AMERICAN ACADEMY OF
OTOLARYNGOLOGY–
HEAD AND NECK SURGERY®

September 10, 2025

SUBMITTED VIA ELECTRONIC MAILING

The Honorable Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1834-P, P.O. Box 8010
Baltimore, MD 21244-1850

Re: **CMS-1834-P; CY 2026 Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Overall Hospital Quality Star Ratings; and Hospital Price Transparency**

Dear Administrator Oz,

On behalf of the American Academy of Otolaryngology–Head and Neck Surgery (AAO-HNS)[1], I write in response to the calendar year (CY) 2026 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment Systems, as published in the July 17 version of the *Federal Register*. Our comments address the following issues within the proposed rule: I) Ambulatory Surgical Center Payment Updates; II) Changes to the List of ASC Covered Services; III) Ambulatory Payment Classifications (APCs); IV) Changes to the List of Device Intensive Procedures; and V) Changes to the In-Patient Only List.

I. Ambulatory Surgical Center Payment Update

Considering the COVID-19 public health emergency and its impact on both the economy and healthcare, we appreciate the Agency's thoughtful approach to ASC payment updates over the past three years. The Academy supports CMS's decision to extend the use of the hospital market basket update for the ASC payment system for an additional calendar year.

[1] The AAO-HNS is the world's largest organization representing specialists who treat the ears, nose, throat, and related structures of the head and neck. The Academy has approximately 13,000 members.

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II. Changes to the List of ASC Covered Services

The Academy appreciates the opportunity to review and comment on the changes to the APC classifications for Healthcare Common Procedure Coding System (HCPCS) codes relevant to the field of otolaryngology. We are pleased to see the Agency's continued recognition of the level of work, expertise, and resources required to effectively perform these procedures reflected in their APC classifications.

III. APC Classifications

A. 61885 - Cranial Nerve Stimulator

The AAO-HNS appreciates the opportunity to comment on the continued accuracy and effectiveness of the current APC classifications for cranial nerve stimulators, including *hypoglossal nerve stimulation*—a procedure widely performed by otolaryngologists and sleep surgeons to treat moderate-to-severe obstructive sleep apnea in adults.[2] We believe that innovation and technological advancements have significantly increased the cost of cranial nerve stimulators since the classifications were first established, and it is time to revisit the adequacy of the current APC levels.

The Academy's clinical experts note that the cost associated with hypoglossal nerve stimulators currently aligns with the high end of the level-5 APC value. Due to this and continuing technological developments, we urge CMS to consider a level-6 APC to adequately cover the costs associated with more expensive devices on the market. This adjustment would ensure that physicians are able to use the device that is most clinically appropriate for each patient, based on their expertise and training. An additional level of reimbursement would also allow more flexibility in device usage for relevant cases.

Adequate reimbursement in this space is essential not only for physicians but also for patients, ensuring access to the most appropriate treatment options for each patient's clinical needs. As technology advances and new devices enter the market, it will be critical for reimbursement options to support the

[2] AAO-HNS Position Statement: *Hypoglossal Nerve Stimulation for Treatment of Obstructive Sleep Apnea (OSA)*. Nov 13, 2019. https://www.entnet.org/resource/position-statement-hypoglossal-nerve-stimulation-for-treatment-of-obstructive-sleep-apnea-osa/

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availability of all clinically appropriate options—allowing physicians to make choices based on clinical judgment and ensuring the best quality patient care is delivered.

IV. Changes to the List of Device Intensive Procedures

The AAO-HNS appreciates the opportunity to comment on the "device intensive" status of procedures pertaining to otolaryngology. Specifically, we wish to comment on the addition of CPT code 31295 to the device-intensive list and the removal of CPT code 31298.

A. 31295 - Nasal/Sinus endoscopy, surgical, with dilation (eg, balloon dilation); maxillary sinus ostium, transnasal or via canine fossa

We fully support the designation of CPT code 31295 as "device intensive." This designation accurately recognizes the device costs associated with this procedure and results in a more appropriate payment.

B. 31298 - Nasal/Sinus endoscopy, surgical, with dilation of frontal and sphenoid sinus ostia (eg, balloon dilation)

The AAO-HNS has concerns regarding the removal of CPT code 31298 from the device intensive list. While we recognize that Medicare claims data indicate a significant change in the device offset percentage, we firmly believe that this procedure continues to involve a high device cost and should thus retain its "device-intensive" classification. We are concerned that continuing to reclassify this procedure each year characterizes ASC payments as unpredictable, which will threaten patient access to this procedure.

We respectfully urge the Agency to reexamine the Medicare claims data file for accuracy. Current data depict CPT 31296 [nasal/sinus endoscopy, surgical, with dilation of frontal sinus ostia (eg, balloon dilation)] with a 28.5% device offset. However, CPT 31298, which combines the frontal *and* sphenoid sinuses, is listed at only 27%. Relatively speaking, this procedure is more device intensive than CPT 31296, because it includes both the frontal *and* sphenoid sinuses. CPT 31298 should therefore have an offset greater than 30%, thus meeting the criteria to remain on the device intensive list.

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V. Changes to the In-Patient Only List

The Academy values the Agency's efforts to eliminate repetition and confusion in the inpatient space. Furthermore, we appreciate CMS's acknowledgment and commitment to deferring to clinician judgment when determining the appropriate site of service for a procedure. Based on this, we support the elimination of the Inpatient Only List over the next three years. Making this major change over time will allow providers and ASCs the opportunity to adjust their business practices over time, ensuring they remain viable and able to offer quality patient care.

Conclusion

The American Academy of Otolaryngology–Head and Neck Surgery appreciates the opportunity to provide comments and recommendations regarding these important policies on behalf of our members and their patients. We look forward to working with CMS as it continues its efforts to improve patient access to quality care and reduce regulatory burdens for clinicians. If you have any questions or require further information, please contact healthpolicy@entnet.org.

Sincerely,

Rahul K. Shah, MD, MBA
Executive Vice President and CEO
American Academy of Otolaryngology–Head and Neck Surgery