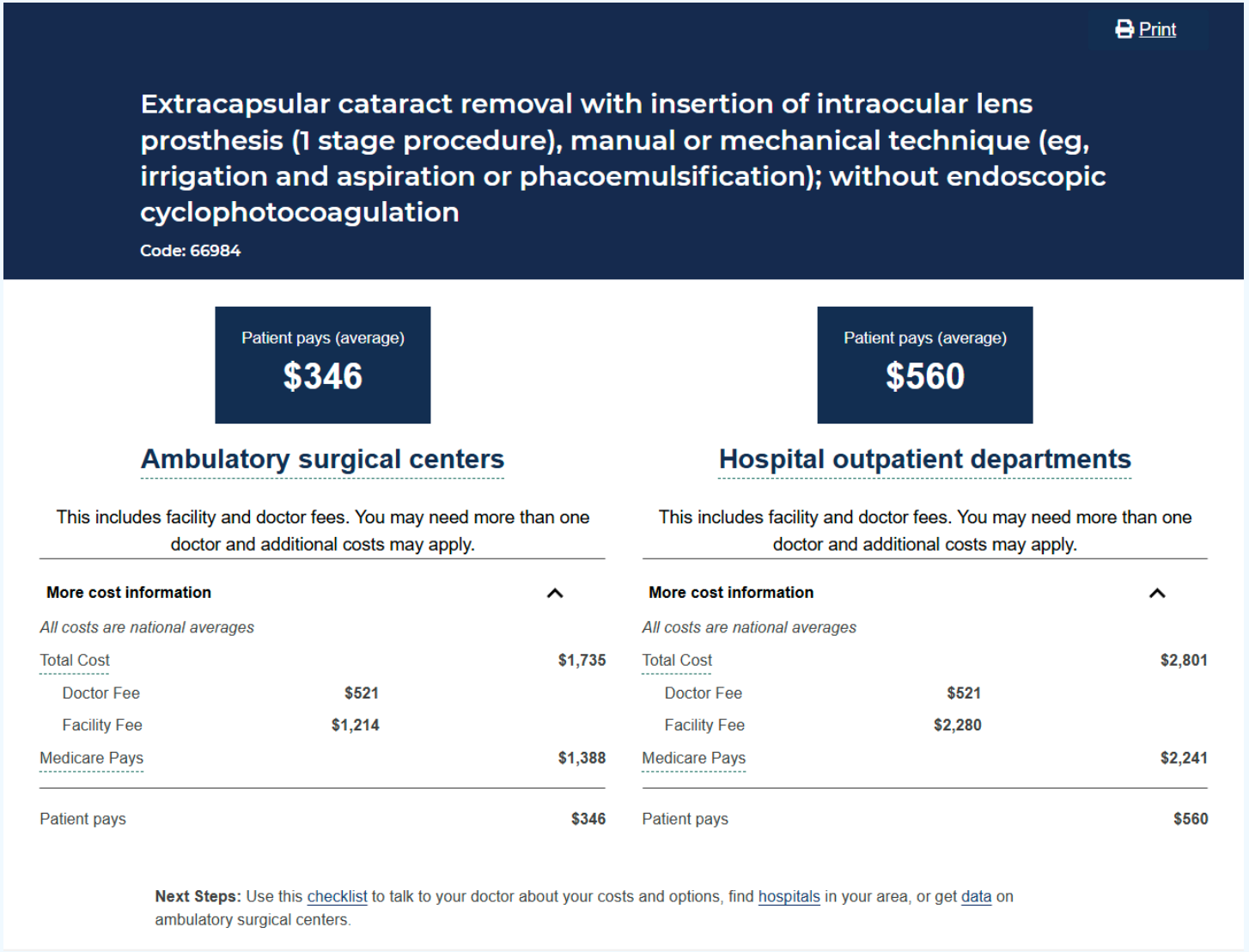
Proposed for Removal	Proposed for Addition
ASC-20: *COVID–19 Vaccination Coverage Among Healthcare Personnel (HCP)* ***ASC-22:*** *Screening for Social Drivers of Health (SDOH)* ***ASC-23:*** *Screen Positive Rate for SDOH* ***ASC-24:*** *Facility Commitment to Health Equity (FCHE)*	***Information Transfer PRO–PM:*** *Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery, Patient Reported Outcome-Based Performance Measure*

Legislative Update

New Congress, New Approach

- *Medicare Beneficiary Co-Pay Fairness Act (HR 3006/S 1776)*
  - Sole focus on eliminating co-pay cap penalty on Medicare beneficiaries when seeking care in ASCs
  - Introduced on April 24 and May 15 in House and Senate, respectively
- Second bill containing other provisions
  - CPI-U to HMB
  - Transparency re: ASC-approved procedures list
  - ASC weight scalar

ASC to HOPD Beneficiary Comparison



Print

Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); without endoscopic cyclophotocoagulation

Code: 66984

Patient pays (average)
$346

Ambulatory surgical centers

This includes facility and doctor fees. You may need more than one doctor and additional costs may apply.

More cost information

All costs are national averages

Total Cost		$1,735
Doctor Fee	$521	
Facility Fee	$1,214	
Medicare Pays		$1,388
Patient pays		$346

Patient pays (average)
$560

Hospital outpatient departments

This includes facility and doctor fees. You may need more than one doctor and additional costs may apply.

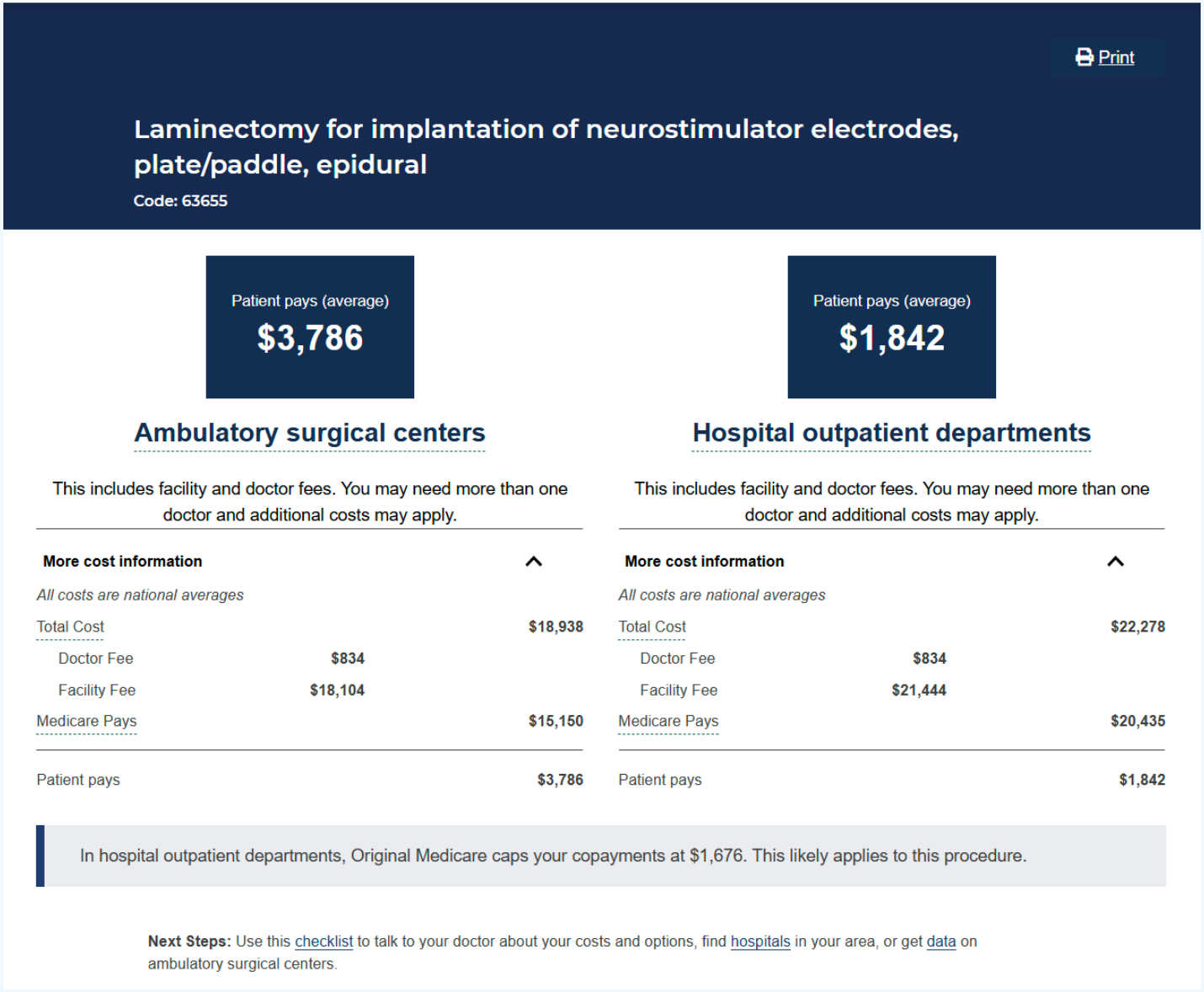
More cost information

All costs are national averages

Total Cost		$2,801
Doctor Fee	$521	
Facility Fee	$2,280	
Medicare Pays		$2,241
Patient pays		$560

Next Steps: Use this checklist to talk to your doctor about your costs and options, find hospitals in your area, or get data on ambulatory surgical centers.

Co-Pay Cap Issue



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Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural

Code: 63655

Patient pays (average)
$3,786

Ambulatory surgical centers

This includes facility and doctor fees. You may need more than one doctor and additional costs may apply.

More cost information

All costs are national averages

Total Cost		$18,938
Doctor Fee	$834	
Facility Fee	$18,104	
Medicare Pays		$15,150
Patient pays		$3,786

Patient pays (average)
$1,842

Hospital outpatient departments

This includes facility and doctor fees. You may need more than one doctor and additional costs may apply.

More cost information

All costs are national averages

Total Cost		$22,278
Doctor Fee	$834	
Facility Fee	$21,444	
Medicare Pays		$20,435
Patient pays		$1,842

In hospital outpatient departments, Original Medicare caps your copayments at $1,676. This likely applies to this procedure.

Next Steps: Use this checklist to talk to your doctor about your costs and options, find hospitals in your area, or get data on ambulatory surgical centers.

Same Care, Lower Cost Act (S. 1629)

- Evaluates HOPD, ASC and physician office volume over four-year period
  - HOPD volume highest: status quo
  - ASC volume highest: HOPDs drop to ASC rate; physician office remains on MPFS
  - Physician office volume highest: all drop to MPFS

Questions?

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