CY 2027 Medicare Physician Fee Schedule (MPFS) CMS-1848-P, Proposed Rule Summary

Introductory Summary and Background

On July 14, 2026, the Centers for Medicare & Medicaid Services (CMS) issued the proposed Calendar Year (CY) 2027 Medicare Physician Fee Schedule (MPFS) rule, CMS-1848-P. The full proposed rule is available at the following link: https://www.federalregister.gov/public-inspection/2026-14327/medicare-and-medicaid-programs-calendar-year-2027-payment-policies-under-the-physician-fee-schedule.

Key Proposals for IR

- The two conversion factors (CFs) for CY 2027 are proposed as follows:
  - Qualifying APM conversion factor, a decrease of $0.40 (-1.19%) from the CY 2026 CF to equal $33.1693.
  - Non-qualifying APM conversion factor, a decrease of $0.56 (-1.68%) from the CY 2026 CF to equal $32.8409.
- The efficiency adjustment factor implemented in CY 2026 will continue with no proposed changes.
- The site of service payment differential adjustment will continue, but CMS is seeking comments related to concerns raised about independent physicians and group practices not employed by hospitals.
  - CMS is seeking comments on indirect practice expense costs and whether a claim-level identifier could distinguish hospital-employed physicians from independent physicians for purposes of valuing PE overlap.
- CMS proposes to continue shifting practice expense (PE) relative value unit (RVU) establishment away from the American Medical Association (AMA) Relative Value Scale Update Committee (RUC) survey data.
  - Proposal to gradually eliminate the use of specialty-level PE RVUs in historical practice expense per hour (PE/HR) data. Replace with a PE stabilizer to reduce the fluctuations in values year-over-year.
  - Proposal for indirect PE (e.g., billing, scheduling, rent, IT) for all services to be allocated using the sum of both work and clinical labor RVUs, except for 10- and 90-day global periods. This is the current process for all codes with professional and technical components (e.g., diagnostic and imaging services). It would now also be applied to those services that are not split in this manner.
  - Remove Steps 12-17 of the PE methodology
  - Add a new Step 19 and renumber the current Step 19 as Step 20.
- CY 2027 estimated impact on total allowed charges by specialty would see interventional radiology with proposed increases at both the facility and nonfacility settings.
  - Total RVU impact = 3%
  - Nonfacility RVU impact = 5%
  - Facility RVU impact = 1%
- The following specific code and code set valuations reflect areas where SIR's CPT and RUC teams were key in achieving changes and code updates:

- Fine Needle Aspiration (FNA) CPT codes 10005 and 10006
    - CMS proposed accepting the RUC-recommended wRVUs (CPT 10005 wRVU of 1.35 and CPT 10006 wRVU of 1.00) and direct PE inputs with a change related to the portable US unit, creating a new equipment code for the higher valued unit.
- Intraosseous Fiducial Marker Placement (CPT codes 209X1 and 209X2)
    - CMS proposed accepting the RUC-recommended wRVUs (CPT 209X1 wRVU of 7.66 and CPT 209X2 wRVU of 1.76) and direct PE inputs.
- Sacroiliac Joint Arthrodesis (CPT codes 27278 and 27279)
    - CMS proposed accepting the RUC-recommended wRVUs (CPT 27278 wRVU of 3.00 and CPT 27279 wRVU of 11.00) and direct PE inputs.
- Treatment of Incompetent Veins (CPT codes 36470, 36471, 36465, 36466, 36473, and 36474)
    - CMS proposed accepting the RUC-recommended wRVUs (CPT 36470 wRVU of 0.73, 36471 wRVU of 1.18, 36465 wRVU of 2.29, 36473 wRVU of 3.41, and 36474 wRVU of 1.71) for all but code 36466 (wRVU of 2.62 reduced from 2.93), they have proposed a reduction. CMS did propose accepting the direct PE inputs without refinement.
- Prostate Biopsy (CPT codes 55705, 55707, 55708, 55709, 55710, 55711, 5XX14, 55714, and 55715)
    - CMS proposed accepting the RUC-recommended wRVUs (CPT code 55705 wRVU of 1.88, 55707 wRVU of 2.63, 55708 wRVU of 3.39, 55709 wRVU of 3.23, 55710 wRVU of 3.81, 55711 wRVU of 2.37, 55714 wRVU of 3.62, and 55715 wRVU of 1.80) for all but code 5XX14, which is a urology code, (wRVU of 0.68 reduced from 0.80) they have proposed a reduction. CMS did propose accepting the direct PE inputs without refinement.
- Percutaneous Lumbar Decompression (CPT code 62287)
    - CMS did not agree with the RUC-recommended wRVUs (wRVU of 7.06) and proposed a new value that is a reduction (wRVU of 6.23). CMS did propose accepting the direct PE inputs without refinement.
- Evaluation and Management (E/M) Visit Complexity Add-On (HCPCS code G2211)
    - CMS proposed to delete code G2211 and replace it with modifier MOD1.
- Vascular Embolization or Occlusion Procedure with Use of a Pressure-Generating Catheter (HCPCS code G0577)
    - CMS created a new code effective July 1, 2026, which allows OBLs to account for the technology utilized for vascular embolization or occlusion procedures.

- CMS has proposed to allow residents to perform more complex E/M visits (levels 4 and 5) under direct supervision of the teaching physician and still receive payment under the MPFS.
- CMS proposed that for any E/M visits billed on the same date as a 0-, 10-, or 90-day global procedure where modifier 25 is applied to the E/M visit, the service that is the lower reimbursed code would be paid at 50%, while the higher paid code would be paid at 100%. CMS is seeking comments on whether a 25% reduction would be more appropriate than 50%.
- CMS proposed to postpone the data collection related to 99024 (post-op follow-up visit) and whether they should expand its use to all physicians. Data supports physicians are not

performing the post-operative visits as valued by the RUC. They also provided a table of 10- and 90-day global procedures which include post-op visits valued and what they would look like if CMS reduced the number of visits. There are 22 interventional radiology procedures provided in a table below.

- Telehealth visit flexibilities will continue through December 31, 2027. CMS is creating two new modifiers "BB" and "CC", information on these modifiers will be provided by CMS outside of the rulemaking process.
- Current Procedural Terminology (CPT) Request for Information (RFI): CMS is seeking input regarding the ownership and copyrights of the Current Procedural Terminology (CPT®) system and that CMS relies on a private organization to develop and define the codes used for reporting medical services as well as provide the time, intensity, resources, and proposed values for the same services. Some have expressed concern about a potential conflict of interest. Some of these same entities have also recommended that CMS develop its own experts to recommend values and alternative sources of data.
    - CMS is seeking input on five main points for this RFI
- Request for Information (RFI) on Duplicate Laboratory Testing, Imaging, and Result Sharing and Interoperability: CMS is separately seeking input on strategies to reduce unnecessary duplicate diagnostic laboratory and imaging services while improving the interoperability of clinical information across the healthcare system.

Changes to the MPFS Payment Rates

Conversion Factor (CF)

Beginning in CY 2026, Section 1848(d)(1)(A) of the Social Security Act establishes two separate Physician Fee Schedule (PFS) conversion factors (CFs): one applicable to qualifying Alternative Payment Model (APM) participants (QPs) and another for clinicians who are nonqualifying APM participants. For CY 2027, CMS proposes a qualifying APM conversion factor that is $0.40 (1.19%) lower than the CY 2026 value. The proposed nonqualifying APM conversion factor also decreases, declining by $0.56 (1.68%) compared with the CY 2026 value.

CMS calculated the proposed CY 2027 conversion factors by starting with the CY 2026 conversion factors, excluding the one-time 2.50% statutory payment increase that applied only to CY 2026 services. The agency then applied the required budget neutrality adjustment of +0.53%, along with the statutory annual update factors of 0.75% for qualifying APM participants and 0.25% for nonqualifying APM participants. Based on this methodology, CMS estimates the CY 2027 Physician Fee Schedule conversion factors will be $33.1690 for qualifying APM participants and $32.8409 for nonqualifying APM participants.

The finalized factors and estimates are outlined below in Tables D-B1 and D-B2 from CMS, respectively:

TABLE D-B1: CALCULATION OF THE CY 2027 PFS QUALIFYING APM CONVERSION FACTOR

CY 2026 Conversion Factor		33.5675
Conversion Factor without One Year 2.50% Increase		32.7488
CY 2027 Qualifying APM Update Factor	0.75 percent (1.0075)	
CY 2027 RVU Budget Neutrality Adjustment	0.53 percent (1.0053)	
CY 2027 Conversion Factor		**33.1693**

TABLE D-B2: CALCULATION OF THE CY 2027 PFS NON-QUALIFYING APM CONVERSION FACTOR

CY 2026 Conversion Factor		33.4009
Conversion Factor without One Year 2.50% Increase		32.5863
CY 2027 Non-Qualifying APM Update Factor	0.25 percent (1.0025)	
CY 2027 RVU Budget Neutrality Adjustment	0.53 percent (1.0053)	
CY 2027 Conversion Factor		**32.8409**

Relative Value Units (RVUs)

Relative Value Units (RVUs) are assigned to all Current Procedural Terminology (CPT®) codes; RVUs are based on resource costs associated with physician work, practice expense (PE), and professional liability insurance (i.e., malpractice (MP)). The assigned RVUs are adjusted by geographic cost index (GPCIs) values, which reflect the variances in practice costs for locations throughout the country; essentially, how the cost-of-living impacts business costs. The Conversion Factor (CF) is a scaling factor used to convert geographically adjusted RVUs into dollar amounts.

The proposed CY 2027 Physician Fee Schedule (PFS) changes would affect specialties differently, with the largest impacts driven by updates to relative value units (RVUs) resulting from the misvalued code initiative, including valuations for new and revised CPT® codes. CMS projects the greatest positive payment impacts for clinical psychologists, clinical social workers, physical and occupational therapists, interventional radiologists, and vascular surgeons.

Additional payment increases for certain specialties are attributed to proposed revisions to HCPCS code G2211, the final phase of the behavioral health work RVU update, revised valuations for select services following recommendations from the American Medical Association (AMA) Relative Value Scale Update Committee (RUC) and CMS review, and updates to supply and equipment pricing.

CMS projects payment reductions for several specialties due to multiple proposed policy changes, including revisions to payment for services when modifier -25 is billed, removal of the Indirect Practice Cost Index (IPCI) from practice expense RVU calculations, and the continued implementation of previously finalized code-level valuation reductions. Specialties expected to experience decreases include dermatology, otolaryngology, orthopedic surgery, hand surgery, ophthalmology, podiatry, audiology, neurosurgery, portable X-ray suppliers, and plastic surgery.

CMS reminds readers that the specialty impacts in Table D-B5 reflect changes within the total pool of RVUs. The overall percentages are based on aggregate estimated allowed charges totaled across services by all providers for a specialty and compared to the previous year.

TABLE D-B5: CY 2027 PFS Estimated Impact on Total Allowed Charges by Specialty

(A) Specialty	(B) Total: Non-Facility/Facility	(C) Allowed Charges (mil)	(D) Impact of Work RVU Changes	(E) Impact of PE RVU Changes	(F) Impact of MP RVU Changes	(G) Combined Impact
Interventional Radiology	TOTAL	$545	0%	3%	0%	3%
	Non-Facility	$361	0%	5%	0%	5%
	Facility	$183	0%	1%	0%	1%
Radiology	TOTAL	$4,706	0%	2%	0%	2%
	Non-Facility	$2,075	0%	2%	0%	2%
	Facility	$2,631	0%	1%	0%	1%

Efficiency Adjustment for CY 2027

CMS reiterated its longstanding concerns regarding the process used to establish physician work relative value units (RVUs). While the agency frequently relies on recommendations from the American Medical Association's (AMA) Relative Value Scale Update Committee (RUC), it does not automatically adopt those recommendations. CMS has previously rejected RUC-recommended values when it determined they did not accurately reflect changes in physician time, intensity, or resource use.

The agency also continues to question the reliability of the RUC survey process, citing low physician response rates, variability in survey results, and the potential for selection bias among respondents. CMS further noted that many CPT® codes have never been evaluated through the RUC survey process, and when surveys are conducted, it can take several years before updated values are incorporated into the Medicare Physician Fee Schedule.

CMS maintains that physician work values should recognize improvements in efficiency over time. As physicians become more experienced performing non-time-based services, the agency believes those services generally require less time, effort, and complexity, which should be reflected in lower physician work RVUs.

Beginning in CY 2026, CMS implemented a 2.5% efficiency adjustment to physician work RVUs and intra-service physician time for all non-time-based services paid under the Medicare Physician Fee Schedule (MPFS). For CY 2027, CMS proposes to continue applying this adjustment across all non-time-based services. In addition, CMS proposes to apply the efficiency adjustment to newly established or revised non-time-based services for CY 2027 whose RUC-recommended values did not already account for expected efficiency gains.

Practice Expense

CMS reiterated its concerns with the current methodology used to establish practice expense (PE) relative value units (RVUs), which has historically relied on survey data developed through the American Medical Association (AMA). According to CMS, the existing approach is limited by low survey response rates, inconsistent data collection methodologies, and the lack of objective, empirical cost information. The agency believes these limitations are particularly evident in the specialty-specific practice expense data used to allocate indirect PE costs.

CMS indicated it is undertaking a multi-year effort to modernize the PE methodology by transitioning away from reliance on specialty survey data toward more objective, routinely updated, and auditable cost information. The agency believes this approach will improve payment accuracy, better reflect market conditions, increase transparency, and create opportunities to better align payments across outpatient care settings.

CMS is proposing to accomplish this by gradually eliminating the methodology that ties specialty-level PE RVUs to historical practice expense per hour (PE/HR) data collected in the 2007 Physician Practice Information Survey (PPIS). Instead, PE RVUs would continue to be calculated using existing service-level inputs, including physician work RVUs, direct practice expense inputs, and specialty-specific indirect allocators, but the final adjustment based on outdated PE/HR data would be phased out over several years. CMS proposes replacing this step with a practice expense stabilizer designed to reduce year-to-year payment fluctuations while allowing PE values to better reflect current practice costs.

Currently CMS utilizes billing data to identify the dominant specialties of a given service. This information is used when calculating the weighted averages to the results of the survey data from the RUC. When services are low volume or there are irregularities in the data, it can be challenging for CMS to accurately determine the specialty mix assignment. Generally, the timing of input from societies would happen during the comment period to the proposed rule. This process does not allow for a formal proposal of assigned specialties to be commented on.

CMS did not finalize any of the specialty assignments for low volume services for CY 2026, instead waiting for the CY 2027 proposed rule. CMS included Table A-B1 with the list of low volume services and the expected specialty assignments submitted for proposal. CMS also believes aligning with the February 10th deadline each year for submissions of any specialty changes for low volume services is most appropriate. The following is a portion of the table provided by CMS for comment. It has been shortened to focus on the radiology and vascular surgery services.

TABLE A-B1: PROPOSED NEW ADDITIONS TO THE EXPECTED SPECIALTY ASSIGNMENT LIST

HCPCS	Short Descriptor	Expected Specialty Assignment
34813	Femoral endovas graft add-on	VASCULAR SURGERY
35682	Composite byp grft 2 veins	VASCULAR SURGERY
35881	Revise graft w/vein	VASCULAR SURGERY
36474	Endovenous mchnchem add-on	VASCULAR SURGERY
61055	Injection into brain canal	DIAGNOSTIC RADIOLOGY
74415	Urography nfs drip&/bls w/nf	DIAGNOSTIC RADIOLOGY
76145	Med physic dos eval rad exps	INTERVENTIONAL RADIOLOGY

For CY 2027, CMS proposed for the indirect PE (e.g., billing, scheduling, rent, IT) for all services to be allocated using the sum of both work and clinical labor RVUs, except for 10- and 90-day global periods. The proposed indirect allocator is indirect PE percentage*(direct PE RVUs/direct percentage) + work RVUs + clinical labor RVUs. This is the current process for all codes with professional and technical components (e.g., diagnostic and imaging services). It would now also be applied to those services which are not split in this manner.

For the PE RVUs for facility-based services, as initiated in CY 2026 CMS reiterated, *"when work RVUs are used to allocate indirect PE to the facility RVUs, they are assigned at one-half the amount allocated to the non-facility PE RVUs for that same service."*

For CY 2027, CMS is proposing a 2-year phase-in for the removal of steps 12-17 of the PE methodology which relies on the indirect practice expense cost index (IPCI) when calculating PE RVUs. The agency believes the methodology favors the aggregate survey data of the specialty rather than the code level inputs and allocators. Year 1 half of the measured variation in the IPCI would be applied and then in year 2, the IPCI would not be applied.

CMS has also proposed a new Step 19: "Calculate *and apply the PE stabilization factor for each PE RVU by comparing the result of step 18 with the results of the prior year's PE RVUs from step 18."* The belief is the introduction of PE stabilization adjustment would remove the volatility in PE RVUs by "stabilizing" the year-to-year changes that often occur. A cap would be instated for any outliers where the increase or decrease would not exceed 5%. Codes which are new, revised, formerly contractor priced and now nationally priced, and revalued codes would be exempt from this proposed adjustment.

The current Step 19 would now be Step 20. Any significant RVU reductions for work, PE, and MP, ≥20% must be phased in over a 2-year period.

Site of Service Payment Differential

CMS is continuing its efforts to address perceived duplication of practice expense (PE) payments for services furnished in facility settings. Beginning in CY 2026, the agency implemented a site of service payment differential, which reduces the physician's PE RVUs in the facility setting to account for indirect practice expenses that CMS believes are already supported by the hospital or other facility.

Following implementation of the CY 2026 policy, CMS received significant stakeholder feedback indicating the site of service payment differential did not adequately account for independent physician practice models. Commenters noted that many physicians providing hospital-based services are employed by independent medical groups rather than hospitals and continue to incur their own administrative and overhead expenses. They expressed concern that the payment

reduction disproportionately affects these practices, potentially accelerating physician practice consolidation into hospital systems. While CMS acknowledged these concerns, the agency stated that it has not identified sufficient evidence to support broader changes to the policy at this time.

For CY 2027, CMS continues to seek stakeholder input on potential approaches to better align practice expense payments while avoiding duplicative reimbursement for services furnished in facility settings. Specifically:

1. How do PE costs vary for physicians and other professionals? Not only based on whether they practice in part or exclusively in a facility setting but also based on how their costs vary when they are employed by health systems, hospitals, or other entities.
    a. When a physician is employed by and practicing in a hospital, what portion of the indirect PE [coding, billing, and scheduling expenses] is associated with the PFS service, versus costs that are associated with the payment to the hospital, such as those paid under the OPPS?
2. What is the amount of indirect PE hospital-employed physicians incur when they furnish care within a facility?
    a. For these physicians, is the 50 percent indirect PE allocation accurate, or could it possibly be less than 50 percent, such as 0 percent?
3. Whether a new HCPCS modifier for employed physicians would be a reasonable way to identify and reduce facility PE from the services they perform in the facility setting, or whether there are other methods CMS could consider.
    a. What are the primary variables CMS should consider continuing to improve data sources, allocation methodologies, and payment rates across settings of care, to best reflect the resources involved in furnishing PFS services by professionals and suppliers operating in a complex marketplace, across settings of care?

CMS also provided an additional file that breaks down the impacted specialties by estimated percentage of the weighted total RVUs. This estimate shows that physicians of the same specialty may experience different reimbursement impacts due to practice patterns and site of service.

Distribution of Practitioners by % Change in Total RVUs and IMPACT Specialty, (weighted by total RVUs) NPRM2026 (using 2025 CCW claims)

Impact Specialty		Practitioner RVUs (millions)	% Change in Total RVUs *per practitioner*										
			< -%20	-20% to < -10%	-10% to < -5%	-5% to < -2%	-2% to < -1%	-1% to < 1%	1% to < 2%	2% to < 5%	5% to < 10%	10% to < 20%	>=20%
Total		**2,726**	**Share of Total Practitioner RVUs in Specialty**										
20	Interventional Radiology	3	0%	0%	0%	0%	0%	5%	30%	43%	15%	4%	2%
37	Radiology	34	0%	0%	0%	0%	0%	5%	56%	35%	2%	1%	0%

Specific Codes and Code Set Valuations

Within the CY 2027 proposed rule, CMS addressed multiple misvalued and/or proposed value changes to a specific series of new and established CPT codes. CMS explains that its rationale for the changes is based on values recommended by the Relative Value Scale Update Committee (RUC) and other organizations, which CMS utilizes for assistance in setting appropriate values for codes.

Fine Needle Aspiration (FNA) CPT codes 10005 and 10006

At the request of an interested stakeholder, the AMA Relative Value Scale Update Committee (RUC) re-evaluated CPT® codes 10005 (Fine needle aspiration biopsy, including ultrasound guidance; first lesion) and 10006 (each additional lesion) during its January 2026 meeting after identifying the services as potentially misvalued.

For CY 2027, CMS proposes to adopt the RUC-recommended physician work RVUs for both codes. The agency also accepted RUC's recommended direct practice expense (PE) inputs but proposed a modification related to the portable ultrasound equipment used to perform the procedures.

CMS reviewed an updated invoice submitted for the existing portable ultrasound equipment item (EQ250), which reflected an increase in price from $41,612.53 to $83,750.00. Based on its own market assessment, CMS concluded that current portable ultrasound pricing trends do not support such a significant increase. Rather than revising the value of the existing EQ250 equipment item, CMS proposes creating a new equipment item, ER130 *(Fine Needle Aspiration portable ultrasound),* that would be assigned specifically to CPT® codes 10005 and 10006.

HCPCS	Descriptor	Current Work RVU	RUC Work RVU	CMS Work RVU	CMS Work Time Refinement
10005	Fine needle aspiration biopsy, including ultrasound guidance; first lesion	1.42	1.35	1.35	No
10006	Fine needle aspiration biopsy, including ultrasound guidance; each additional lesion)	0.98	1.00	1.00	No

Intraosseous Fiducial Marker Placement (CPT® codes 209X1 and 209X2)

At the May 2025 CPT® Editorial Panel meeting, two new codes for reporting percutaneous intraosseous fiducial marker placement, 209X1 and 209X2, were created. These codes are not considered new technology, but codes to better define the work being performed for existing technology.

For CY 2027, CMS proposed the RUC-recommended values for work RVUs and the direct PE inputs without refinement.

HCPCS	Descriptor	Current Work RVU	RUC Work RVU	CMS Work RVU	CMS Work Time Refinement
209X1	Placement of localization marker(s) (eg, fiducial marker[s]), intraosseous, percutaneous, including imaging guidance, when performed; first target site	NEW	3.00	3.00	No
209X2	Placement of localization marker(s) (eg, fiducial marker[s]), intraosseous, percutaneous, including imaging guidance, when performed; each additional target site	NEW	1.76	1.76	No

Sacroiliac Joint Arthrodesis (CPT® codes 27278 and 27279)

At the May 2025 CPT® Editorial Panel meeting, CPT® code 27278 was revised to include imaging guidance, placement of placement of intra-articular structural bone graft, metal, and/or synthetic device(s) without cortical piercing; and CPT® code 27279 was revised to include placement of transarticular and/or intra-articular device(s) that engage bone with intrinsic fixation (eg, screw(s), flange(s), blade(s)) piercing the lateral cortex of the sacrum and the medial cortex of the ilium.

For CY 2027, CMS proposed the RUC-recommended values for work RVUs and the direct PE inputs without refinement.

HCPCS	Descriptor	Current Work RVU	RUC Work RVU	CMS Work RVU	CMS Work Time Refinement
27278	Arthrodesis, sacroiliac joint, percutaneous or minimally invasive, including imaging guidance, unilateral; placement of intraarticular structural bone graft, metal and/or synthetic device(s) without cortical piercing, including use of osteopromotive material and/or obtaining bone graft, when performed	7.66	7.66	7.66	No
27279	Arthrodesis, sacroiliac joint, percutaneous or minimally invasive, including imaging guidance, unilateral; placement of transarticular and/or intra-articular device(s) that engage bone with intrinsic fixation (eg, screw[s], flange[s], blade[s]) piercing the lateral cortex of the sacrum and the medial cortex of the ilium (with or without piercing the lateral cortex of the ilium), including use of osteopromotive material and/or obtaining bone graft, when performed	11.83	11.00	11.00	No

Treatment of Incompetent Veins (CPT codes 36470, 36471, 36465, 36466, 36473, and 36474)

CPT code 36465 was identified through CMS's potentially misvalued code screen after Medicare utilization increased by more than 100% between 2018 and 2023, with annual volume exceeding 10,000 services. As a result, the RUC reviewed the entire family of CPT codes describing sclerosant treatment of incompetent veins.

For CY 2027, CMS proposes to adopt the RUC-recommended physician work RVUs for five of the six codes in the family: 36465, 36470, 36471, 36473, and 36474. However, CMS does not agree with the RUC's recommendation for CPT code 36466. The agency noted that the recommended intraservice time decreased from 35 minutes to 30 minutes, while the work RVU remained unchanged. CMS stated that maintaining the existing work RVU would require evidence of increased physician intensity, which it believes was not demonstrated.

Instead, CMS proposes valuing CPT code 36466 by crosswalking it to CPT code 57156 *(Insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy),* resulting in a proposed reduction in the physician work RVU from 2.93 to 2.62 for CY 2027.

CMS proposed the RUC-recommended direct PE inputs for all CPT codes in this family without refinement.

HCPCS	Descriptor	Current Work RVU	RUC Work RVU	CMS Work RVU	CMS Work Time Refinement
36470	Injection of sclerosant; single incompetent vein (other than telangiectasia)	0.73	0.73	0.73	No
36471	Injection of sclerosant; multiple incompetent veins (other than telangiectasia), same leg	1.46	1.18	1.18	No
36465	Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; single incompetent extremity truncal vein (eg, great saphenous vein, accessory saphenous vein)	2.29	2.29	2.29	No
36466	Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; multiple incompetent truncal veins (eg, great saphenous vein, accessory saphenous vein), same leg	2.93	2.93	2.62	No
36473	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated	3.41	3.41	3.41	No
36474	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; subsequent vein(s) treated in a single extremity, each through separate access sites	1.71	1.71	1.71	No

Prostate Biopsy (CPT codes 55705, 55707, 55708, 55709, 55710, 55711, 5XX14, 55714, and 55715)

The prostate biopsy code family was initially reviewed and valued following the September 2024 RUC meeting. During that review, the specialty societies determined that the descriptors did not accurately reflect the services being performed and requested that the code family be returned to the CPT® Editorial Panel for revision and subsequent reevaluation. Because the revised codes were not available in time for the CY 2026 rulemaking cycle, CMS finalized interim values with the expectation that the updated code set would be reconsidered for CY 2027.

The revised prostate biopsy code family now consists of nine codes following the deletion of CPT code 55712.

For CY 2027, CMS proposes to adopt the RUC-recommended physician work RVUs for eight of the nine codes: 55705, 55707, 55708, 55709, 55710, 55711, 55714, and 55715. However, CMS does not agree with the RUC-recommended work RVU of 0.80 for the new add-on code 5XX14. The agency concluded that the recommended value is not appropriately relative to the other services in the

code family and would result in a work value nearly three times greater than the comparable add-on code, 55715. As a result, CMS proposes a lower physician work RVU for the new code. CMS does, however, propose to accept the RUC-recommended direct practice expense (PE) inputs without modification.

HCPCS	Descriptor	Current Work RVU	RUC Work RVU	CMS Work RVU	CMS Work Time Refinement
55705	Biopsy, prostate, any approach, nonimaging-guided	1.88	1.88	1.88	No
55707	Biopsy, prostate, transrectal, including imaging guidance, regional	2.63	2.63	2.63	No
55708	Biopsy, prostate, transrectal, including imaging guidance, regional and fusion-targeted lesion(s)	3.39	3.39	3.39	No
55709	Biopsy, prostate, transperineal, including imaging guidance, regional	3.23	3.23	3.23	No
55710	Biopsy, prostate, transperineal, including imaging guidance, regional and fusion-targeted lesion(s)	3.81	3.81	3.81	No
55711	Biopsy, prostate, transrectal or transperineal, including imaging guidance, fusion-targeted lesion(s) without regional; first targeted lesion	2.61	2.37	2.37	No
5XX14	Biopsy, prostate, transrectal or transperineal, including imaging guidance, fusion-targeted lesion(s) without regional; each additional targeted lesion (List separately in addition to code for primary procedure)	New	0.80	0.68	No
55714	Biopsy, prostate, including imaging guidance, in-bore CT- or MRI-guided; first targeted lesion	3.62	3.62	3.62	No
55715	Biopsy, prostate, including imaging guidance, in-bore CT- or MRI-guided; each additional targeted lesion (List separately in addition to code for primary procedure)	1.05	1.80	1.80	No

Percutaneous Lumbar Decompression (CPT® code 62287)

CPT code 62287 was initially recommended for deletion at the January 2025 RUC meeting due to declining utilization. However, after updated utilization data were presented at the May 2025 CPT Editorial Panel meeting, the neurosurgery and radiology societies requested that the code be retained and re-surveyed. As a result, CPT code 62287 was reviewed during the September 2025 RUC meeting after remaining in the code set.

For CY 2027, CMS does not agree with the RUC-recommended physician work RVU of 7.06 for CPT code 62287. The agency determined that the survey reflected a decrease in physician work time that was not adequately incorporated into the RUC recommendation. Instead, CMS proposes a work RVU of 6.23, based on a crosswalk to CPT code 46707 (Repair of anorectal fistula with plug). CMS also proposes adopting the RUC-recommended direct practice expense (PE) inputs without refinement.

HCPCS	Descriptor	Current Work RVU	RUC Work RVU	CMS Work RVU	CMS Work Time Refinement
62287	Decompression, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle-based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar	9.03	7.06	6.23	No

Evaluation and Management (E/M) Visit Complexity Add-On (HCPCS code G2211)

CMS finalized HCPCS code G2211 in the CY 2019 Physician Fee Schedule (PFS) final rule to recognize the additional resources associated with providing longitudinal, relationship-based care during office and outpatient evaluation and management (E/M) visits. Implementation of the code was delayed by the Consolidated Appropriations Act, 2021, and Medicare began reimbursing G2211 in CY 2024.

Since implementation, the policy has generated significant stakeholder concern, particularly from specialties affected by the budget neutrality reductions required to fund payment for the code. In reviewing utilization and resource assumptions, CMS concluded that many of the activities represented by G2211 are already inherent in the underlying E/M service and do not warrant a separately payable add-on code. Instead, the agency believes the longitudinal relationship between the practitioner and patient can be more appropriately identified through a modifier.

For CY 2027, CMS proposes deleting HCPCS code G2211 and replacing it with modifier MOD1. The modifier would be reported under the same clinical circumstances as G2211 but would eliminate the need for a separate line-item charge on the claim, reducing administrative burden. CMS also proposes minor revisions to the descriptor to better reflect the intended use of the new modifier.

G2211 2026 Descriptor	Modifier MOD1 2027 Descriptor
Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (add-on code, list separately in addition to home or residence or office/outpatient evaluation and management service, new or established)	Visit complexity inherent to new or established office/outpatient or home or residence evaluation and management service, associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition.

CMS also proposes a new methodology for valuing modifier MOD1 compared with the current payment approach for HCPCS code G2211. Rather than assigning a fixed payment amount, CMS proposes calculating payment for the modifier as a percentage of the value of the associated E/M service. CMS proposes to apply 16% of the base E/M code value for the add-on payment. According to CMS, this approach better preserves the relativity among E/M visit levels by preventing lower-level visits with the modifier from receiving higher total payment than higher-level E/M services. CMS included the following example to illustrate the proposed payment methodology.

TABLE A-D7: COMPARISON OF HCPCS CODE G2211 WITH BASE CODES

Base CPT code	Total NF RVU of HCPCS code G2211	Total NF RVF of Base CPT code	HCPCS code G2211 as percentage of base-code
99212	0.52	1.78	0.52/1.78: **29%**
99215	0.52	5.76	0.52/5.76: **9%**

Vascular Embolization or Occlusion Procedure with Use of a Pressure-Generating Catheter (HCPCS code G0577)

In April 2025, CMS established HCPCS code C9797 *(Vascular embolization or occlusion procedure with use of a pressure-generating catheter (eg, one-way valve, intermittently occluding), inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction)*. At the same time, CMS created HCPCS code C8004 (*Simulation angiogram with use of a pressure-generating catheter (eg, one-way valve, intermittently occluding), inclusive of all radiological supervision and interpretation, intraprocedural road mapping, and imaging guidance necessary to complete the angiogram, for subsequent therapeutic radioembolization of tumors*). Because these are C-codes, they are reportable and payable only under the Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) payment systems. Under the MPFS, physicians continue to report CPT code 37243 for vascular embolization procedures regardless of the technology used.

In response to stakeholder requests for office-based reimbursement that recognizes the additional resources associated with pressure-generating catheter technology, CMS implemented HCPCS code G0577, effective July 1, 2026. Unlike the C-codes, G0577 is payable under the MPFS, OPPS, and ASC payment systems and mirrors the services described by C9797. However, there is currently no equivalent code for C8004 that can be reported in the office-based laboratory (OBL) setting. CMS is seeking stakeholder feedback on whether a comparable code should be established for OBL reporting. The agency also noted that, as of the publication of the proposed rule, no hospital outpatient claims data are available for C8004.

For CY 2027, CMS proposes to value HCPCS code G0577 by linking its practice expense (PE) RVUs to the relationship between CPT code 37243 and HCPCS code C9797 under OPPS, while directly crosswalking the physician work RVUs and physician time from CPT code 37243. An updated Addendum B file published on July 16, 2026, now reflects contractor pricing for G0577, a change from the original posting on July 14, 2026. CMS indicated it will continue to monitor utilization and may revisit the valuation methodology if use of the technology increases over time.

HCPCS	Descriptor	Current Work RVU	RUC Work RVU	CMS Work RVU	CMS Work Time Refinement
G0577	Vascular embolization or occlusion procedure with use of a pressure-generating catheter (eg, one-way valve, intermittently occluding), inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction performed in the non-facility setting	NEW	Contractor Priced	Contractor Priced	Contractor Priced

Revisions to Teaching Physician Policy for Higher Level Evaluation and Management Services

Under current Medicare policy, evaluation and management (E/M) services may be billed when furnished by a resident without the teaching physician's physical presence in qualifying primary care centers, provided specific regulatory requirements are met. The teaching physician must continue to provide direct supervision and be immediately available if needed.

During the COVID-19 public health emergency (PHE), CMS temporarily permitted teaching physicians to satisfy the direct supervision requirement using real-time audio/video technology. Following the end of the PHE, this flexibility was retained only for lower- and mid-level office/outpatient E/M services. Since the implementation of the revised E/M coding guidelines, however, utilization has shifted, with level 4 visits becoming more common than level 3 visits.

In response to ongoing stakeholder requests, CMS proposes to expand this teaching physician exception for CY 2027. Specifically, the agency would allow all levels of office/outpatient E/M services furnished in qualifying primary care centers under 42 CFR § 415.174 to be provided by residents under the direct supervision of a teaching physician when clinically appropriate. To implement this change, CMS proposes removing the regulatory language that limits the exception to services of "of lower and mid-level complexity," thereby extending the policy to include higher-complexity E/M visits.

CMS also proposes corresponding revisions to 42 CFR § 415.174(a) to clarify that Medicare Administrative Contractors (MACs) may make Physician Fee Schedule (PFS) payment for specified E/M services furnished by a resident without the teaching physician's physical presence, provided all applicable requirements for the exception are satisfied.

Evaluation and Management Services and Potential Overlap with Other Services

Global surgical payment packages include the preoperative, intraoperative, and postoperative evaluation and management (E/M) services that are considered part of the procedure. As a result, E/M services are generally not separately payable on the same date as a procedure unless they represent a significant, separately identifiable service, which is reported using modifier 25.

CMS has long maintained policies to reduce payment for multiple procedures performed on the same patient during the same encounter through the Multiple Procedure Payment Reduction (MPPR). Under this policy, the highest-valued service is paid at 100%, while additional procedures are generally reimbursed at 50% of the otherwise applicable payment amount.

For CY 2027, CMS proposes extending this concept to office and outpatient E/M services reported with modifier 25 when furnished on the same date as a procedure with a 0-, 10-, or 90-day global period by the same physician or another physician in the same group practice. Under the proposal, the highest-paid service, either the procedure or the E/M visit, would be reimbursed at 100%, while the remaining service(s) would be reduced by 50%. CMS notes that this approach is intended to align payment for modifier 25 services with the existing MPPR methodology.

CMS is seeking stakeholder feedback on whether a 50% reduction is appropriate or whether a 25% reduction would better reflect the overlap in physician work. The agency also emphasized that providers should not alter scheduling practices solely to maximize reimbursement, as doing so could create unnecessary burden for beneficiaries. CMS indicated it will continue to use claims analytics to identify potentially inappropriate billing patterns and is requesting comments on whether additional payment policies are needed to discourage such practices.

Global Surgical Packages

CMS originally planned to transition all 10-day and 90-day global surgical packages to 0-day global periods beginning in CY 2015. However, the Medicare Access and CHIP Reauthorization Act (MACRA) prohibited implementation of that policy and instead directed CMS to collect data to better assess and value services included in global surgical packages.

Since then, CMS has undertaken several initiatives to evaluate the utilization of postoperative visits included in global payments. One effort required selected practices in nine states with 10 or more practitioners to report CPT code 99024 (Postoperative follow-up visit) when postoperative E/M services related to the original procedure were furnished. Based on the reported data, CMS found that only 4% of 10-day global procedures and 67% of 90-day global procedures had one or more documented postoperative visits.

CMS has also implemented policies to better track postoperative care when management is transferred from the operating surgeon to another practitioner, including the use of transfer-of-care modifiers and an add-on code to recognize the resources associated with postoperative management furnished by a different clinician.

For CY 2027, CMS proposes to defer additional mandatory reporting of CPT code 99024, stating that the data collected to date suggest postoperative visits included in many global surgical packages occur less frequently than assumed when the services were originally valued. The agency is seeking stakeholder input on whether broader reporting of CPT code 99024 should be required and whether alternative data sources could more accurately inform future valuation of global surgical services.

To support this discussion, CMS released the supplemental file CMS-1848-P Global Surgical Services Visit Summary, which compares current physician work RVUs for selected 10- and 90-day global procedures with projected values if the postoperative visits included in the global package were removed. The report also summarizes the findings from CMS's postoperative visit data collection. The table below highlights the interventional radiology procedures included in that analysis.

Global Surgical Services: Post-Operative Visit and Valuation Summary Statistics
(2024 Medicare fee-for-service claims)

April 29, 2026; RAND

HCPCS	Short Description (HCPCS)	Global Period	(A) Addendum B total wRVUs	(B) CMS pre-service wRVUs	(C) CMS immed. post-service wRVUs	(D) CMS post-op visit wRVUs	(E) CMS intra-service wRVUs [A-B-C-D]	(H) Time File visits (n)	(I) Time File wRVUs / visit [D/H]	(J) Median 99024-observed post-op visits	(L) Total wRVUs removing all post-op visits [A-D]	(N) Total wRVUs removing visits not observed, median [A-((H-J)*I)]
34705	Evac rpr a-biiliac ndgft	90	29.58	3.07	0.90	6.12	19.49	5	1.22	1	23.46	24.68
34706	Evasc rpr a-biiliac rpt	90	45.00	1.95	1.34	16.27	25.43	10	1.63	1	28.73	30.36
10160	Pnxr aspir absc hmtma bulla	10	1.25	0.49	0.22	0.48	0.06	1	0.48	0	0.77	0.77
22513	Perq vertebral augmentation	10	8.65	0.89	0.45	1.61	5.70	1.5	1.07	0	7.04	7.04

22514	Perq vertebral augmentation	10	7.99	0.89	0.45	1.61	5.04	1.5	1.07	0	6.38	6.38
36558	Insert tunneled cv cath	10	4.59	0.55	0.34	1.12	2.58	1.5	0.75	0	3.47	3.47
36561	Insert tunneled cv cath	10	5.79	0.42	0.34	1.12	3.92	1.5	0.75	0	4.67	4.67
36581	Replace tunneled cv cath	10	3.23	0.53	0.34	1.12	1.25	1.5	0.75	0	2.11	2.11
36589	Removal tunneled cv cath	10	2.28	0.45	0.34	0.82	0.68	1.5	0.55	0	1.46	1.46
36590	Removal tunneled cv cath	10	3.10	0.42	0.34	1.12	1.23	1.5	0.75	0	1.98	1.98
37765	Stab phleb veins xtr 10-20	10	4.80	0.64	0.31	0.97	2.88	1	0.97	0	3.83	3.83
37766	Phleb veins - extrem 20+	10	6.00	0.64	0.34	0.97	4.05	1	0.97	0	5.03	5.03
49440	Place gastrostomy tube perc	10	3.93	0.74	0.45	0.76	1.99	1	0.76	0	3.17	3.17
62264	Epidural lysis on single day	10	4.42	0.90	0.45	0.64	2.44	0.5	1.28	0	3.78	3.78
64612	Destroy nerve face muscle	10	1.41	0.22	0.11	0.48	0.59	1	0.48	0	0.93	0.93
64615	Chemodener v musc migraine	10	1.85	0.34	0.11	0.00	1.40	0	0.00	0	1.85	1.85
64616	Chemodener v musc neck dyston	10	1.53	0.34	0.11	0.00	1.08	0	0.00	0	1.53	1.53
64617	Chemodener muscle larynx emg	10	1.90	0.36	0.11	0.00	1.43	0	0.00	0	1.90	1.90
64624	Dstrj nulyt agt gnclr nrv	10	2.50	0.44	0.22	0.48	1.35	1	0.48	0	2.02	2.02
64633	Destroy cerv/thor facet jnt	10	3.32	0.56	0.22	1.61	0.93	1.5	1.07	0	1.71	1.71
64635	Destroy lumb/sac facet jnt	10	3.32	0.56	0.22	1.61	0.93	1.5	1.07	0	1.71	1.71
64640	Injection treatment of nerve	10	1.98	0.35	0.20	0.48	0.94	1	0.48	0	1.50	1.50

Payment for Telehealth Services

Telehealth Flexibilities and Modifiers

The Consolidated Appropriations Act (CAA), 2026 extends several Medicare telehealth flexibilities through December 31, 2027, including the waiver of geographic restrictions, the expanded list of

eligible originating sites, and the expanded list of practitioners authorized to furnish telehealth services.

The legislation also requires CMS to establish new modifiers to identify certain telehealth services. Specifically, modifiers BB and CC will be required on claims for telehealth services furnished through a virtual telehealth platform when the physician or practitioner contracts with, or has a payment arrangement with, the entity that owns the platform. These modifiers will also be required for telehealth services furnished incident to a physician's or practitioner's professional services.

CMS indicated that additional information regarding the use of modifiers BB and CC will be provided through future sub-regulatory guidance and posted on the agency's website.

Telehealth Originating Site Facility Fee Payment Amount Update

For CY 2027, CMS proposed to continue payment for telehealth services to the originating site. CMS uses the baseline rate set in 2002 of $20.00 and adjusts each year based on the percentage increase in the Medicare Economic Index (MEI). The proposed MEI for CY 2027 is 2.5 percent, resulting in a proposed originating site fee of $321.65 for HCPCS Q3014 (*Telehealth originating site facility fee*).

Virtual Presence of Teaching Physicians

CMS previously finalized a temporary policy permitting teaching physicians to satisfy the presence requirement virtually when supervising Medicare telehealth services involving residents. Under that policy, the teaching physician could be virtually present during the key portion of the service using real-time audio/video technology, provided the teaching physician, resident, and patient were each located in separate physical locations.

Stakeholders have indicated that the requirement for all three parties to be in different locations creates operational challenges, as it is common for either the resident or the teaching physician to be physically present with the patient during a telehealth encounter.

For CY 2027, CMS proposes to revise this policy to allow either the teaching physician or the resident to be in the same physical location as the patient, while continuing to permit virtual supervision via real-time audio/video technology. CMS generally interprets "physical presence" to mean that either the teaching physician or the resident is in the same room as the beneficiary. The agency is also seeking stakeholder feedback on whether additional scenarios should be considered under this policy.

CMS emphasized that documentation requirements would remain unchanged. Medical records must clearly indicate whether the teaching physician was physically present or participated through real-time audio/video technology and identify the specific portion of the service during which virtual supervision was provided.

Request for Information Current Procedural Terminology (CPT)

The American Medical Association (AMA) owns and maintains the Current Procedural Terminology (CPT®) code set, which CMS licenses under a royalty-free agreement for use in the Medicare program. Over the years, stakeholders have raised concerns about CMS's reliance on a privately developed coding system to define medical services and inform the valuation of physician work, time, intensity, and practice resources used in Medicare payment.

Some commenters have questioned whether this arrangement creates a potential conflict of interest and has encouraged CMS to expand the use of independent experts and alternative data sources when establishing payment values. Recommendations have included developing a more independent valuation process that relies on broader sources of clinical and utilization data rather than primarily on recommendations associated with the CPT® and Relative Value Scale Update Committee (RUC) processes.

CMS is seeking comments on the following:

1. What, if any, evidence is there for CMS to consider regarding the harms or challenges associated with AMA's monopoly over CPT-4 licenses for health care entities? Please cite potential improvements to patient care diverted or delayed due to AMA'S monopoly over CPT® codes, including inhibited innovations and acquisition or maintenance costs of CPT® licensure.
2. What, if any, evidence is there that the generation of CPT-4 codes follows a process of identification of medical necessity? What opportunities or examples from other populations, sites of care, or international health systems could instruct a process of identification of medical necessity in the CPT-4 code development process?
3. A combination of CPT-4 and HCPCS codes were formally adopted by HHS as the legal standard for national coding for physician and other services as part of implementing HIPAA (45 CFR 162.1002(a)(5)). If CMS were to revisit this standard in future rulemaking, which if any alternatives exist to CPT-4 for CMS to consider as part of the national coding standard for physician services? Would CMS need to specify a separate legal standard, or could CMS allow for private competition to supplement the existing CPT-4 coding standard?
4. What objective alternatives exist, or could be developed, to maintain a more objective process to the current AMA CPT® and RUC committee processes? How would these alternatives support or inhibit innovation?
5. What are the benefits and drawbacks of paying for physician procedural services on the basis of the underlying International Classification of Diseases, 10th Revision (ICD-10) procedure code, as an alternative to CPT-4 code? How could the International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) services be grouped or bundled into payment categories, similar to Medicare Severity Diagnosis Related Groups (MSDRGs), or Outpatient Prospective Payment System (OPPS) Ambulatory Payment Classifications (APCs)? What other alternatives exist for bundling or grouping procedural services?

Request for Information (RFI) on Duplicate Laboratory Testing, Imaging, and Result Sharing and Interoperability

CMS is seeking input from stakeholders (e.g., clinicians, laboratories, imaging health care providers, health systems, payers, health IT developers, and other interested parties) on strategies to reduce unnecessary duplicate diagnostic laboratory and imaging services while improving the interoperability of clinical information across the healthcare system. The agency notes that diagnostic results are frequently inaccessible outside the originating electronic health record (EHR), leading to delayed treatment, unnecessary repeat testing, increased Medicare spending, and, in the case of imaging, avoidable radiation exposure.

To address these concerns, CMS is considering several payment and policy options, such as:

- Clarifications to billing instructions to laboratories and imaging centers on parameters of

duplicate laboratory or imaging tests;

- Local Medicare Administrative Contractor (MAC) edits that would result in nonpayment or reductions in payment as applicable for duplicate laboratory or imaging tests;
- Use of payment integrity levers to recoup payments from health care providers and suppliers who performed duplicate laboratory or imaging tests; and
- Application of frequency limitations to certain tests where clinically appropriate.

CMS did indicate any future policies would need to ensure patients and beneficiaries have access to medically necessary repeat testing. CMS is seeking input on appropriate clinical exceptions, such as trauma, stroke, or other evolving emergencies. The agency is also requesting feedback on whether duplicate testing should be defined by specific timeframes or limited to certain diagnostic services.

CMS also highlighted interoperability as a key strategy for reducing unnecessary duplicate testing. The agency believes that broader exchange of diagnostic laboratory and imaging results through standardized, interoperable health information technology would improve care coordination and reduce redundant services. There are efforts by the Office of the National Coordinator for Health Information Technology (ONC) to advance interoperability standards but it has challenges, including inconsistent implementation of standards, fragmented imaging exchange, limited application programming interface (API) capabilities, patient matching, authentication, authorization, and continued reliance on outdated methods such as CDs and DVDs for image sharing.

CMS is exploring policies to encourage broader participation in national interoperability networks and is considering whether additional Medicare payment, quality, or participation policies could promote the electronic exchange of diagnostic information. The agency is seeking stakeholder feedback on incentives to support adoption of imaging and laboratory interoperability standards, expanded conformance testing and certification, accountability for providers whose failure to share diagnostic results contributes to avoidable repeat testing, and the potential establishment of minimum data-sharing requirements using standardized formats such as Fast Healthcare Interoperability Resources (FHIR) and Portable Document Format/Archive (PDF/A) as a condition of Medicare payment. CMS is also seeking comments on how these requirements could be implemented without creating undue burden for providers, particularly those in rural or resource-limited settings.

Submitting Comments

Comments to CMS regarding the MPFS proposed rule must refer to file code **CMS-1848-P** and be received no later than **5 pm EST on September 14, 2026**. Electronic and mail submissions are acceptable, electronic submissions are encouraged: https://www.regulations.gov/docket/CMS-2026-2377. Follow the instructions under the “submit a comment” tab.