



Top 5 ASC Coding and Reimbursement Challenges

October 30, 2026



Today's Speakers:



Nancy Stephens

ASC Growth and Optimization
ASC Business Operations
Revenue Cycle Management
ASC Software Implementation



Kirk Mack, COMT, COE, CPC, CPMA

Coding & Documentation Audits
Compliance Training & Education
Investigation, Audit, & Appeals Response
Provider Benchmarking & Risk Assessment
Reimbursement Consulting & Analytics
Due Diligence



Today's Agenda

1. Drugs – documentation, reimbursement, & audits
2. Corneal tissue challenges
3. Collecting for upgrades cataract surgery
4. Coding and NCCI bundles/edits (cat III codes)
5. Chart note requests
6. Questions



Separately reported drugs



ASC Separately Reported / Payable Drug (*common*)

Drug	J – Code description dose	Units	ASP (Q4 2026)	Total pmt
Omidria	J1097 - Phenylephrine 10.16 mg/mL and ketorolac 2.88 mg/mL ophthalmic irrigation solution, 1 mL	4	\$96.06/unit	\$ 384.24
Dextenza	J1096 - Dexamethasone, lacrimal ophthalmic insert, 0.1 mg	4	\$87.90/unit	\$ 351.60
Durysta	J7351 - Injection, bimatoprost, intracameral implant, 1 microgram	10	\$213.80	\$ 2,138.00
Ozurdex	J7312 - Injection, dexamethasone, intravitreal implant, 0.1 mg	7	\$202.42	\$ 1,416.94
iDose	J7355 - Injection, travoprost, intracameral implant, 1 microgram	75	\$196.80	\$14,760.00



ASC Separately Reported / Payable Drug Documentation Standards

- Physician orders
- Dose, route, frequency
- Invoice/evidence of purchase
- Diagnosis
- Operative report
- Documentation of both used and/or wasted



Medicare FFS Medical Review

3 Connected Layers of Scrutiny

OIG Work Plan Identifies Risk: E/M Services on Same Day as Minor Surgery With No Modifier 25
National oversight priority that can inform CMS medical-review focus

Targeted Probe and Educate (TPE) – MAC-led

- Cataract Extraction (66984, 66982)
- Complex Cataract + Stent (66989)
- YAG capsulotomy (66821)
- Complex RD repair (67113)
- Skin Lesions (11440-11446)
- Drugs (J2278, J0178, J0585)
- E/M Services (99204, 99213, 99214, 99215)
- Modifier -25
- Botox (in office)

Supplemental Medical Review Contractor (SMRC) – National Review

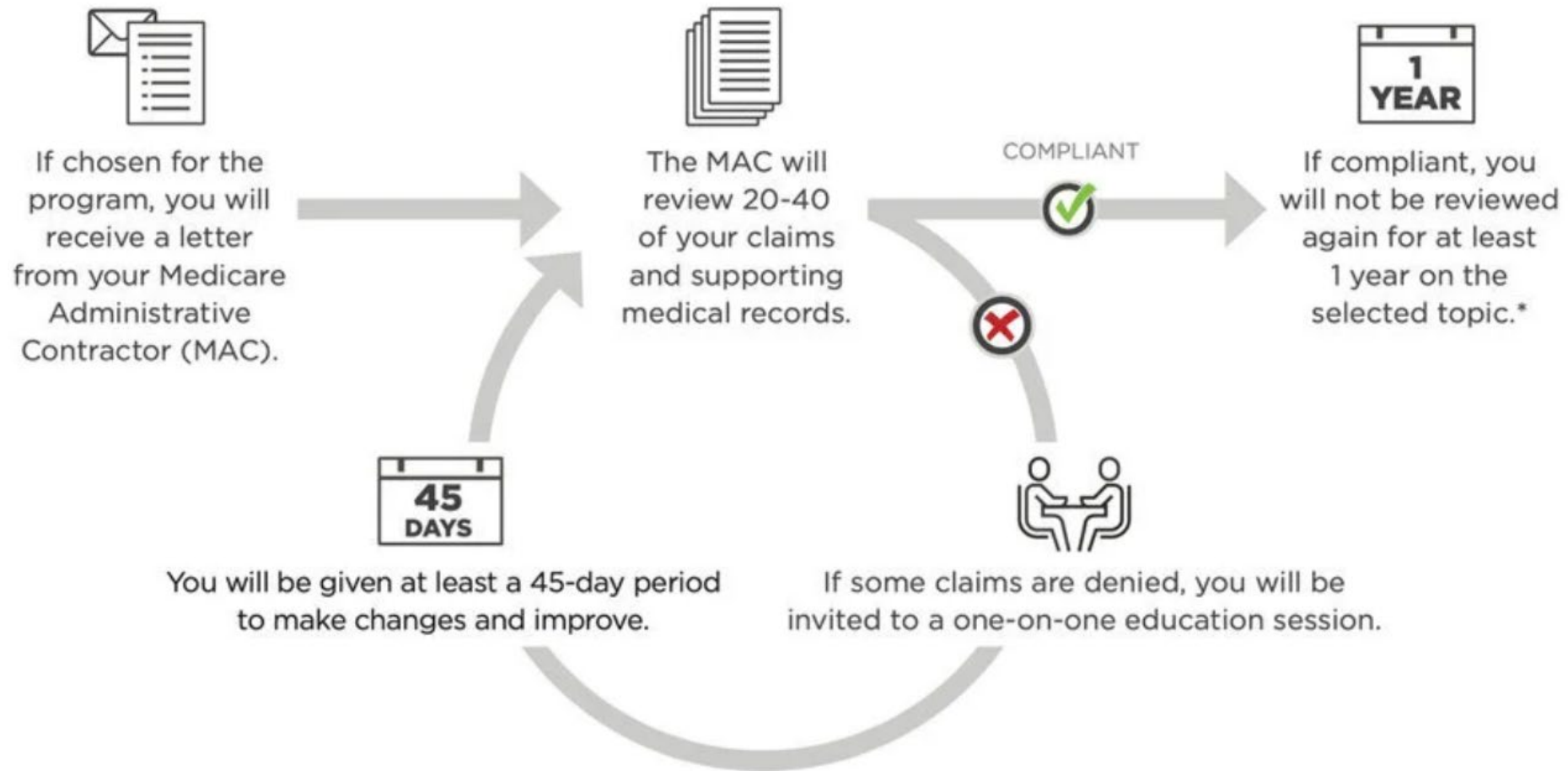
Noridian Healthcare Solutions serves as CMS's current SMRC

- Botulinum Toxins in the office setting
- OIG E/M Optometry Services in Nursing Facilities Notification of Medical Review
- OIG E/M Modifier -25 with eye injections (Completed March 2026)
- Cataract surgery (completed)
- Ophthalmology injections (completed)

NOTE: If you receive a TPE request *do not ignore it*



TPE Process | How does it work?



TPE Request

J1097 - Omidria

NORIDIAN
HEALTHCARE SOLUTIONS

Noridian Healthcare Solutions, LLC
P.O. Box 6713
Fargo, ND 58108-6713
Return Service Requested

54,1
EMC5

010/EMC5 052/EMC5

DATE: 09/24/2026

RE: [REDACTED]

DOCUMENT # 03402626712226266034620PR

DEAR DOCTOR OR SUPPLIER

ADDITIONAL DOCUMENTATION REQUEST

WE ARE PROCESSING A CLAIM FOR THOMAS PAULSON RECEIVED ON 09/23/2026, AND WE CANNOT COMPLETE THIS PROCESSING WITHOUT THE INFORMATION REQUESTED BELOW. PLEASE ANSWER EACH QUESTION AND RETURN THIS LETTER BY 11/08/2026. WE APPRECIATE YOUR ASSISTANCE.

PLEASE RETURN THIS LETTER WITH THE REQUESTED INFORMATION. IF THE REQUESTED INFORMATION HAS NOT BEEN RECEIVED BY 11/08/2026, PROCESSING OF THE CLAIM WILL BE DECIDED BY THE INFORMATION PRESENT. PAYMENT MAY BE REDUCED OR DENIED IF THIS INFORMATION HAS NOT BEEN RECEIVED.

PLEASE SUBMIT ALL APPLICABLE DOCUMENTATION TO SUBSTANTIATE SERVICES AS BILLED AND TO SUPPORT THE MEDICAL NECESSITY OF THE DRUG / ADMINISTRATION SERVICES, CODE J1097, RENDERED ON 09/21/2026. THIS MAY INCLUDE:

S02 32 377

- BENEFICIARY IDENTIFICATION, DATE OF SERVICE, AND PROVIDER OF THE SERVICE SHOULD BE CLEARLY IDENTIFIED ON EACH PAGE OF THE SUBMITTED DOCUMENTATION
- PRACTITIONER, NURSE, AND ANCILLARY PROGRESS NOTES
- PHYSICIAN ORDER FOR THE MEDICATION(S) ADMINISTERED WITH VALID PHYSICIAN SIGNATURE, INCLUDING DATE, DOSE, ROUTE AND FREQUENCY
- MEDICATION ADMINISTRATION RECORD (MAR) AND/OR INFUSION FLOWSHEET DOCUMENTING THE QUANTITY ADMINISTERED INCLUDE A DOSE, ROUTE, AND FREQUENCY GIVEN AND/OR MEDICATION INVOICE OR EVIDENCE OF FREE DRUG PROGRAM IF APPLICABLE



TPE Request

J1097 - Omidria

Phaco:

No Phaco documented.

MAR:

Medication Name	Dose	Unit	Schedule	Administer	Frequency	Lot	Initials	Expiration Date
1% Preservative-Free Lidocaine 1cc	1	Units	one time	OD	1		02:10 PM	
BSS	1	gtt		OD	1		02:10 PM	
Dexamethasone 1%/Moxifloxacin 0.5%/Ketorolac 0.4%				OD	1		02:16 PM	
Duovisc	1	Units	one time	OD	1		02:10 PM	
Omidria (ketorolac tromethamine 4.24 mg/ml (ketorolac 2.88 MG/ML) / phenylephrine HCl 12.4 mg/ml (phenylephrine 10.16 MG/ML) Concentrate for Ophthalmic Irrigation Solution				OD	1		02:10 PM	

1. Permit for: CATARACT EXTRACTION WITH INSERTION OF AN ARTIFICIAL LENS IMPLANT AND INSERTION OF GLAUCOMA STENTS

☐ Left

☒ Right

2. Vital signs upon admission to the ASC

3. Anesthesia Plan:

☒ with MAC ☐ without MAC

☐ Local; local anesthetic injection

☒ Topical; local anesthetic drops

☐ Regional; retrobulbar or peribulbar block

Medications:

☒ 1. Start IV as needed

☐ 2. IV Fluids: 0.9% Normal Saline at 25 ml/hr.

☒ Proparacaine 0.5% one drop prior to dilation

4. Upon arrival, dilate the operative eye with 2 drops of the following pledget mixture:

Tropicamide 1% ophthalmic drops

Cyclopentolate 1% ophthalmic drops

Phenylephrine 2.5% ophthalmic drops

5. MKO Melt Dose Pack per Anesthesia.

☐ Zofran 4mg IV once now for nausea.

6. Proparacaine 0.5% one drop as needed every five minutes up to three total doses for ophthalmic discomfort

7. Phenylephrine 10% one drop every five minutes as needed up to a total of three doses for poor dilation.

8. Obtain urine HCG upon admission if female patient of childbearing age and has not had a tubal ligation or hysterectomy or fill out a pregnancy refusal form. Notify surgeon/CRNA of results.

9. Perform blood sugar on admission for all Insulin Dependent Diabetics. If blood sugar <70 mg/dl or >300 mg/dl notify surgeon/CRNA



TPE Request

J1097 - Omidria

Procedure Note:

After appropriate preoperative consent was obtained, the patient was brought to the operating room and prepped and draped in the usual sterile fashion. Attention was then turned to the operative eye where a lid speculum was inserted. A drop of Tetracaine and a drop of 5% Betadine was administered. A paracentesis was made and intraocular lidocaine was instilled. Viscoelastic was instilled and a clear corneal wound was created. Capsulorrhexis was completed and hydrodissection was achieved. The lens was removed with phacoemulsification, and the remaining cortical material was removed with irrigation and aspiration. The capsular bag was filled with viscoelastic and an intraocular lens was inserted. At this point the operating microscope was brought into position and viscoelastic was inserted into the anterior chamber. A modified Swan-Jacob gonioscopy lens was placed on the eye using viscoelastic as a coupling agent. The injector was inserted into the anterior chamber through the clear cornea incision, making sure to avoid the wound lip. Under direct gonioscopic visualization, the injector tip was advanced into the trabecular meshwork and the leading trocar tip was placed through the center of the trabecular meshwork pigment band. A small amount of blood reflux was noted. With the injector tip firmly within Schlemm canal the trigger was depressed making sure to hold the tip in Schlemm canal. This process was repeated a **second and third** time to ensure the proper placement of **three** stents was achieved. The injector was carefully removed from the eye. Viscoelastic was used for adequate visualization and inspection of the eye stents. A small amount of blood reflux was noted at the time confirming proper placement. Once proper position of the **Stents** was assured, irrigation and aspiration of the remaining viscoelastic was performed. The wounds were hydrated and found to be watertight. An injection of Dexamethasone, Moxifloxacin, and Ketorolac was injected into the anterior chamber. A flush of 5% Betadine were given. **Omidria (Phenylephrine and Ketorolac 1%/0.3%) was added to the BSS solution and instilled throughout the procedure.** The patient was transferred to the PACU in stable condition and considered ready for discharge.

Tissue to Pathology: None



Corneal Tissue



Corneal Transplant Procedure and Supply

What is V2785?

V2785	Processing, preserving and transporting corneal tissue
65710	Keratoplasty (corneal transplant); anterior lamellar
65730	Keratoplasty (corneal transplant); penetrating (except in aphakia or pseudophakia)
65750	Keratoplasty (corneal transplant); penetrating (in aphakia)
65755	Keratoplasty (corneal transplant); penetrating (in pseudophakia)
65756	Keratoplasty (corneal transplant); endothelial

CONSIDERATIONS

- Eyebank invoice
- Full thickness cornea
- Endothelial pre-cut tissue



Corneal Transplant Procedure and Supply

Medicare

“Under the revised ASC payment system effective January 1, 2008, Medicare makes separate payment to ASCs for corneal tissue acquisition (which is billed using V2785). Contractors pay for corneal tissue acquisition based on acquisition cost or invoice.” The Healthcare Common Procedure Coding System (HCPCS) Level II Professional Edition defines V2785 as “Processing, preserving and transporting corneal tissue.”

MCPM Chapter 12§40 Payment for Ambulatory Surgery

What if the Medicare patient is in a skilled nursing facility (SNF)?



Corneal Tissue Reimbursement | Current Models

1

Pre-2008 ASC Groupers

Separate
tissue payment

2

APC or ASC Grouper Rates

Tissue included
in procedure
payment

3

APC or ASC Grouper Rates

Certain CPTs
carved out
with more
favorable rates



Cornea Tissue Reimbursement

What are my options if reimbursement is less than the cost of the tissue?

Yell at/blame the surgeon

Appeal and hope the payer aligns to Medicare

Review your contract

Renegotiate with payer – list all the advantages to payer and patient

Ask the eye bank for a discount

Charge the patient the difference



Cornea Tissue Reimbursement

What are my options if reimbursement is less than the cost of the tissue?

Yell at/blame the surgeon	<i>Not a good idea</i>
Appeal and hope the payer aligns to Medicare	YES
Review your contract	YES
Renegotiate with payer – list all the advantages to payer and patient	YES
Ask the eye bank for a discount	<i>Maybe</i>
Charge the patient the difference	NO!!

***Bundled/low pay does not shift to patient responsibility**



Cornea Tissue Reimbursement | Non-Medicare

Review your contract.

- Know the Medicare billing rules well - explain why you are seeking a Medicare-based contract.
- Equip yourself with information if you are forced to consider a “carve out” contract.
- Know your case costs for each type of keratoplasty (low, average, and high).
- Negotiate a price escalation clause into your contract to address inflation or technological advances. (Endothelial transplants such as DSAEK and DMEK were not being performed in ASCs when some contracts were initially negotiated, and corneal tissue preparation costs were not as high).
- Be persistent (this may take months.....)

If this fails, what are the options?

- **Discontinue**
- **Send to HOPD**



Collecting For Cataract Surgery Upgrades



Refractive IOLs (Astigmatic/Presbyopia Correcting)

History:

1. 2003 – Ruling 05-01:
Presbyopia correcting IOLs.
2. 2007 – Ruling CMS-1536-R:
Astigmatism correcting IOLs
3. Allowed beneficiaries to request an upgrade
4. ASC charge for “*insertion of the IOL is considered partially covered*”
5. CMS approved IOL list:
<https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitaloutpatientpps/downloads/pci-ol-aciol.pdf>

Questions/Issues:

- Who should collect for the upgrade?
- What is the ASC charging for and how much can the ASC charge?
- How do we handle the “partially covered” aspect?
- What about the femto-laser costs?
- Do we need an ABN or waiver?



Refractive IOLs (and Femto Laser)

Who should collect for the upgrade fee?

The beneficiary is responsible for payment of that portion of the facility charge that exceeds the facility charge for insertion of a conventional IOL following cataract surgery.

In addition, the beneficiary is responsible for the payment of facility charges for resources required for fitting and vision acuity testing of a presbyopia-correcting IOL that exceeds the facility charges for resources furnished for a conventional IOL following cataract surgery.

***ASC should collect directly from the patient to avoid any potential for AKS violation.**

Do we need an ABN/Waiver?

- Yes and No?!?!?
- CMS MLN 907165 Vision Services: voluntary
- AAO – “not required” due to statute

Best Practices:

- Use an ABN or Waiver to reduce confusion
- Clearly differentiate covered from non-covered services
- Defending against “buyer’s remorse” without ABN/waiver is difficult without a signed notification. (he said/she said)
- Difficult concept for patients to process



Refractive IOLs (and Femto Laser)

How much can the ASC charge?

- IOL is partially covered
- Determine value of covered portion (3 options)
 - \$150 (pre-2008 methodology)
 - V2632 - \$145.73 (Oct 2026 DMEPOS)
 - Avg monofocal IOL acquisition cost
- Modest/justifiable mark up on the implant

Option 1

ASC's cost for premium IOL:	\$1,200
Less std IOL (V2632):	<u>- \$ 146</u>
	\$1,054

Reasonable handling fee:	+\$ 50
Total patient charge:	<u>\$1,104</u>

Option 2

ASC's cost for premium IOL:	\$1,200
Avg IOL acquisition cost:	<u>- \$ 90</u>
	\$1,110

Reasonable handling fee:	\$ 50
Total patient charge:	<u>\$1,160</u>

Source | 1. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/downloads/cmsr0501.pdf>
2. <https://www.cms.gov/regulations-and-guidance/guidance/rulings/downloads/cms1536r.pdf>
3. <https://www.cms.gov/medicare/medicare-fee-for-service-payment/ascpayment/downloads/cms-pc-ac-iol-laser-guidance.pdf>
4. <https://www.cms.gov/medicare/payment/fee-schedules/dmepos/dmepos-fee-schedule/dme26-d>
5. https://www.aao.org/practice-management/news-detail/compliance-concerns-when-collecting-premium-iols?utm_source=chatgpt.com



Refractive IOLs (and Femto Laser)

What about the femto laser costs?

Medicare coverage and payment for cataract surgery is the same irrespective of whether the surgery is performed using conventional surgical techniques or a bladeless, computer controlled laser. Under either method, Medicare will cover and pay for the cataract removal and insertion of a conventional intraocular lens.

The use of radial keratotomy and/or keratoplasty for the purpose of refractive error compensation is considered a substitute or alternative to eyeglasses or contact lenses, which are specifically excluded by §1862(a)(7) of the Act (NCD 80.7)

Observations

- Additional Patient Charge for femto laser
 - Femto laser used in conjunction with an upgrade IOL to address presbyopia or astigmatism
 - Femto laser to treat astigmatism (AK, LRI) regardless of the IOL
- Using femto laser “alone” without addressing upgrade IOL or astigmatism correction does not support an additional charge



NCCI Edits & Category III



NCCI Edits

CMS developed the National Correct Coding Initiative (NCCI) program to prevent inappropriate payment of services that should not be reported together.

Each edit table contains edits which are pairs of HCPCS/CPT codes that in general should not be reported together.



NCCI Edits

Cataract extraction with anterior vitrectomy

**CHAPTER VIII SURGERY:
ENDOCRINE, NERVOUS, EYE AND OCULAR ADNEXA, AND AUDITORY SYSTEMS**

...the minimal vitreous loss occurring during routine cataract extraction does not represent a vitrectomy and is not separately reportable.

If an iridectomy or vitrectomy that is separate and distinct from the cataract extraction is performed for an unrelated reason at the same patient encounter, the iridectomy and/or vitrectomy may be reported separately with an NCCI PTP associated modifier.

CPT only copyright 2025 American Medical Association. All rights reserved

Column1/Column2 Edits				
Column 1	Column 2	*=in existence prior to 1996	Effective Date	Deletion Date
				*=no data
66984	67005	*	19960101	*
66984	67010		19961001	*



NCCI Edits

Blepharoplasty with ptosis surgery

**CHAPTER VIII SURGERY:
ENDOCRINE, NERVOUS, EYE AND OCULAR ADNEXA, AND AUDITORY SYSTEMS**

CMS payment policy does not allow separate payment for a medically necessary blepharoptosis procedure (CPT codes 67901-67908) and medically necessary blepharoplasty procedure (CPT codes 15822, 15823) on an ipsilateral upper eyelid. The NCCI program contains PTP edits that bundle blepharoplasty procedure CPT codes 15822-15823 into blepharoptosis procedure CPT codes 67901-67908.

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Column1/Column2 Edits				
Column 1	Column 2	*=in existence prior to 1996	Effective Date	Deletion Date
				*=no data
67904	15822		20090401	*
67904	15822		20001001	20090331
67904	15823		20090401	*
67904	15823	*	19960101	19960101
67904	15823		20001001	*



Modifiers 59, XE, XP, XS & XU

-59 - Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day.

XE —“Separate encounter, a service that is distinct because it occurred during a separate encounter.”
Only use XE to describe separate encounters on the same DOS.

XP —“Separate practitioner, a service that is distinct because it was performed by a different practitioner.”

XS —“Separate structure, a service that is distinct because it was performed on a separate organ/structure.”

XU —“Unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service.”

***This should be rare!
(fellow eye is the unicorn)**



Category III Codes

Category III CPT codes are a set of temporary codes for emerging technology, services, and procedures. These codes are intended to be used to track the usage of these services, and the data collected may be used to substantiate widespread usage in the Food and Drug Administration (FDA) approval process.

ASC Rates are published:

<https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-payment-rates-addenda>



Category III Codes

Addendum AA -- ASC Covered Surgical Procedures for CY 2026 (Including Surgical Procedures for Which Payment is Packaged)						
CPT codes and descriptions only are copyright 2025 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply. Dental codes (D codes) are copyright 2025 American Dental Association. All Rights Reserved.						
HCPCS Code	Short Descriptor	Subject to Multiple Procedure Discounting	October 2026 Payment Indicator	October 2026 Payment Weight	October 2026 Payment Rate	
0095T	Rmvl artific disc addl crvcl	N	N1			
0098T	Rev artific disc addl	N	N1			
0101T	Esw muscskel sys nos	Y	R2	2.4065	\$135.54	
0102T	Esw phy anes lat hmrl epcndl	Y	G2	29.2047	\$1,644.87	
0164T	Remove lumb artif disc addl	N	N1			
0165T	Revise lumb artif disc addl	N	N1			
0184T	Exc rectal tumor endoscopic	Y	G2	50.0600	\$2,819.48	
0200T	Perq sacral augmt unilat inj	Y	J8	83.7955	\$4,719.53	
0201T	Perq sacral augmt bilat inj	Y	G2	65.6144	\$3,695.53	
0202T	Post vert arthrplst 1 lumbar	Y	J8	184.9137	\$10,414.71	
0213T	Njx paravert w/us cer/thor	Y	R2	8.6202	\$485.51	
0214T	Njx paravert w/us cer/thor	N	N1			
0215T	Njx paravert w/us cer/thor	N	N1			
0216T	Njx paravert w/us lumb/sac	Y	R2	8.6202	\$485.51	
0217T	Njx paravert w/us lumb/sac	N	N1			
0218T	Njx paravert w/us lumb/sac	N	N1			
0219T	Plnt post facet implt cerv	Y	J8	190.8554	\$10,749.36	
0220T	Plnt post facet implt thor	Y	J8	168.5659	\$9,493.97	
0221T	Plnt post facet implt lumb	Y	J8	83.1343	\$4,682.29	
0222T	Plnt post facet implt addl	N	N1			
0232T	Njx platelet plasma	N	N1			
0238T	Trluml perip athrc iliac art	Y	J8	245.7610	\$13,841.75	
0253T	Insert aqueous drain device	Y	J8	55.1257	\$3,104.79	
0263T	Im b1 mrw cel ther cmpl	N	G2	42.4336	\$2,389.95	
0264T	Im b1 mrw cel ther xcl hrvst	N	G2	42.4336	\$2,389.95	
0265T	Im b1 mrw cel ther hrvst onl	N	G2	42.4336	\$2,389.95	
0274T	Prq lamot/lam dcmpr crv/thrc	Y	G2	65.6144	\$3,695.53	



Requests for Medical Records



Targeted Probe and Educate (TPE)

TPE Process:

1. Notice from MAC RE: identified issue
2. 20-40 claims identified and requested pre-payment
3. 30-45 days to submit (extension?)
4. Results
 - a. Pass – 1 year stay
 - b. Fail – Demand education (TPE)
 - i. 45 days repeat
 - ii. Possible 3 rounds
5. Fail 3 rounds – refer to MAC, UPIC, etc

Questions/Issues:

- Draft detailed cover letter explaining the situation
- Review medical record
- Submit requested
- Use sources/references (e.g., prescribing information, FDA approval, etc.)
- Make it easy for the CMS reviewer to understand and locate the necessary documents



Medical Records Request

1. Review the request to determine who sent the request and the basis for request
2. Confirm submission deadline
3. Gather the necessary documentation
 - Work with the surgeon's office (e.g., medical necessity)
4. Draft a cover letter to help the reviewer navigate
5. Ask for an extension if needed



Tips for a Successful Response

Build a strong case.

- Treat each request individually
- Draft a cover letter
- Include an acronym/abbreviations list
- Use screenshots/ highlight details
- Label each exhibit
- Each chart is organized similarly
- Tie it all together
- Make copies



What to Avoid

- No abbreviation list
- Verbiage not corresponding to the payer's guideline verbiage
- “See attached chart notes” instead of helpful verbiage
- Not providing quality copies, especially of tests
- Not labeling documentation for the payer



Summary / Key Takeaways

- Don't overlook drug documentation
- Review corneal tissue contracts
- Review current premium IOL process
 - Establish defensible fees
 - Look at charges for femto
 - Review/Revise ABNS to state why the patient is responsible
- Avoid breaking claim edits with -59 & -X modifiers
- Do not ignore or under-value a documentation request
 - Submit a detailed packet with cover letter



Additional questions?
Would you like to learn more?
Let's dive deeper. Contact us today!



CONTACT US:

 (800)-832-0609

 kirk.mack@vmghealth.com
nancy.stephens@vmghealth.com
support-asc@vmghealth.com

Thank you.



eSupport > Business Ops > Medicare Fee Schedule

2026 ASC Medicare Fee Schedule – Q4

Available to
eSupport
Members



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A number of variables determine your specific Medicare payment rates for procedures on the ASC-payable list. The average rate update highlighted in the proposed and final payment rules is an average across all covered procedures; individual procedures may increase or decrease by differing amounts.

The ASC Consulting team at VMG Health has worked to provide this tool that clearly and easily payment rates for ASC-payable procedures. By selecting your location, the calculator automatically wage index and calculates the total payment, Medicare payment and beneficiary copayment will update this tool as new rates are released by CMS, most notably in the summer for the p and in the fall for the final payment rule. New calculators are also posted if CMS provides ad payment rates at other times. So be sure to check back here periodically to ensure you have

This calculator shows your national and local payment rates for 2026. Simply look up your easy-to-use chart and type it into the calculator and the calculator does the rest.

- 2026 ASC Medicare Fee Schedule - Q4
- 2026 ASC Medicare Fee Schedule - Q3
- 2026 ASC Medicare Fee Schedule - Q2
- 2026 ASC Medicare Fee Schedule - Q1

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ASC - 2026 Medicare Payment Rates

CBSA Name: ALABAMA CBSA: 01 Wage Index 0.6367

HCPCS Code	Notes	Short Description	Subject to Multiple Procedure Discounting	Oct 2025 Payment Indicator	Oct 2025 Payment Weight	Oct 2025 Payment Rate	Oct 2026 ASC Payment Rate
66820		Incision secondary cataract					
66821		After cataract laser surgery	Y				
66830		Reposition intraocular lens	Y				
66840		Removal of lens lesion	Y				
66850		Removal of lens material	Y				
66852		Removal of lens material	Y				
66920		Extraction of lens material	Y				
66930		Extraction of lens	Y				
66940		Extraction of lens	Y				
66982		Extraction of lens	Y				
66983		Xcapsl ctrc mml cplx w/o ecp	Y				
66984		Cataract ctrc mml w/o ecp	Y				
66985		Xcapsl ctrc mml w/o ecp	Y				
66986		Insert lens prosthesis	Y				
66987		Exchange lens prosthesis	Y				
66988		Xcapsl ctrc mml cplx w/o ecp	Y				
66989		Xcapsl ctrc mml w/o ecp	Y				
66990		Xcapsl ctrc mml w/o ecp	Y				
66991		Ophthalmic endoscope add-on	Y				
67005		Partial removal of eye fluid	Y				
67010		Partial removal of eye fluid	Y				
67015		Release of eye fluid	Y				



CE Credit

VMG Health is approved by the California Board of Registered Nurses, Provider #17841 and BASC, Provider #1016.



RN	1 CE Contact Hour
CASC	1 AEU



Complete Course
Evaluation sent
via email by
**Friday,
November 27th**



Allow up to 2 weeks
to process your
certificates



Any questions
regarding CE Credit,
contact Customer Support
support-asc@vmghealth.com





PROGRESSIVE
SURGICAL
eSupport

POWERED BY  VMG HEALTH

The **leading**
online membership for
ASC nurse leaders who want
to run a compliant, efficient,
and profitable ASC **with confidence.**



less
RUNNING AN ASC CAN BE OVERWHELMING
^



Join our *Private* Facebook Group

A place to **connect**, **support**,
and **network** with other ASC
managers all over the country.



Upcoming Webinars

DATE		CE	WEBINAR TOPIC	SPEAKER
NOV 23	20		Staying Ahead of the Surveyor: Key Findings and Focus Areas for 2026	Lisa Nagle, RN <i>VMG Health</i>
DEC 18	60	RN, CASC	A Guide to ASC Risk Assessments	Debra Stinchcomb, MBA, BSN, RN, CASC <i>VMG Health</i>
JAN 11	20		2027 ASC Quality Reporting Update	Gina Throneberry <i>ASC Association</i>

Registration opens each month on vmghealth.com





2027 WEBINAR CALENDAR

