CY 2027 Medicare Physician Fee Schedule (MPFS) CMS-1848-F, Final Rule Summary

Introductory Summary and Background

On November 4, 2026, the Centers for Medicare & Medicaid Services (CMS) issued the final Calendar Year (CY) 2027 Medicare Physician Fee Schedule (MPFS) rule, CMS-1848-F. The full final rule is available at the following link: https://www.federalregister.gov/public-inspection/2026-22743/medicare-and-medicaid-programs-calendar-year-2027-payment-policies-under-the-physician-fee-schedule.

Key Provisions for IR

- The two conversion factors (CFs) for CY 2027 were finalized as follows:
    - Qualifying APM conversion factor, a decrease of $0.62 (-1.83%) from the CY 2026 CF to equal $32.9548.
    - Non-qualifying APM conversion factor, a decrease of $0.77 (-2.31%) from the CY 2026 CF to equal $32.6286.
- The efficiency adjustment factor implemented in CY 2026 will continue with no changes.
- The site of service payment differential adjustment will continue, CMS sought comments related to concerns raised about independent physicians and group practices not employed by hospitals.
    - CMS did not modify the site-of-service payment differential for CY 2027. However, the agency acknowledged concerns that facility place of service may not accurately reflect whether physicians incur indirect practice expenses, particularly for independent physician groups, and indicated it may consider these issues in future rulemaking.
- CMS continued its shift away from reliance on historical specialty-level practice expense data and introduced a PE stabilization factor to limit year-to-year fluctuations.
    - CMS finalized changes to indirect PE methodology so that indirect costs (e.g., billing, scheduling, rent, IT) for all services 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 which are not split in this manner.
    - CMS finalized removal of Steps 12-17 of the PE methodology.
    - CMS finalized the addition of a new Step 19 implementing the PE stabilizer calculation.
- CY 2027 estimated impact on total allowed charges by specialty, estimate interventional radiology with increases in both the facility and nonfacility setting. 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.
    - Total RVU impact = 3%
    - Nonfacility RVU impact = 4%
    - Facility RVU impact = 1%

  These estimates reflect aggregate changes in RVUs and do not represent the expected payment change for every individual physician or practice; actual impacts will vary based on service mix and site of service.
- The following reflect specific codes and code set valuations that SIR's CPT and RUC Teams

were key in achieving many of the changes and code updates:

- Fine Needle Aspiration (FNA) CPT codes 10005 and 10006
    - CMS proposed and finalized 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.
    - CMS indicated based on comments the values could negatively impact interventional radiology practices and access to care, they would continue to work with the AMA and specialty societies, in particular interventional radiology, to monitor this for future rulemaking.
- Intraosseous Fiducial Marker Placement (CPT codes 20988 and 20989)
    - CMS proposed and finalized the RUC-recommended wRVUs (CPT 20988 wRVU of 3.00 and CPT 20989 wRVU of 1.76) and direct PE inputs.
- Sacroiliac Joint Arthrodesis (CPT codes 27278 and 27279)
    - CMS proposed and finalized the RUC-recommended wRVUs (CPT 27278 wRVU of 7.66 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 and finalized 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), which was finalized with the proposed reduction. CMS proposed and finalized accepting the direct PE inputs without refinement.
- Prostate Biopsy (CPT codes 55705, 55707, 55708, 55709, 55710, 55711, 55714, 55715, and 55716)
    - CMS proposed and finalized 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). New code 55716, which is a urology code, proposed wRVU of 0.68 reduced from RUC-recommended 0.80 was finalized at reduced value. CMS proposed and finalized 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 and finalized a reduction (wRVU of 6.23). CMS proposed and finalized the direct PE inputs without refinement.
- Evaluation and Management (E/M) Visit Complexity Add-On (HCPCS code G2211)
    - CMS proposed and finalized deletion of code G2211 and replaced it with modifier B1 and B2.
    - CMS finalized as proposed the valuation of modifier B1 to be 16% of the E/M visit value rather than a flat rate.
    - CMS finalized modifier B2, valued at 32% of the associated E/M visit value, for qualifying services furnished by eligible participants in the Medicare Shared Savings Program, LEAD Model, and ACO PC Flex Model.
- 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 finalized values for this code amending their methodology and using a ratio between CPT 37243 and HCPCS C9797 under OPPS.
- CMS proposed and finalized allowing 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 finalized a 20% payment reduction for the lower-valued service when an office/outpatient E/M visit reported with modifier -25 is furnished on the same day as a 0-day global procedure by the same physician, or a physician of the same specialty in the same group practice.
    - CMS made several changes to their proposal for this payment policy in response to comments received. The biggest being the change from 50% reduction to 20% and removal of 10- and 90-day surgical global services due to rules already in place for valuation of the packaged surgical services.
- CMS proposed and finalized postponing the data collection related to 99024 (post-op follow-up visit).
    - Although data supports physicians may not perform the post-operative visits as valued by the RUC. CMS 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 the table included in this summary.
    - CMS did not move forward with any valuation changes based on the data provided and will consider the comments for future rulemaking.
- Telehealth visit flexibilities will continue through December 31, 2027. CMS created two new non-payment modifiers “BB” and “BC.” CMS provided the finalized descriptors and directed stakeholders to the CMS website for additional information.
- A request for information (RFI) 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 sought input on five main points. Summaries of the comments received as included in the final rule have been provided below. For CY 2027, CMS is not making any changes other than those that may already be in place regarding valuation of services when not in agreement with RUC-recommended values.
- A request for information (RFI) regarding strategies to reduce unnecessary duplicate diagnostic laboratory and imaging services while improving the interoperability of clinical information across the healthcare system.
    - CMS indicated the comments to be considered for future rulemaking.

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 finalized a qualifying APM conversion factor that is $0.62 (-1.83%) lower than the CY 2026 value, and lower than the proposed value. The finalized non-qualifying APM conversion factor also reflects a decrease of $0.77 (-2.31%) compared with the CY 2026 value, and is lower than the proposed value.

CMS calculated the finalized 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 -0.12%, along with the statutory annual update factors of 0.75% for qualifying APM participants and 0.25% for non-qualifying APM participants. Based on this methodology, CMS estimates the CY 2027 Physician Fee Schedule conversion factors will be $32.9548 for qualifying APM participants and $32.6286 for non-qualifying 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	-0.12 percent (0.9988)	
CY 2027 Conversion Factor		**32.9548**

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	-0.12 percent (0.9988)	
CY 2027 Conversion Factor		**32.6286**

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 CY 2027 Physician Fee Schedule (PFS) changes affect specialties differently, with the largest impact 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, with smaller increases for 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 significant decreases include otolaryngology, dermatology, and podiatry, hand surgery, physician's assistants, and colon and rectal surgery due to the changes with modifier -25 and surgical procedures on the same date of service.

Rather than include the estimated impact on charges by specialty within the body of the final rule, CMS instead published it as a public use file (PUF) for download from the website for CY 2027. CMS also reminded stakeholders the estimated impacts on specialties 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.

CY 2027 PFS Final Rule Estimated Impact on Total 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	$553	0%	3%	0%	3%
	Non-Facility	$368	0%	4%	0%	4%
	Facility	$185	0%	1%	0%	1%
Radiology	TOTAL	$4,726	0%	1%	0%	1%
	Non-Facility	$2,085	0%	1%	0%	1%
	Facility	$2,641	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 did not make any changes to the adjustment and will continue applying across all non-time-based services. In addition, CMS applied the efficiency adjustment to a small set of RUC reviewed non-time-based services effective for CY 2027 whose RUC-recommended values did not already account for expected efficiency gains due to overlap in timing of the recommendations to the rulemaking process. CMS also clarified they will post the Code Subject to Efficiency Adjustment file for each year it is applicable, the file will be posted again for CY 2029 rulemaking which will be the next update period.

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 proposed 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.

For CY 2027, CMS finalized to eliminate Steps 12-17 of the PE calculation process which relies on the indirect practice expense cost index (IPCI) over a 2-year process as proposed and creation and addition of 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,"* calculation and application of PE stabilization adjustment for each PE RVU.

Although CMS has historically transitioned changes that have significant impacts on values over a 4-year transition, they believe the intent of the PE valuations and changes should be on a shorter timeframe for relevancy. The phase-in would still apply a 5% cap to any changes applied, so they are not all instituted at once.

The PE stabilization adjustment would not be applied to new, revised, or newly national priced codes (i.e., code that transitioned from contractor priced to national value by CMS).

Currently, CMS utilizes an average of the 3 most recent years of Medicare claims 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 with the finalized specialty assignments. 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 and finalized 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 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 will 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."*

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 sought 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?

For CY 2027, CMS received comments in response to their request for information. The following are summarized comments as listed within the final rule.

- Commenters agreed that using facility place-of-service as a proxy for physician employment is imprecise but were divided on how to structure the differential going forward, with some supporting refinements such as additional specialty-specific adjustments and more detailed impact data.
- Most recommended replacing or supplementing this proxy with a more direct method of identifying hospital-employed physicians, with several suggesting independent practices self-identify given their incentive to do so.
- Many commenters cautioned that employment status alone is not a reliable indicator of who bears indirect costs, noting that practices often continue to incur substantial administrative costs regardless of employment or site of service, and that the variety of employment arrangements makes any binary classification difficult to administer and prone to disputes.
- Commenters broadly urged CMS to take a more data-driven approach, including easing the impact on independent practices and reconsidering the reduction until better evidence is available. They also raised specialty-specific concerns and warned the policy could accelerate practice consolidation into hospital employment or acquisition by other entities.

For CY 2027, CMS did not make any modifications to the site-of-service payment differential. Following the comments received, CMS indicated it may consider these issues in future rulemaking.

CMS provides 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		**2,757**	**Share of Total Practitioner RVUs in Specialty**										
20	Interventional Radiology	17	0%	0%	0%	1%	0%	10%	20%	36%	29%	3%	1%
37	Radiology	143	0%	0%	0%	0%	1%	36%	54%	6%	2%	0%	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 proposed to adopt the RUC-recommended physician work RVUs for both codes. The agency also proposed RUC's recommended direct practice expense (PE) inputs but proposed a modification related to the portable ultrasound equipment used to perform the procedures.

CMS received a few comments expressing concern the proposed values would result in approximately 5% reduction in reimbursement, significantly impacted interventional radiology and procedural services. Stressing the values could impact access to care which they indicated is high-value and cost effective for diagnosing cancer.

CMS indicated they appreciated the comments, but absent additional or alternative survey data from the commenters believe the 25th percentile of the work RVU (1.35) which was based on a robust RUC survey with 268 responses, this was the best information available and supported their valuation. CMS did indicate they would continue to work with the RUC, specialty societies (specifically indicating interventional radiology) regarding the ongoing valuation of the FNA services in future rulemaking.

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.

For CY 2027, CMS finalized the work RVUs as proposed, without modification for CPT® codes 10005 and 10006. Additionally, CMS finalized their adjustments, as proposed, for the PE and new equipment item ER130.

HCPCS	Descriptor	2026 Work RVU	2027 Work RVU	2027 Total NF RVU	2027 Total Fac RVU
10005	Fine needle aspiration biopsy, including ultrasound guidance; first lesion	1.42	1.35	4.79	1.77
10006	Fine needle aspiration biopsy, including ultrasound guidance; each additional lesion)	0.98	1.00	3.02	1.31

Intraosseous Fiducial Marker Placement (CPT® codes 20988 and 20989)

At the May 2025 CPT® Editorial Panel meeting, two new codes for reporting percutaneous intraosseous fiducial marker placement, 20988 and 20989, 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 and finalized the RUC-recommended values for work RVUs and the direct PE inputs without refinement.

HCPCS	Descriptor	2026 Work RVU	2027 Work RVU	2027 Total NF RVU	2027 Total Fac RVU
20988	Placement of localization marker(s) (eg, fiducial marker[s]), intraosseous, percutaneous, including imaging guidance, when performed; first target site	-	3.00	37.74	5.43
20989	Placement of localization marker(s) (eg, fiducial marker[s]), intraosseous, percutaneous, including imaging guidance, when performed; each additional target site	-	1.76	23.73	2.58

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 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 and finalized the RUC-recommended values for work RVUs and the direct PE inputs without refinement.

HCPCS	Descriptor	2026 Work RVU	2027 Work RVU	2027 Total NF RVU	2027 Total Fac RVU
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	412.87	12.66
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	595.79	19.97

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 did not agree with the RUC's recommendation for CPT code 36466. The agency noted 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 proposed and finalized valuing CPT code 36466 by crosswalking it to CPT code 57156 *(Insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy),* resulting in a reduction in the physician work RVU from 2.93 to 2.62 for CY 2027.

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

HCPCS	Descriptor	2026 Work RVU	2027 Work RVU	2027 Total NF RVU	2027 Total Fac RVU
36470	Injection of sclerosant; single incompetent vein (other than telangiectasia)	0.73	0.73	6.36	1.02
36471	Injection of sclerosant; multiple incompetent veins (other than telangiectasia), same leg	1.46	1.18	7.12	1.64

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	41.90	3.19
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	2.62	42.97	3.62
36473	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated	3.41	3.41	33.81	4.78
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	7.50	2.39

Prostate Biopsy (CPT codes 55705, 55707, 55708, 55709, 55710, 55711, 55714, 55715, and 55716)

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 proposed and finalized adoption of 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 55716. The agency concluded 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 proposed and finalized a lower physician work RVU for the new code. CMS proposed and finalized the RUC-recommended direct practice expense (PE) inputs without modification.

HCPCS	Descriptor	2026 Work RVU	2027 Work RVU	2027 Total NF RVU	2027 Total Fac RVU
55705	Biopsy, prostate, any approach, nonimaging-guided	1.88	1.88	7.36	3.01
55707	Biopsy, prostate, transrectal, including imaging guidance, regional	2.63	2.63	10.60	4.04
55708	Biopsy, prostate, transrectal, including imaging guidance, regional and fusion-targeted lesion(s)	3.39	3.39	12.98	5.05
55709	Biopsy, prostate, transperineal, including imaging guidance, regional	3.23	3.23	17.80	4.83
55710	Biopsy, prostate, transperineal, including imaging guidance, regional and fusion-targeted lesion(s)	3.81	3.81	19.95	5.60
55711	Biopsy, prostate, transrectal or transperineal, including imaging guidance, fusion-targeted lesion(s) without regional; first targeted lesion	2.61	2.37	10.54	3.70
55714	Biopsy, prostate, including imaging guidance, in-bore CT- or MRI-guided; first targeted lesion	3.62	3.62	21.43	5.05
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	15.52	2.38
55716	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)	-	0.68	1.37	0.91

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.

CMS did not agree with the RUC-recommended physician work RVU of 7.06 for CPT code 62287. The agency determined the survey reflected a decrease in physician work time that was not adequately incorporated into the RUC recommendation.

For CY 2027, CMS proposed and finalized a work RVU of 6.23, based on a crosswalk to CPT code 46707 *(Repair of anorectal fistula with plug).* CMS also proposed and finalized adoption of the RUC-recommended direct practice expense (PE) inputs without refinement.

HCPCS	Descriptor	2026 Work RVU	2027 Work RVU	2027 Total NF RVU	2027 Total Fac RVU
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	6.23	NA	12.94

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 proposed and finalized deleting HCPCS code G2211 and replacing it with modifier B1 and B2. Reference to MOD1 and MOD2 as included in the proposed rule was a placeholder and not the actual proposed modifier. Modifier B1 will 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 proposed and finalized minor revisions to the descriptor to better reflect the intended use of the new modifier.

G2211 2026 Descriptor	Modifier B1 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

For CY 2027, CMS also proposed and finalized a new methodology for valuing modifier B1 compared with the current payment approach for HCPCS code G2211. Rather than assigning a fixed payment amount, CMS will calculate payment for the modifier as a percentage of the value of the associated E/M service. CMS will 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

indicated they are grateful for the comments received which indicated the use of a percentage could negatively impact primary care and indicated they will monitor for potential future rulemaking.

CMS also finalized modifier B2 for qualifying services furnished by eligible participants in the Medicare Shared Savings Program, LEAD Model, and ACO PC Flex Model. Modifier B2 will be valued at 32% of the associated E/M visit RVUs, compared with 16% for modifier B1. Use of modifier B2 is voluntary and is limited to eligible office/outpatient and home or residence E/M visits.

CMS included the following example to illustrate the 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 RVU 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 sought 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 proposed 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. Additionally, an updated Addendum B file published on July 16, 2026, reflected contractor pricing for G0577, a change from the original posting on July 14, 2026.

For CY 2027, CMS revised their proposal for valuation of nonfacility PE RVUs for G0577. The agency outlined how they calculated the value for 2027.

"…we compared the relative payment relationship between CPT code 37243 and HCPCS code

C9797 under two measures of OPPS payment: the ratio of the OPPS APC payment amounts for the two codes, and the ratio of the OPPS geometric mean costs for the two codes. We then averaged the resulting ratios to produce a single adjustment factor. We are applying this adjustment factor to the existing non-facility PE RVUs for CPT code 37243 to derive the non-facility PE RVUs for HCPCS code G0577. Consistent with our proposal, we are finalizing a direct crosswalk of the work RVUs, malpractice RVUs, and physician time from CPT code 37243 to HCPCS code G0577. We confirm that the adjustment factor is applied to the PE RVUs only; the work and malpractice RVUs are added afterward to determine total RVUs."

HCPCS	Descriptor	2026 Work RVU	2027 Work RVU	2027 Total NF RVU	2027 Total Fac RVU
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	-	11.45	422.58	19.78

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 proposed and finalized expanding 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 proposed and finalized 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 proposed and finalized 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 proposed 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 noted that this approach was intended to align payment for modifier -25 services with the existing MPPR methodology.

Several commenters pointed out potential concerns when a patient schedules multiple services on the same date of service with large multi-specialty group practices and academic medical centers, especially when due to need for travel for the appointments. Requests were made to alter the language to address this is intended only when services are provided by the same physician.

The agency indicated appreciation for this feedback and in response indicated this was not intended to target services the same day by practitioners of different specialties and amended the finalized language.

For CY 2027, CMS amended the language for application of this policy to apply to services furnished by, *"the same physician (or a physician in the same specialty in the same group practice)."* This aligns with guidance already located within the Medicare Claims Processing Manual, Chapter 12.

CMS sought stakeholder feedback on whether a 50% reduction was appropriate to reflect the overlap in physician work. Commenters indicated potential issues with the already valued services within 10-and 90-day surgical global periods and the reduction as part of this payment policy would create overlap of reduced values.

For CY 2027, CMS amended their proposal of 50% reduction to 0-, 10- and 90-day surgical global periods and finalized a 20% reduction in payment to all services except the highest value service when an O/O E/M visit (CPT codes 99202, 99203, 99204, 99025, 99211, 99212, 99213, 99214, and 99215) is performed on the same day with the same practitioner (or a practitioner of the same specialty in the same group practice) as a service with a 0-day global period.

The agency also emphasized that providers should not alter scheduling practices solely to maximize reimbursement, as doing so could create unnecessary burden on beneficiaries. CMS indicated it will continue to use claims analytics to identify potentially inappropriate billing patterns.

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.

To support this discussion, CMS released the supplemental file CMS-1848-F 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 summarized 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	Chemodene rv musc migraine	10	1.85	0.34	0.11	0.00	1.40	0	0.00	0	1.85	1.85
64616	Chemodene rv musc neck dyston	10	1.53	0.34	0.11	0.00	1.08	0	0.00	0	1.53	1.53
64617	Chemodene r 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

For CY 2027, CMS proposed and finalized pausing the data collection of CPT code 99024. The data collected to date suggested postoperative visits included in many global surgical packages occur less frequently than assumed when the services were originally valued. The agency sought 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.

Comments varied with many not in support of using the information in the PUF to assist in valuation of global surgical packages. Some commenters believed it was a good start, while others expressed concern that CPT 99024 did not specify the level of visit provided to the patient during the global period. Additional comments were in support of the PUF for valuation and still others expressed CMS should not use missing or lack of reporting of postoperative care as proof it was not being furnished to the patient.

For CY 2027, CMS also indicated they were appreciative of the comments received and would consider them for possible future rulemaking. They did not move forward with valuation changes indicated in the table above for CY 2027.

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 BC 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 BC will be provided through future sub-regulatory guidance and posted on the agency's website, https://www.cms.gov/medicare/coverage/telehealth.

Below are the descriptors for the new modifiers, which do not have payment implications, as provided within the final rule which go into effect January 1, 2027.

Modifier	Descriptor
BB	Claims for telehealth services that are furnished through a telehealth virtual platform by a physician or practitioner that contracts with an entity that owns such virtual platform, or for which a physician or practitioner has a payment arrangement with an entity for use of such virtual platform
BC	Telehealth services that are furnished incident to a physician's or practitioner's professional service

Telehealth Originating Site Facility Fee Payment Amount Update

For CY 2027, CMS proposed and finalized continuing 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 MEI for CY 2027 is 2.6 percent, resulting in a finalized originating site fee of $32.68 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 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 proposed and finalized revising 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. As a reminder, 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 sought stakeholder feedback on whether additional scenarios should be considered under this policy. In response, CMS did receive a couple of comments asking for clarification surrounding some additional scenarios.

Comment: Commenters requested clarification regarding this policy. Specifically, commenters asked If clinical instances when the service is a three-way telehealth visit, with the teaching physician, resident, and patient all in different locations, would still be permitted.

Response: Yes, this proposal was intended to be additive to the policy finalized in the CY 2026 Final Rule.

Comment: Commenters requested that we allow for the teaching physician and resident to be in the same location, with the beneficiary being present remotely. Another commenter requested that we define these services based on the location of the patient, not of the teaching physician and/or resident.

Response: We thank commenters for their feedback and may consider this for future rulemaking.

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 sought and received comments on the following. The comments included here are taken as summarized and included with the final rule publication.

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.

   Comment: Commenters identified issues with the AMA's CPT® licensure process, but many commenters shared their concerns with the challenges associated with introducing alternative coding standards to CPT® and highlighted the importance of having a unified national coding standard. Very few commenters agreed with removing royalties from the CPT process. Issues identified by commenters included the perceived legal discrepancy

between the CPT-4 code set being federally mandated and the fact that it is owned privately.

Response: We thank commenters for their feedback, and we will use these comments to advise us for future rulemaking.

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?

   Comment: Commenters generally answered this question by highlighting the importance of differentiating between the AMA's process for CPT-4 code development and the subsequent and distinct process for the RUC to assign relative payment recommendations. Commenters emphasized the role of CPT® as a nomenclature system and that medical necessity decisions are left to payors.

   Response: We thank commenters for their feedback, and we will use these comments to advise us for future rulemaking.

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?

   Comment: Many commenters expressed concern about transitioning to alternative or multiple coding standards, and advocated for CMS to improve the current standard. Others highlighted that while there is no unified national standard the CPT functions can decompose across a number of code sets (for example, inpatient procedures may utilize the CMS ICD-10-PCS coding system, general clinical services may utilize SNOWMED CT®, labs may utilize LOINC®, etc.) and highlighted where CMS has already begun to make progress on this mapping through CMS' development of HCPCS codes such as chronic care management or principal illness navigation.

   Response: We thank commenters for their feedback, and we will use these comments to advise us for future rulemaking.

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?

   Comment: Many commenters suggested opportunities to improve the AMA CPT® Editorial Panel process of developing new CPT® codes and the AMA Relative Value Update Committee or RUC process of making recommendations to CMS on the valuation, or relative resources involved in, furnishing a physician service. In addition to specific suggestions for improvements, commenters also highlighted a perceived bias against 'cognitive' in favor of 'procedural' services (including several examples of cognitive work that was 'invisible' such as managing patient portal messages) and the challenges in measuring and attributing resources of diffuse longitudinal work, especially regarding the undervaluation of primary care services. Commenters also highlighted the contribution of the AMA RUC towards creating a shortage of primary care practitioners.

The response to this question and the comments CMS shared were extensive and included a great deal of varied and defined recommendations. The following is additional summarization of the comments received for brevity.

CPT® Editorial Panel

- Improve transparency, including publishing a formula defining "widespread use" so the process keeps pace with technological advances.

AMA RUC: Data sources

- Incorporate more objective or empiric data, such as EMR or registry data, rather than relying on surveys of practicing physicians.

AMA RUC: Committee composition

- Change specialty composition, e.g., more geriatrics and primary care representation.
- Make representation proportional to the number of practicing physicians rather than one representative per specialty.

AMA RUC: Conflict of interest

- Reduce the conflict of interest inherent in physicians recommending how they or their colleagues are reimbursed.

AMA RUC: Transparency

- Publish the methodology in a public repository, including the standards and data used in physician work valuation recommendations.

CMS oversight and alternative structures

- Have CMS independently verify RUC recommendations before accepting them.
- Establish an external advisory body, such as a technical expert panel or an existing Federal Advisory Committee, to work alongside the RUC. Commenters disagreed on:
  - Membership: non-physician experts only, or physician and non-physician experts.
  - Role: supplementing or replacing the RUC.
- If the RUC is replaced, model the replacement body on MedPAC.

Expanded RUC scope

- Extend RUC recommendations beyond relative resource costs and valuation to other CMS priorities, such as value-based or outcomes-based payment.
- Have the AMA identify a process for retiring low-value services.

Response: We thank commenters for their feedback. While the original intent of this request for information was for CMS to better understand potential harms associated with the AMA's monopoly on CPT-4 licensing and solicit comments on alternative coding standards for physician services, to adequately describe the CPT-4 code development process required us to describe both the CPT® Editorial Panel and the AMA Relative Value Scale Update Committee (RUC). We will consider comments received on the CPT® process for future rulemaking. The overwhelming majority of public comments focused on the AMA RUC.

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?

Comment: Commenters highlighted that while CPT-4 codes and ICD-10 procedure codes may overlap, there are differences, and suggested there may be potential drawbacks to considering physician payment on the basis of ICD-10 procedure codes. There were few commenters specifically addressing bundling services in methods analogous to the MS-DRGs or OPPS APCs.

Response: We thank commenters for their feedback, and we will use these comments to advise us for future rulemaking.

Beyond the comments to the specific RFIs above, CMS indicated due to the robust response to the RFI they are focused on improvements to the AMA RUC and are considering various potential means to improving the process, while also taking into consideration the suggested ways to do this as submitted by stakeholders. CMS did reiterate the RUC, or other organizations are encouraged to submit data to support valuation of physician services.
CMS did remind stakeholders that any example should be empiric data and data on market prices. CMS also indicated they welcome data from providers of their negotiated rates with private payers, specifically rates negotiated by Medicare Advantage plans caring for a comparable population to Original Medicare, self-insured employers, or commercial payers both within and outside of other government health programs.

CMS would also appreciate data based on clinical outcomes the service(s) would be expected to achieve. This aligns with the focus CMS has had on quality not quantity of services.

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

CMS sought 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 FHIR and 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.

CMS received public comments in response to the RFI. They indicated the responses were provided from professional organizations, hospitals, physician offices, and the public. At this time, CMS has not finalized any changes but has provided a summary of the comments received.

Comment: In general, commenters support CMS efforts to reduce costs associated with duplicative testing and imaging. However, some commenters do not support CMS denying Medicare payment for duplicative testing. These commenters noted that often times duplicate testing may be clinically necessary, and health care providers should not be penalized if access to prior results is not readily available. Some commenters expressed that improving laboratory and digital imaging interoperability should be addressed and recommend CMS work with interested parties and solicit feedback.

Response: We thank the commenters for their feedback.