2025 Medicare Outpatient and Ambulatory Surgical Center Final Rule

Background:

The Centers for Medicare & Medicaid Services (CMS) released the Calendar Year (CY) 2025 Medicare Outpatient Prospective Payment System/Ambulatory Surgical Center Final Rule on November 1, 2024. The rule takes effect on January 1, 2025.

What this rule will do:

The final rule updates policies for the device payment, the ambulatory surgical center covered procedures list, and the outpatient quality reporting program. Key changes include the following:

- **ASC Covered Procedure List (ASC-CPL) Transparency:** While AAOS appreciated CMS's efforts to clarify the process for submitting recommendations to the ASC-CPL, we urged the agency to enhance transparency by listing procedures submitted by stakeholders in the proposed rule, even if not proposed for inclusion. This would allow for more informed stakeholder feedback and contribute to a more inclusive decision-making process. Additionally, we advocated for the separate reimbursement of essential "add-on" services in ASCs, critical to patient safety. CMS explained that they examine clinical data on the procedures from multiple sites of services, reviewing literature and experiential data from public comments, and examining claims volumes to ensure procedures are not expected to pose a threat to patient safety when performed in an ASC. While CMS has not historically published pre-proposed rule recommendations for which they did not propose any changes, CMS does address and publish a list of all codes that are recommended during the public comment period in the OPPS/ASC final rule.
- **Inpatient Only (IPO) List Decisions:** AAOS remained concerned about the exclusion of certain services from the IPO list, advocating for decisions informed by expert clinical knowledge and peer-reviewed evidence. We stressed the importance of allowing surgeons to determine the appropriate surgical setting without the imposition of pre-authorization requirements, ensuring patient care remains paramount. CMS responded by explaining that they are open to suggestions from interested parties on improving the IPO list review process and reiterated that recommendations and changes to the IPO list are thoroughly reviewed by their clinicians.
- **Support for Device Payment Proposals**: AAOS supported CMS's proposals to enhance access to innovative medical devices through add-on payments for new technologies. We encouraged expanding this program to include a wider range of devices under the Transitional Coverage for Emerging Technologies (TCET) pathway, promoting competition and advancing patient care. In response, CMS finalized to apply a default device offset percentage that is the greater of 31 percent or the device offset percentage of the APC to which the procedure has been assigned for a new HCPCS code that describes a procedure that requires the implantation or insertion of a single-use device that meets the definition of a device for purposes of its device offset policy and for which the procedure lacks claims data (from either the new HCPCS code or any predecessor code).
- **Patient-Reported Outcome-Based Performance Measures (PRO-PMs):** AAOS appreciated the adoption of the Risk-Standardized PRO-PM for Elective Primary Total Hip Arthroplasty (THA) and Total Knee Arthroplasty (TKA). However, we urged CMS to extend the voluntary reporting period to four years, consider partial-year reporting options, and address the significant costs and infrastructure

challenges associated with PRO-PM implementation. We also recommended that CMS provide technical support, establish a reimbursement pathway for PRO-PMs, and consider the long-term impacts of the COVID-19 pandemic on data collection and reporting. In the final rule, CMS confirmed that they will not extend the voluntary reporting period. The mandatory reporting will begin with the CY 2028 reporting period.

- **Non-Opioid Pain Relief Policies:** AAOS commended CMS for proposing separate payments for non-opioid pain relief products under the OPPS and ASC payment systems, aligning with our long-standing support for non-opioid pain management. We encouraged CMS to clarify whether these payments will apply to specific orthopaedic treatments such as indwelling nerve catheters and cryoneurolysis, and to continue exploring alternative chronic pain management strategies. CMS finalized the policies for separate payment as proposed but did not clarify policies for specific orthopedic treatments.
- **Concerns with Prior Authorization Process:** AAOS supported the proposed alignment of Medicare Fee-For-Service (FFS) prior authorization review timeframes with Medicare Advantage standards but remained concerned about the overall burden of prior authorization. We recommended that CMS streamline the prior authorization process, enhance transparency, and ensure that these requirements are evidence-based and clinically appropriate to avoid delays in patient care. CMS finalized this policy, which will shorten the standard review timeframe from 10 business days to 7 calendar days but maintain the existing 2-business-day rule for expedited requests.
- **Hospital Outpatient Quality Reporting Program:** CMS finalized the adoption of the Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery PRO-PM beginning with voluntary reporting in CY 2026 and mandatory reporting in CY 2027, as well as the removal of the MRI Lumbar Spine for Low Back Pain measure since the performance on the measure was not tied to improved patient outcomes.

What Happens Next:

AAOS will continue to advocate for the policies we recommended as well as monitor CMS policy for changes.

For more information, contact Lori Shoaf in the AAOS Office of Government Relations at shoaf@aaos.org.
www.aaos.org/dc