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August 27, 2025

The Honorable Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1834-P
P.O. Box 8010
Baltimore, MD 21244-8010.

Submitted online via www.regulatons.gov

RE: Code CMS-1834-P Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Overall Hospital Quality Star Ratings; and Hospital Price Transparency: Proposed Rule

Dear Administrator Dr. Oz:

The American Association of Oral and Maxillofacial Surgeons (AAOMS) representing more than 9,000 oral and maxillofacial surgeons (OMSs) across the United States, appreciates the opportunity to comment on the proposed CY 2026 revisions to the Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment Systems rule. We commend CMS for its continued efforts to improve access to high-quality, affordable healthcare. While AAOMS supports several aspects of the proposed rule, we also identify areas where further refinement could help reduce barriers to care across all settings.

Proposed Updates to OPPS and ASC payment rates

AAOMS supports CMS's proposal to increase facility rates for hospitals and ASCs that meet quality reporting requirements. This approach appropriately incentivizes high-quality care and aligns with value-based principles.

However, we urge CMS to consider the challenges faced by facilities serving vulnerable populations or operating in resource-constrained environments. Many such providers—including rural health clinics, Federally Qualified Health Centers (FQHCs), and smaller or independent ASCs—struggle with infrastructure limitations that hinder their ability to comply with reporting benchmarks, despite consistently delivering essential care.

In particular, ASCs that do not have certified electronic health record (EHR) systems face significant barriers to participating in quality reporting programs. The cost and complexity of implementing certified EHR technology can be prohibitive for many ASCs, especially those with limited financial margins or serving high-risk populations. Without alternative pathways or transitional support, these facilities risk being excluded from payment incentives, despite their commitment to safe, effective care. **We encourage CMS to explore flexible reporting options and targeted assistance to ensure that all providers—regardless of size or technological capacity—can participate meaningfully in quality improvement initiatives**.

Phased Elimination of Inpatient Only List

AAOMS appreciates CMS's proposal to begin phasing out the IPO list in 2026, starting with the removal of **285 procedures** which are primarily musculoskeletal in nature. This policy shift reflects a thoughtful and clinically grounded approach to modernizing Medicare payment systems and expanding access to care in more cost-effective settings.

By allowing these procedures to be reimbursed in the **hospital outpatient setting** and/or Ambulatory Surgical Centers (ASC) when deemed clinically appropriate, CMS is empowering physicians to exercise their professional judgment in selecting the most suitable site of service for each patient. This flexibility enhances patient-centered care and supports efficient resource utilization across the healthcare continuum.

We also strongly support CMS's proposal to **continue the exemption from certain medical reviews under the Two-Midnight Rule** for procedures removed from the IPO list. Maintaining this exemption ensures that providers are not penalized for exercising clinical discretion and facilitates a smoother transition for procedures newly eligible for outpatient reimbursement. We appreciate CMS's recognition that this exemption should remain in place **until the procedure becomes common in outpatient care**, allowing time for practice patterns and infrastructure to adapt appropriately.

Hospital Outpatient Covered Procedures

AAOMS commends CMS for its continued recognition of dental rehabilitation services, particularly the separately payable procedure G0330. The proposed payment rate of $3,402.23 reflects a meaningful step toward ensuring hospitals are adequately reimbursed for this medically necessary service. **To further expand access to outpatient dental care, we respectfully request that CMS add the following procedures to the list of covered outpatient services:**

- **D7440 – Excision of malignant tumor-lesion diameter up to 1.25cm**
- **D7441 – Excision of malignant tumor- lesion diameter greater than 1.25 cm**

These procedures are typically completed within an hour, do not involve major body cavities, and are well-suited for outpatient and ASC settings. Their CPT equivalents are already listed on the ASC Covered Procedures List and OPPS list, reflecting CMS's recognition of their appropriateness in the outpatient facility setting. However, Medicaid programs often require oral and maxillofacial surgeons to report via CDT codes, and the absence of D7440 and D7441

creates a reimbursement barrier for OMSs treating Medicaid patients in outpatient facilities. Including these CDT codes would promote equitable access and align policy across payer systems.

ASC Covered Procedures List (ASC CPL)

AAOMS supports CMS' proposal to move ASC exclusion criteria 1–5 to the physician considerations section, resulting in the addition of 276 procedure codes to the ASC-CPL. This change empowers providers to exercise clinical judgment in determining the most appropriate site of service, enhancing access to care while maintaining safety and efficiency.

AAOMS is particularly encouraged by the inclusion of 22 OMS codes based on the updated criteria and an additional 24 OMS codes from the IPO list. These additions recognize the evolving capabilities of ASCs and the specialized training of oral and maxillofacial surgeons. **We respectfully request that CMS consider adding the following procedures to the ASC-CPL:**

- **D7440 – Excision of malignant tumor-lesion diameter up to 1.25cm**
- **D7441 – Excision of malignant tumor- lesion diameter greater than 1.25 cm**
- **21195 – Reconstruction of mandibular rami, horizontal, vertical, or both; sagittal split**

These procedures are core components of OMS training and meet ASC-CPL inclusion criteria. They do not involve major body cavities, require complex anesthesia, or necessitate prolonged recovery. Including these codes would improve access to timely, cost-effective surgical care and ensure equitable reimbursement across payer types—particularly for Medicaid patients, where CDT code reporting is often required.

We also appreciate the proposed rate of $1,475.63 for dental rehabilitation (G0330) and CMS's continued recognition of the importance of dental rehabilitation services in the ASC setting. This adjustment reflects the complexity and resource intensity of dental rehabilitation and supports broader access for vulnerable patient populations.

Access to Non-Opioid Treatments for Pain Relief

AAOMS appreciates CMS's proposals to support separate payment for non-opioid pain relief treatments under the CY 2026 OPPS and ASC rule. The identification of specific drugs—Exparel, Omidria, Dextenza, Zynrelef, and Ketorolac—and devices such as ON-Q Pump, SPRINT Peripheral Nerve Stimulator, Cryo Nerve Block Therapy, ambIT Infusion Pump, Iovera System, and IceMan, reflects a thoughtful commitment to expanding multimodal pain management strategies and reducing opioid reliance.

We commend CMS for inviting public comment on additional drugs, biologics, or devices for inclusion. This inclusive approach allows stakeholders to share clinical insights and real-world experience, helping ensure that coverage decisions remain evidence-based and responsive to

patient needs. Continued dialogue with providers, researchers, and patient advocates will be essential to refining these policies and advancing safe, effective pain management.

Skin Substitutes

AAOMS supports CMS's proposal to unpackage skin substitute products from their associated application procedures and categorize them based on FDA regulatory status (361 HCT/Ps, PMAs, and 510(k)s). This alignment with product characteristics and regulatory pathways is a positive step toward recognizing clinical and resource differences and may foster innovation and competition.

However, we are concerned about the proposed use of a single payment rate across all three categories for CY 2026. This approach risks undervaluing products that have undergone rigorous FDA review, such as PMA-approved devices, which often involve higher development costs and stronger clinical evidence. A uniform rate may disincentivize innovation and limit access to clinically superior options.

We urge CMS to engage stakeholders—including clinicians, manufacturers, and patient advocates—to ensure future differentiated payment rates reflect the true clinical and economic value of each product type. Additionally, CMS should consider the operational impact on providers and offer transitional support to ease implementation. Thoughtful execution will be key to achieving policy goals without compromising access or quality of care.

Thank you for considering these comments. We look forward to continued collaboration with CMS to strengthen the outpatient care system and ensure that payment policies support both quality and sustainability. Please contact Patricia Serpico, AAOMS Director of Health Policy, Quality, and Reimbursement with any questions at 800-822-6637, ext. 4394, or pserpico@aaoms.org.

Sincerely,

J. David Morrison DMD

J. David Morrison, DMD
AAOMS President