



# TRAUMA CENTER

Association of America

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September 15, 2025

The Honorable Mehmet Oz  
Administrator  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244

RE: Calendar Year 2026 Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems Proposed Rule (CMS-1834-P)

Dear Administrator Oz:

The Trauma Center Association of America (TCAA) is pleased to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule to update the Medicare Hospital Outpatient Prospective Payment System (OPPS) for Calendar Year (CY) 2026.

TCAA is dedicated to securing the viability and sustainability of America's Trauma Centers and systems of trauma care. The Association's vision would result in access to optimal trauma care for all. TCAA supports and represents 498 trauma centers across the country through advocacy, operations, finance, and educational opportunities. These trauma centers are staffed with specially trained health care providers who are experts in the care of severely injured patients. These providers may include trauma surgeons, neurosurgeons, orthopedic surgeons, cardiothoracic surgeons, and critical care physicians. Unlike other hospitals, hospitals with trauma centers must carry an array of specialty resources to treat injured individuals, such as availability of a trauma resuscitation area in the emergency department, operating rooms, blood banks, and comprehensive diagnostic testing.

In response to CMS's proposed rule, we wish to focus our comments on three areas: (1) recommended comprehensive ambulatory payment classification (C-APC) complexity adjustments; (2) the need for clarification in reporting the trauma team response code on outpatient claims; (3) policies related to falls and fracture care.

### C-APC Complexity Adjustments

TCAA has long been concerned that neither the Inpatient or Outpatient Hospital Prospective Payment Systems (IPPS and OPSS, respectively) adequately covers the actual costs of trauma care. In the proposed rule, CMS proposes to begin to phase-out the Inpatient Only (IPO) list of procedures covered and paid exclusively under IPPS. The first 285 procedures CMS proposes to remove from the IPO list and pay via OPSS are mostly musculoskeletal procedures. Traumatic injuries, like falls, often precipitate the need for musculoskeletal surgeries many of which may be able to occur with a short inpatient stay. Therefore, TCAA believes it is vitally important for CMS to acknowledge the cost of trauma teams with a complexity adjustment to C-APCs.

Currently, CMS limits the complexity adjustment solely to an evaluation of surgical Healthcare Common Procedure Coding System (HCPCS) codes having OPSS status indicator "J1." However, there are many services that have other non-surgical OPSS status indicators that explain patient acuity and resource utilization. Accordingly, TCAA asks that CMS consider the following HCPCS code for a complexity adjustment:

- G0390 for trauma activation with critical care. TCAA's preference is that CMS use UB-04 Form Locator 14 type 5 for cases having a trauma activation as often trauma activations must be properly billed under revenue code 068x without a HCPCS code. However, TCAA understands OPSS is a payment system based on HCPCS codes.

This HCPCS code is likely to explain significant resource utilization, but CMS is not likely to have claims data to test this given the 285 procedures are currently on the IPO list but are proposed to be removed. To properly recognize this code for complexity adjustment, TCAA asks CMS to use its equitable adjustment authority under section 1833(t)(2)(E) of the *Social Security Act* to recognize this code for C-APC complexity adjustment.

### **Clarification of Reporting Trauma Team Response on Outpatient Claims**

Elsewhere in this proposed rule and in last year's OPSS rule, CMS described inappropriate edits preventing hospitals from billing correctly coded UB-04 claims for services. Increasingly, our members who are verified and designated trauma centers report that claim edits prevent correct billing of an uncoded charge under National Uniform Billing Committee (NUBC) revenue code series 068x (trauma team activation), when the separately coded emergency department (ED) visit does not include Current Procedural Terminology (CPT) code 99291 for critical care. Indeed, one benefit of trauma centers is that they are able to provide specialized team care effectively stabilizing a patient in less than 30 minutes which is the durational threshold for billing CPT code 99291 for critical care. When CPT code 99291 cannot be billed, it does not necessarily mean the patient was not critical, but it could represent a critical care time of less than 30 minutes, per coding requirements. As noted above, the patient may proceed to an operating room in less than 30 minutes, again resulting in the separately billed ED visit not meeting criteria to be billed under CPT code 99291.

Because CMS created HCPCS code G0390 for the OPSS, clearinghouse and other payer edits increasingly misinterpret this to mean a trauma response charge cannot be billed under NUBC revenue code series 068x unless the ED visit includes critical care (indicated by CPT code 99291). This is inconsistent with NUBC. TCAA urges CMS to clarify that a trauma team response charge is allowed when CPT code 99291 is not reported.

As a reminder, when CMS established HCPCS code G0390 in the CY 2007 OPSS final rule, the agency stated:

.... [W]e see meaningful cost differences between critical care when billed with and without trauma activation, we will pay differentially for critical care when there is trauma activation associated with the critical care and when there is no trauma activation. This will improve the accuracy of payments as related to resource use. Trauma centers provide important local and regional health services and serve valuable roles in their communities through their well-developed emergency capabilities."<sup>1</sup>

TCAA agrees with CMS. Confusingly, the agency, via a December 2006 Change Request, said "...we believe that trauma activation is a one-time occurrence in association with critical care services."<sup>2</sup> TCAA

<sup>1</sup> CY 2007 OPSS Final Rule, 71 Fed. Reg. 67960, 68133 (Nov. 24, 2006).

<sup>2</sup> Transmittal 1139, Change Request 5438, January 2007 Update of the Hospital Outpatient Prospective Payment System (OPSS): Summary of Payment Policy Changes and OPSS PRICER Logic Changes and Instructions for Updating the Outpatient Provider Specific File (OPSF), Ctrs. for Medicare & Medicaid Servs. (Dec. 22, 2006), <https://www.cms.gov/regulations-and-guidance/guidance/transmittals/downloads/r1139cp.pdf>.

disagrees with this statement because correct coding and billing means trauma activation billed under 068x revenue codes occurs with or without critical care and moreover, often prevents a case from becoming critical per American Medical Association's (AMA) CPT definition.

TCAA urges CMS to succinctly restate its policy in the final rule that it is appropriate to report a trauma team response charge under revenue code 068x when pre-arrival notification and trauma center certifications per NUBC requirements are met, whether or not CPT code 99291 is separately reported for the ED. As a trade association who frequently educates their members on the proper billing of trauma activation codes, this clarity is essential for the organization and our members, who are increasingly frustrated by the undervaluation of their essential services. Given that our organization serves as a specialized resource on trauma coding/billing education for our large and varied membership across the country, we have observed significantly growing confusion on this issue in recent years, making clarification from CMS all the more necessary. We further note that this issue has downstream effects on commercial payor rates, as commercial payors often rely on Medicare policies to set their own payment guidelines. Therefore, the longer that a lack of clarity on the use of the trauma team response charge exists, the more common it will be for trauma services to be underpaid across payors.

### **Fracture Care and Prevention of Falls**

TCAA is particularly interested in CMS' Request for Information (RFI) in the CY 2026 Medicare Physician Fee Schedule (MPFS) proposed rule on how evidence-based care can prevent fractures and chronic conditions and disabilities from fractures for Medicare beneficiaries. TCAA will comment more in our comment letter to that proposed rule, but here we wish to remind CMS that TCAA has previously commented about the fact that falls are the single largest traumatic event for Medicare beneficiaries and trauma centers, and that TCAA believes it is important for CMS to engage in policies designed to prevent falls and mitigate the incidence of hip and extremity fractures, which are a major source of disability for seniors. Importantly, designated and verified trauma programs are required to engage in injury prevention. Accordingly, TCAA asks CMS to consider injury prevention as a requirement for any Center for Medicare and Medicaid Innovation (CMMI) models involving procedures for fractures.

As CMS is aware, data is key to developing evidence-based strategies for prevention of injuries and TCAA has repeatedly requested CMS require hospitals and clinicians report International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) code Z91.81 (History of falling for use when a patient has fallen in the past and is at risk for future falls). TCAA asks recommends that the agency find ways to improve hospitals' reporting of Z91.81 and to consider establishing an OPPS payable HCPCS code for fall prevention planning.

\* \* \*

Thank you again for the opportunity to comment on the CY 2026 Medicare OPPS proposed rule. Please contact Jennifer Ward, President of TCAA, via email at [jennifer@traumacenters.org](mailto:jennifer@traumacenters.org), with any questions or concerns.

Sincerely,

A handwritten signature in black ink that reads "Jennifer Ward". The signature is written in a cursive, flowing style.

Jennifer Ward  
President  
Trauma Center Association of America

A handwritten signature in black ink that reads "J. Kevin Croston, MD FACS". The signature is written in a cursive, flowing style.

J. Kevin Croston, MD  
Chair, Board of Directors  
Trauma Center Association of America