American College of Radiology

American College of Radiology Detailed Summary of Radiology Provisions in the 2026 MPFS Proposed Rule

The Centers for Medicare and Medicaid Services (CMS) released the calendar year (CY) 2026 Medicare Physician Fee Schedule (MPFS) proposed rule on Monday, July 14, 2025. The summary outlines Medicare payment provisions and updates to the Quality Payment Program (QPP). The ACR plans to submit comments to CMS by its September 12 deadline.

Conversion Factor and CMS Overall Impact Estimates (Page 1188)
The 2025 conversion factor is $32.3465. Beginning CY 2026 there will be 2 separate conversion factors resulting from the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The conversion factor for services provided by qualifying participants in Advanced Alternative Payment Models (APMs) is proposed to be $33.5875, inclusive of a .75% annual update. Services provided by non-APM participants have a proposed conversion factor of $33.4209, which includes a .25% annual update. Both conversion factors also include a 2.5% one year increase to the MPFS conversion factor included in the recent budget reconciliation bill as well as a proposed 0.55% budget neutrality adjustment.

If the provisions within the proposed rule are finalized, CMS estimates an overall impact of the MPFS proposed changes to be -2 percent for radiology, -1 percent for nuclear medicine, 2 percent for interventional radiology and -1 percent for radiation oncology. However, these impacts do not take into account the updates to the qualifying and non-qualifying APM conversion factors of 0.75 percent and 0.25 percent, respectively. It also does not take into account the 2.50 percent single year increase to the 2026 conversion factor.

Adjusting RVUs to Match the PE Share of the Medicare Economic Index (MEI) (Page 27)
The Medicare Economic Index (MEI) is a measure of the relative weights between physician work, practice expense, and malpractice expense. In 2023, the CMS finalized their proposal to revise and rebase the MEI to reflect the current market conditions that physicians are facing. However, CMS had delayed implementation due to concerns about the large redistributive effects and to wait for the American Medical Association's (AMA) Physician Practice Information (PPI) Survey to be completed.

CMS received the PPI and Clinician Practice Information (CPI) survey data from the AMA and addressed their concerns with the data and its accuracy in this proposed rule. As a result of these concerns, CMS is choosing not to use the (Physician Expense per hour) PE/HR or cost shares data from the AMA survey at this time. CMS is proposing to maintain the current PE/HR and the 2006-based MEI cost shares for CY 2026.

Proposed Efficiency Adjustment (Page 142)
The CMS has relied on the AMA's Relative Value Scale Update Committee (RUC) data is used to estimate physician time, work intensity, and PE and uses this information to establish RVUs in the MPFS. However, CMS continues to express their concerns about the low response rate, low number of responses, large response range, and possible response bias of the RUC data. Additionally, external data from other sources, such as a study by the Urban Institute in 2016 suggest an overestimation of physician times.

CMS believes that non-time-based codes (procedures, radiology services, and diagnostic tests) should become more efficient over time as they become more common, as technology improves, and as professionals gain experience, and that these efficiency gains have not been reflected in the work RVUs for these services. Therefore, CMS is proposing an efficiency adjustment to the work RVUs, and corresponding updates to the intra-service time, since both the intra-service time and work intensity should decrease as the practitioner develops their expertise.

CMS believes that applying an efficiency adjustment to non-time-based services more broadly instead of only to certain services that are more likely to have efficiency gains will improve the overall accuracy of the valuation of services under the MPFS. CMS proposes to use the Medicare Economic Index (MEI) productivity adjustment of negative 2.5% for CY 2026, which is equivalent to if this adjustment had been applied every year for the past five years. Moving forward, CMS proposes to update this efficiency adjustment every three years.

CMS is seeking comments on several aspects of their proposal, including the initial five-year look back period, potential future adjustments to the direct PE inputs that correspond with physician time, and whether efficiencies stop accruing for services after a predefined number of years, and what kind of data they should consider as valid and reliable empiric data, among other things.

Development of Strategies for Updates to Practice Expense Data Collection and Methodology (Page 47)

The AMA PPI survey was introduced in 2007 to collect comprehensive and reliable data on direct and indirect PEs incurred by physicians. The four-year implementation process began in 2014. The current PE methodology utilizes this data, which has not been updated since the 2007 survey.

In recent years, CMS engaged with stakeholders through the rulemaking process, soliciting feedback on ways to improve the PE inputs' accuracy and reliability, asking for public comment on strategies for updating the PE methodology and data collection process, as well as comments on trends in health care business arrangements and the use of technology. CMS also has contracted with the RAND Corporation to develop alternatives to the PE methodology.

The AMA launched an updated PPI survey and CPI survey and submitted their data to CMS in time for consideration in the CY 2026 PFS. While CMS shared that they appreciated the AMA's data collection efforts, they expressed concerns about the low response rates and representativeness of the surveys, the small sample size and sampling variation, the lack of comparability to previous survey data, the potential measurement error, and also missing and incomplete data submission. For these reasons, CMS is proposing to not implement the PPI and CPI data into the CY 2026 rate setting. CMS feels that a more efficient and transparent system that could be regularly updated is possible using publicly available administrative data such as Medicare claims data or public tax information.

CMS notes that there has been a steady decline of physicians in private practice and that an increased number are being employed by hospitals. The PE methodology allocates the same amount of indirect costs per work RVU regardless of the setting (facility or non-facility), since it was based on the assumption that physicians maintain an office even when practicing in a facility setting. With the increase in physicians working in the facility setting, CMS feels that the indirect costs may now be overstated for physicians who no longer maintain an office. Therefore, CMS is proposing to reduce the portion of the facility PE RVUs allocated based on work RVUs to half the amount allocated to non-facility (NF) PE RVUs for each service valued in the facility setting.

CMS is soliciting comment from the public on the specific types and magnitude of indirect PE costs incurred by physicians who practice in part or exclusively in a facility setting and any variables that affect whether and to what extent a practice would incur them, whether the proposal to reduce the facility PE RVUs is an appropriate reduction and/or if a different percentage reduction should be considered for CY2026 or future years, whether there are additional data sources to help identify a more precise site of service difference in the allocation of indirect PE RVUs, ways to improve the allocation of facility and non-facility PE RVUs in the future, and also how this policy should apply to maternity services and whether it could affect access to these services.

Alternatives Considered for Adjusting RVUs to Match PE Share in the American Medical Association's (AMA) Physician Practice Information (PPI) and Clinician Practice Information (CPI) Surveys (Page 1262)

As part of the PE methodology, CMS usually holds the work RVU constant, and adjusts the PE RVUs, malpractice (MP) RVUs, and the conversion factor to maintain the appropriate balance in RVUs among the PFS components and payment rates for each service. The current MEI cost shares are ~51% work RVU, ~45% PE RVU, and ~4% MP RVU.

As an alternative to adjusting the aggregate pools of direct and indirect PE costs and using a relativity adjustment based on the currently used 2006-based MEI, CMS proposes 3 alternatives using the PPI and CPI survey data:

- Full implementation of the updated PPI and CPI PE/HR data, while maintaining the current cost shares.
- Full implementation of the updated shares, as reported by the AMA, while maintaining the current PE/HR data.
- Full implementation of the updated shares, weighted by Medicare RVUs, while maintaining the current PE/HR data.

All of the alternatives yield significant redistributive effects, so CMS is proposing to delay any adjustments at this time to allow for public comments on the PPI and CPI surveys. The Agency is also proposing to delay implementation of any updated cost share weights in the PE Geographic Practice Cost Index (GPCI) for CY 2026 to allow for public comment.

Determination of Malpractice Relative Value Units (RVUs) (Page 380)
Three factors comprise the Malpractice (MP) relative value units (RVUs), specialty-level risk values derived from the data on specialty-specific MP premiums incurred by practitioners, service-level risk values derived from Medicare claims data of the weighted average risk values of the specialties that furnish each service, and an intensity/complexity of service adjustment to the service-level risk value based on either the higher of the work RVU or clinical labor portion of the direct PE RVU.

As part of the recent review and update of the MP RVUs in 2023, CMS finalized a methodological improvement to move from MP risk factors to a MP risk index, which is calculated as a ration of the specialty's national average premium to the volume-weighted national average premium across all specialties. This will increase consistency with the MP RVU calculations so that changes int eh MP risk index reflect changes in payment, as opposed to changes relative only to the specialty with the lowest national average premium.

For the CY 2020 MP RVU update, CMS assigned a risk factor of 1.00 for TC-only services, mapping it to the lowest physician specialty risk factor, which is allergy/immunology. For the proposed CY 2023 update, CMS had sufficient premium data to directly assign a risk value for TC-only services, but due to a technical error, the 1.00 risk factor was assigned. This was corrected in the PFS CY 2023 final rule, with the correction once again mapping the services to allergy/immunology, with a risk index value of 0.430.For CY 2026, CMS proposes to map TC-only services to the allergy/immunology which is consistent with their approach in the 2020 and 2023 updates of the MP RVUs. Allergy/immunology has a risk index value of 0.427 now. CMS is requesting comments regarding the risk index value for TC-only services.

Alternatives Considered for the Practice Expense (PE) Geographic Practice Cost Index (GPCI) (Page 1272)
The four components of the Practice Expense Geographic Practice Cost Index (PE GPCI) are: employee wages, office rent, purchased services, and medical equipment, supplies, and other miscellaneous expenses. As the MEI cost shares are updated, CMS has historically updated the GPCI cost share weights to make them consistent with the most recent update to the MEI.

CMS is currently maintaining the 2006-based MEI cost share weights and is proposing to delay implementation of updated cost share weights for the 2006 GPCIs as well. CMS notes that the AMA's PPI and CPI surveys lack the breakdown of PE that they would need to weight the four components of the PE GPCI for CY 2026, specifically information regarding office rent and purchased services. CMS is considering possible derivations of weights from the PPI and CPI surveys for use int eh PE GPCI for future rulemaking, which would require mapping and methodology proposals.

CMS displays the alternative derived weights in the proposed rule but are also welcoming alternative methodologies to weight and/or map the CPI and PPI data.

CY 2026 Identification and Review of Potentially Misvalued Services (Page 75)
For CY 2026, CMS received 11 public nominations for potentially misvalued codes. One of the code families nominated—Fine Needle Aspiration—pertains to imaging.

CPT codes 10021 *(Fine needle aspiration biopsy, without imaging guidance; first lesion)*, 10004 *(Fine needle aspiration biopsy, without imaging guidance; each additional lesion (List separately in addition to code for primary procedure))*, 10005 *(Fine needle aspiration biopsy, including ultrasound guidance; first lesion)*, and 10006 *(Fine needle aspiration biopsy, including ultrasound guidance; each additional lesion (List separately in addition to code for primary procedure))* were nominated as potentially misvalued. This family of fine needle aspiration (FNA) codes have been nominated several times in previous years and addressed by CMS in previous rulemaking.

The nominator is requesting CMS to continue to reevaluate these codes, stating that the payment changes based on the CMS 2019 work RVU reductions have created downstream negative outcomes, impacting the care of patients with thyroid nodules and cancer. The nominator continues to encourage CMS to accept the values previously recommended by the RUC and strongly disagrees with the methodology applied for this service.

The nominator expressed great concern about the comparison code, 36440 *(neonatal blood transfusion)* stating this code is fundamentally a different service and patient demographic than the code in question. The nominator highlighted that the work RVU for CPT code 10005 was recently decreased by 10.5% from 1.94 to 1.64 and thus will substantiate a decrease in payment of 35.7% overall. To compound matters the decreased payment has forced a site of service shift from the office setting to the facility setting, which has greatly decreased accessibility to patients.

CMS commented that while they appreciate the very comprehensive research and data provided by the nominator, given the multiple reviews and the rationale provided by CMS in CY 2019 and subsequent years, CMS does not consider these codes misvalued. The agency states they will continue to monitor the site of service trends and should the pattern persist, a new survey may be needed. However, CMS welcomes stakeholder and RUC comment on whether this family does require re-review in light of the information submitted by the nominator.

Valuation of Specific Codes for CY 2026 (Page 162)

Lower Extremity Revascularization (CPT codes 37XX1, 37X02, 37X03, 37X04, 37X05, 37X06, 37X07, 37X08, 37X09, 37X10, 37X11, 37X12, 37X13, 37X14, 37X15, 37X16, 37X17, 37X18, 37X19, 37X20, 37X21, 37X22, 37X23, 37X24, 37X25, 37X26, 37X27, 37X28, 37X29, 37X30, 37X31, 37X32, 37X33, 37X34, 37X35, 37X36, 37X37, 37X38, 37X39, 37X40, 37X41, 37X42, 37X43, 37X44, 37X45, and 37X46) - (Page 172)

In Fall 2018, three CPT codes (37225, 37227, and 37229) were flagged by the Relativity Assessment Workgroup's (RAW) high-cost supplies screen. This commenced a deep dive into the lower extremity revascularization (LER) family, and the CPT Editorial Panel ultimately created four new subsections and 46 new codes to replace the existing 16 codes. These codes

were presented at the September 2024 RUC meeting. CMS is proposing to accept the RUC's proposed work RVUs for all 46 codes. See the table below.

CPT CODE	LONG DESCRIPTOR	PROPOSED CY 2026 WORK RVU
37XX1	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, initial vessel	7.30
37X02	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)	3.00
37X03	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, initial vessel	10.75
37X04	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)	3.89
37X05	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel	8.75
37X06	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for	4.00

	accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)	
37X07	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel	12.69
37X08	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel.	4.25
37X09	Intravascular lithotripsy(ies), iliac vascular territory, including all imaging guidance and radiological supervision and interpretation necessary to perform the intravascular lithotripsy(ies) within the same artery (List separately in addition to code for primary procedure)	3.00
37X10	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, initial vessel	7.75
37X11	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)	3.00
37X12	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery	10.50

	and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, initial vessel	
37X13	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, each additional vessel	4.00
37X14	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel (List separately in addition to code for primary procedure)	8.75
37X15	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)	3.73
37X16	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel	14.75
37X17	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement	5.00

	and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)	
37X18	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel	9.00
37X19	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel	4.00
37X20	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel	12.63
37X21	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)	5.50
37X22	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation	11.00

	necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel	
37X23	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)	4.25
37X24	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel	15.00
37X25	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)	6.00
37X26	Intravascular lithotripsy(ies), femoral and popliteal vascular territory, including all imaging guidance and radiological supervision and interpretation necessary to perform the intravascular lithotripsy(ies) within the same artery (List separately in addition to code for primary procedure)	4.00
37X27	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological	9.80

	supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, initial vessel	
37X28	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, each additional vessel	3.00
37X29	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, initial vessel (List separately in addition to code for primary procedure)	12.31
37X30	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)	4.26
37X31	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel	10.00
37X32	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement	3.34

	and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)	
37X33	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel	13.46
37X34	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)	5.00
37X35	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel	13.50
37X36	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition	4.75

	to code for primary procedure)	
37X37	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel	17.00
37X38	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)	6.50
37X39	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel	15.00
37X40	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for	6.50

	primary procedure)	
37X41	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel	18.00
37X42	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)	8.16
37X43	Revascularization, endovascular, open or percutaneous, inframalleolar vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, initial vessel	11.00
37X44	Revascularization, endovascular, open or percutaneous, inframalleolar vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)	4.00
37X45	Revascularization, endovascular, open or percutaneous, inframalleolar vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and	13.70

	crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, initial vessel	
37X46	37X46 - Revascularization, endovascular, open or percutaneous, inframalleolar vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)	5.00

CMS is proposed to accept all of the PE recommendations from the RUC, with several revisions to address discrepancies that were noted.

PE refinements	CMS proposed change	CPT Codes
ED053 (professional PACS workstation)	Amend from RUC-recommended 34 mins to standard equipment formula of for the professional PACS workstation (sum of intra service work time + 1/2 of pre-service work time)	All 46 codes
SD382 (drug-coated balloon)	Amend quantity from two units to one unit for the initial vessel while maintaining one unit for additional vessels	37X10,3X012, 37X18 & 37X20
SD379 (drug eluting stent, tibial)	CMS is proposing to reduce the quantity from two to one	37X33, 37X34, 37X41 & 37X42

Additionally, CMS is soliciting comments on whether they should create G-codes to describe the use of high-cost disposable supplies or whether they should use the Hospital Outpatient Prospective Payment System (OPPS) mean unit cost data (MUC) to price these services based on how the supplies are paid for in the hospital setting.

Irreversible Electroporation of Tumors (CPT codes 4001X and 5XX11) - (Page 180)

CPT codes 4001X and 5XX11 were created for reporting of percutaneous irreversible electroporation ablation of one or more tumors. CMS is proposing to accept the RUC-recommended work RVUs for both codes. See the table below.

CPT CODE	LONG DESCRIPTOR	PROPOSED CY 2026 WORK RVU
4001X	Ablation, irreversible electroporation, liver, 1 or more tumors, including imaging guidance, percutaneous	9.41
5XX11	Ablation, irreversible electroporation, prostate, 1 or more tumors, including imaging guidance, percutaneous	13.50

While CMS is proposing to accept the RUC-recommended PE inputs for CPT code 5XX11, they are recommending refinements to some of the inputs for CPT code 4001X. CMS disagrees with the use of the standard 90-day global pre-service clinical labor times in the Facility setting for CPT code 4001X since this is a 0-day global procedure. CMS is, instead, proposing the standard 000/010 global day extensive pre-service clinical labor times in the Facility setting. See the table below.

PE refinements	CMS proposed change	CPT Codes
CA002 (Coordinate pre-surgery services (including test results))	Reduce from 20 minutes to 10 minutes	4001X
CA003 (Schedule space and equipment in facility)	Reduce from 8 minutes to 5 minutes	4001X
CA004 (Provide pre-service education/obtain consent)	Reduce from 20 minutes to 7 minutes	4001X
CA005 (Complete pre-procedure phone calls and prescription)	Reduce from 7 minutes to 3 minutes	4001X

Prostate Biopsy Services (CPT codes 55705, 55706, 5XX00, 5XX01, 5XX02, 5XX03, 5XX04, 5XX07, 5XX08, 5XX09, 5XX10, and 76872) – (Page 186)

This family was caught on the Relativity Assessment Workgroup (RAW) screen for services performed 75% of the time or more by the same physician on the same date of service. The societies developed an action plan that opted to refer the family to the CPT editorial panel for revision. As a result, CPT code 55700 was deleted, CPT codes 55705 and 75872 were revised, and 9 new codes were created. CMS is proposing to accept the RUC-recommended work RVUs for all 12 codes. See the table below.

CPT CODE	LONG DESCRIPTOR	PROPOSED CY 2026 WORK RVU
55705	Biopsy, prostate; any approach, nonimaging-guided	1.93
55706	Biopsies, prostate, needle,transperineal, stereotactic template guided saturation sampling, including imaging guidance	4.27
5XX00	Biopsy, prostate, transrectal,ultrasound-guided (ie, sextant), ultrasound-localized	2.63
5XX01	Biopsy, prostate, transrectal,ultrasound-guided (ie, sextant) with MRI-fusion guidance	3.39
5XX02	Biopsy, prostate,transperineal, ultrasound-guided (ie, sextant), ultrasound-localized	3.23
5XX03	Biopsy, prostate,transperineal, ultrasound-guided (ie, sextant) with MRI-fusion guidance	3.81
5XX04	Biopsy,prostate, transrectal, MRI-ultrasound-fusion guided, targeted lesion(s) only	2.61
5XX07	Biopsy,prostate, transperineal, MRI-ultrasound-fusion guided, targeted lesion(s) only, first targeted lesion	3.10
5XX08	Biopsy, prostate, in-bore CT- or MRI-guided (ie, sextant), with biopsy of additional targeted lesion(s), first targeted lesion	4.00
5XX09	(Biopsy, prostate, in-bore CT- or MRI-guided targeted lesion(s) only, first targeted lesion	3.62
5XX10	(Biopsy, prostate, each additional, MRI-ultrasound fusion or in-bore CT- or MRI-guided targeted lesion (List separately in addition to code for primary procedure	1.05
76872	Ultrasound, transrectal	0.67

CMS is proposing to accept the RUC-recommended PE inputs for all 12 codes without refinement.

Endovascular Therapy with Imaging (CPT codes 61624, 61626, 75894, and 75898) – (Page 190)

Based on action plans developed in correspondence with the April 2022 RUC meeting, CPT codes 61624, 61626, 75894, and75898 were sent to the CPT editorial panel to evaluate the potential for code bundling. While CMS is proposing to accept the RUC-recommended RVUs for CPT codes 75894 and 75896, they have some concerns about the survey data due to variations in the intraservice times and work values in the responses collected. CMS is seeking public comments on the proposed work RVUs for these two codes.

CMS disagrees with the RUC-recommended values for CPT codes 61624 and 61626. The Agency is proposing to crosswalk CPT code 61624 to CPT code 49622 *(Repair of parastomal hernia, any approach (that is, open, laparoscopic, robotic), initial or recurrent, including implantation of mesh or other prosthesis, when performed; incarcerated or strangulated),* with a work RVU of 17.06. CMS feels that this lower work RVU reflects the significant decrease in both the intraservice time and total time of CPT code 61624.

For CPT code 61626, CMS is proposing to crosswalk CPT code 61624 to CPT code 49594 *(Repair of anterior abdominal hernia[s] [that is, epigastric, incisional, ventral, umbilical, spigelian], any approach [that is, open, laparoscopic, robotic], initial, including implantation of mesh or other prosthesis when performed, total length of defect[s]; 3 cm to 10 cm, incarcerated or strangulated),* with a work RVU of 13.46. CMS feels that this lower work RVU reflects the significant decrease in both the intraservice time and total time of CPT code 61626. See the table below.

CPT CODE	LONG DESCRIPTOR	RUC-Recommended WORK RVU	PROPOSED CY 2026 WORK RVU
61624	Transcatheter permanent occlusion or embolization [for example, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation], percutaneous, any method; central nervous system [intracranial, spinal cord]	20.00	17.06
61626	Transcatheter permanent occlusion or embolization [e.g., for tumor destruction, to achieve hemostasis, to occlude a vascular malformation], percutaneous, any method; non-central nervous system, head or neck [extracranial, brachiocephalic branch]	15.31	13.46
75894	Transcatheter therapy, embolization, any method, radiological supervision and interpretation)	2.25	2.25

75898	Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion, other than for thrombolysis	1.85	1.85

CMS is proposing to accept the RUC-recommended PE inputs for CPT codes 61624, 75894, and 75898 without refinement. However, CMS is proposing some refinements to the PE inputs for CPT code 61626. See the table below.

PE Refinements	CMS proposed change	CPT Codes
CA011 (Provide education/obtain consent)	Reduce from 5 minutes to the standard 2 mins	61626
SD172 (guidewire, cerebral (Bentson)	Change the quantity from 1 to 0. CMS believes this supply is not typically used in this service, as 61624 describes non-central nervous system procedures.	61626
EL011 (Angiography room)	Increase by 3 minutes, from 124 to 127 total minutes to incorporate the 3 minutes from CA024 (clean room/equipment by clinical staff) missing from the room time formula	61626
ED053 (Professional PACS workstation)	Round 151.5 minutes up to 152 minutes.	61626

While CMS is not proposing refinement to the PE inputs for 75894 and 75898, they are requesting public comments to clarify the 60 minutes for 75894 and 45 minutes for 75898 that are attributed to CA021 (Perform procedure/service---NOT directly related to physician work time). The Agency would like feedback on what intraservice clinical labor times would be typical for these procedures, when they are performed in the absence of CPT codes 61624 and 61626.

Percutaneous Decompression of Median Nerve (CPT code 647XX) – (page 197)

The CPT Editorial Panel created new CPT code 647XX to report the percutaneous decompression of the median nerve at the carpal tunnel using ultrasound guidance and a balloon dilation device while transecting the transcarpal ligament. While CMS notes that they received external input suggesting a higher 6.00 work RVU, their review of procedures with similar times does not support a higher work RVU. Therefore, CMS is proposing to accept the RUC-recommended RVU for this service. See the table below.

CPT CODE	LONG DESCRIPTOR	PROPOSED CY 2026 WORK RVU
647XX	Decompression; median nerve at the carpal tunnel, percutaneous, with intracarpal tunnel balloon dilation, including ultrasound guidance	2.70

CMS is also proposing to accept the RUC-recommended direct PE inputs for CPT code 647XX without refinement.

Cerebral Perfusion & CT Angiography-Head & Neck (CPT codes 70496, 70498, 70XX1, 70XX2, and 70XX3) – (Page 202)

The CPT Editorial Panel created three new codes for cerebral perfusion and CT angiography of the head and neck. These codes were surveyed for the September 2024 RUC meeting, along with the existing standalone codes for CTA head and CTA neck. CMS is proposing to accept the RUC-recommended work RVUs for the five codes. See the table below.

CPT CODE	LONG DESCRIPTOR	PROPOSED CY 2026 WORK RVU
70496	Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing	1.75
70498	Computed tomographic angiography, neck, with contrast material(s),including noncontrast images, if performed, and image postprocessing	1.75
70XX1	Computed tomographic angiography (CTA), head and neck, with contrast material(s), including noncontrast images, when performed, and image postprocessing	2.50
70XX2	Computed tomographic (CT) cerebral perfusion analysis with contrast material(s), including image postprocessing performed with concurrent CT or CT angiography of the same anatomy (List separately in addition to code for primary procedure)	0.77
70XX3	Computed tomographic (CT) cerebral perfusion analysis with contrast material(s), including image postprocessing performed	1.00

	without concurrent CT or CT angiography of the same anatomy	

CMS is also proposing to accept the RUC-recommended direct PE inputs without refinements for the entire family.

Coronary Atherosclerotic Plaque Assessment (CPT code 75XX6) – (Page 202)

The CPT Editorial Panel created a new Category I CPT code, 75XX6, to describe coronary atherosclerotic plaque assessment and deleted four existing Category III CPT codes associated with the procedure. CMS is proposing to accept the RUC-recommended work RVU for CPT code 75XX6. See the table below.

CPT CODE	LONG DESCRIPTOR	PROPOSED CY 2026 WORK RVU
75XX6	Quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, derived from augmentative software analysis of the data set from a coronary computed tomographic angiography, with interpretation and report by a physician or other qualified health care professional	0.85

While CMS is proposing to accept the RUC-recommended direct PE inputs without refinement, the Agency notes that the new supply item, Plaque Characterization Analysis Software has a per-patient cost of $1,500 for the plaque data analysis summary generated by the vendor. CMS continues to have concerns that software analysis fees are not well accounted for in the direct PE methodology, but they recognize that it is a significant part of the resource costs associated with this procedure. Therefore, CMS is proposing to crosswalk the PE RVU for CPT code 75XX6 to the PE RVU for CPT code 77373 (Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions), which is a PE-only code with no work RVU and which closely approximates the OPPS assignment assigned by Category III code 0625T (Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; computerized analysis of data from coronary computed tomographic angiography), which was previously used to report this service. Crosswalking the PE RVU allows CMS to recognize the costs that practitioners are incurring that would not otherwise be recognized under the current PE methodology.

Use of the Relationship Between OPPS APC Relative Weights to Establish PE RVUs for Radiation Oncology Treatment Delivery (CPT codes 77387, 77402, 77407, 77412, and 77417), Superficial Radiation Treatment (CPT codes 77X05, 77X07, 77X08, and 77X09), and Proton Beam Treatment Delivery (CPT codes 77520, 77522, 77523, and 77525) (Page 204)

In the proposed rule, CMS details the differences in practice expense differences for radiation oncology services in the physician office (non-facility setting) and the hospital (facility setting). Radiation Oncology services in the facility setting typically exceed the Medicare payment made for the same service in the physician office. CMS has received comments from interested parties that the facilities are shouldering a heavy burden of cost compared to non-facilities due to items such as overhead to maintain the facility 24 hours a day 7 days a week and caring for a higher acuity patient that will need additional support services. CMS notes that they received voluntary submission of "resource costs" via invoices but these submissions are proving hard to verify and even hard to obtain.

In the CY 2016 rule, CMS maintained the HCPCS G-codes under the PFS to report radiation treatment delivery services instead of the new CPT codes, while adopting the CPT codes for use under OPPS. Outpatient radiation therapy services have been reported to Medicare using two different sets of HCPCS codes depending on whether they are provided in a facility or non-facility setting.

The CPT Editorial Panel has revised the radiation treatment delivery codes for CY 2026. If CMS were to adopt the CPT codes under the PFS and utilize the RUC-recommended PE inputs, this could lead to volatility in their payment. Therefore, CMS has determined that identifying an alternative data source that is more routinely updated and standardized would improve the accuracy of the codes' valuation.

CMS is proposing to use the OPPS cost data and applying the CY 2026 proposed APC relative weights to the codes to develop PE RVUs for these radiation oncology services. The Agency is also proposing to value the MP RVUs for these services through their usual methodology for PE-only services. CMS calculated the RVUs for these codes so that the overall PE and MP RVUs for these services represent the same share of total PE and MP RVUs in 2025 and 2026. For CY 2026, CMS approximated the direct costs for these services and allocated indirect PE RVUs per the standard methodology in order to both arrive at PE RVUs based on the proposal described and also maintain relativity within the PE RVUs across the fee schedule. The direct PE input public use file does not include the proxy inputs. CMS is seeking comments on this aspect of the methodology, as they want to maintain transparency in rate setting.

CMS is also seeking comments on their proposal to use the relative relationship between the proposed OPPS ACP relative weights to establish the PE RVUs.

Radiation Oncology Treatment Delivery (CPT codes 77387, 77402, 77407, 77412, and 77417) (Page 212)
The CPT Editorial Panel revised CPT codes 77402, 77407, and 77412 to establish a technique-agnostic family of codes and to bundle imaging into the three codes. They also deleted CPT codes 77385, 77386, and 77014.

CMS has been using 17 G-codes for payment of these services under the PFS. For CY 2026, CMS is proposing to delete the 17 G-codes and recognize the newly revised CPT codes for payment, in conjunction with their proposal to utilize OPPS cost data to establish PE RVUs.

CMS is proposing to accept the RUC-recommended work RVU for CPT code 77387, which is the only code with a physician work component. See the table below.

CPT CODE	LONG DESCRIPTOR	PROPOSED CY 2026 WORK RVU
77387	Guidance for localization of target volume for delivery of radiation treatment, includes intrafraction tracking, when performed	0.70
77402	Radiation treatment delivery; Level 1 (for example, single electron field, multiple electron fields, or 2D photons), including imaging guidance, when performed	-
77407	Radiation treatment delivery; Level 2, single isocenter (eg, 3D or IMRT), photons, including imaging guidance, when performed	-
77412	Radiation treatment delivery; Level 3, multiple isocenters with photon therapy (for example, 2D, 3D, or IMRT) OR a single isocenter photon therapy (eg, 3D or IMRT) with active motion management, OR total skin electrons, OR mixed electron/photon field(s), including imaging guidance, when performed	-
77417	Therapeutic radiology port image(s)	-

CMS is proposing to assign Procedure Status "B" to the technical component of CPT code 77387 to maintain consistency with OPPS payment for this code, which is packaged into payment for the treatment delivery codes, CPT codes 77402, 77407, and 77412, and is not separately payable under OPPS. For CPT code 77387, CMS is proposing that the PE and total RVU for the global service will equal the PE and total for the professional component only since the technical component is not separately payable under the PFS. CMS is seeking feedback on whether displaying the global service equal to the professional component is problematic and if it would

be preferable to eliminate the global code and display only the professional and technical components in Addendum B.

CMS is proposing a similar Procedure Status "B" assignment to CPT code 77417, which is PE-only and also packaged into the payment for the treatment delivery codes, CPT codes 77402, 77407, and 77412.

Superficial Radiation Treatment (CPT codes 77X05, 77X07, 77X08, and 77X09) (Page 216)
The CPT Editorial Panel created four new codes, 77X05, 77X07, 77X08, and 77X09, to describe surface radiation therapy. These codes will replace CPT code 77401(Radiation treatment delivery, superficial and/or ortho voltage, per day) and HCPCS code G6001 (Ultrasonic guidance for placement of radiation therapy fields).

For the two codes with physician work, CPT codes 77X05 and 77X09, CMS is proposing to accept the RUC-recommended work RVUs. See the table below.

CPT CODE	LONG DESCRIPTOR	PROPOSED CY 2026 WORK RVU
77X05	Surface radiation therapy; superficial or orthovoltage, treatment planning and simulation-aided field setting	0.77
77X07	Surface radiation therapy; superficial, delivery, <150 kV, per fraction (eg, electronic brachytherapy)	-
77X08	Surface radiation therapy; orthovoltage, delivery, >150-500 kV, per fraction	-
77X09	Surface radiation therapy; superficial or orthovoltage, image guidance, ultrasound for placement of radiation therapy fields for treatment of cutaneous tumors, per course of treatment (list separately in addition to the code for primary procedure) (use 77x09 in conjunction with 77x07, 77x08)	0.30

For PE RVUs, CMS is proposing a similar approach that they used for the radiation oncology treatment delivery codes. They are proposing to use the relationship between the relative weights of the OPPS APCs to which the codes in this family are assigned to more accurately reflect the actual costs of these services.

CMS is proposing to utilize the relationship between the proposed OPPS APC assignments for APCS 5621 and 5732 to inform the valuation of PE-only CPT codes 77X07 and 77X08, and for the technical component of CPT code 77X05 when paid under the PFS.

CMS is proposing to assign Procedure Status "B" to the technical component of CPT code 77X09 to maintain consistency with OPPS payment for this code, which is packaged into payment for CPT codes 77X07 and 77X08. CMS is seeking feedback on whether displaying the global service equal to the professional component is problematic and if it would be preferable to eliminate the global code and display only the professional and technical components in Addendum B.

Proton Beam Treatment Delivery (CPT codes 77520, 77522, 77523, and 77525) (Page 219)
Proton beam treatment delivery PFS payments are currently determined by local Medicare Administrative Contractors (MACS). These services do not have previously established RVUs due to the unique nature of the equipment costs associated with them compared to other capital costs addressed by CMS's usual PE methodology. With the discussion for the new radiation oncology and superficial radiation treatment delivery services codes, CMS is seeking feedback on whether they should adopt a similar approach to establishing RVUs for these proton beam treatment delivery services.

CPT CODE	LONG DESCRIPTOR
77520	Proton treatment delivery; simple, without compensation
77522	Proton treatment delivery; simple, with compensation
77523	Proton treatment delivery; intermediate
77525	Proton treatment delivery; complex

CMS is specifically seeking comments on how they can establish national pricing and total RVUs for these services to maintain relativity within the PFS. They pose the questions:

- Would using the overall ratio between OPPS and PFS payment for radiation oncology treatment services to establish initial year RVUs for proton beam delivery services accurately reflect the relative resources involved?
- Would it be more appropriate to consider the overall difference between the OPPS and Medicare payments currently determined by the MACs for these services, or are there other alternative methods that CMS should consider?

Direct Supervision via Use of Two-way Audio/Video Communications Technology (Page 125)
Under Medicare Part B, certain types of services, including diagnostic tests described under § 410.32 and services incident to a physician's professional service described under § 410.26 (incident-to services), are required to be furnished under specific minimum levels of supervision by a physician or other practitioner. In the March 31, 2020 COVID-19 IFC, CMS changed the definition of "direct supervision" during the PHE for COVID-19 as it pertains to supervision of diagnostic tests, physicians' services, and some hospital outpatient services, to allow the supervising professional to be immediately available through virtual presence using

two-way, real-time audio/video technology, instead of requiring their physical presence. CMS has previously extended flexibility through rulemaking. The ACR has previously supported CMS's extension of this policy.

CMS is proposing to permanently adopt a definition of direct supervision that allows "immediate availability" of the supervising practitioner using audio/video real-time communications technology (excluding audio-only), for all services described under § 410.26, except for services that have a global surgery indicator of 010 or 090.

CMS is seeking comments on whether to adopt a definition of direct supervision that allows "immediate availability" of the supervising practitioner using audio/video real-time communications technology (excluding audio-only), for all services described under § 410.26, except for services that have a 000, 010, or 090 global surgery indicator.

Policies to Improve Care for Chronic Illness and Behavioral Health Needs (Page 311)
Comment Solicitation on Payment Policy for Software as a Service (SaaS) pg. 319
CMS stated that there has have been rapid developments in the use of software-based technologies to support clinical decision-making in the outpatient and physician office settings, some of which may be devices requiring FDA, clearance, approval, or authorization. CMS has considered most computer software and associated analysis and licensing fees to be indirect costs tied to costs for associated hardware that is considered to be medical equipment. CMS has considered several distinct issues when evaluating SaaS technologies.

CMS has observed wide variations in the purported costs of clinically similar SaaS technologies. The various costs that manufacturers consider when pricing their technologies, including research and development and software maintenance, are often not publicly verifiable. Additionally, due to the novel and evolving nature of these technologies, there are rarely existing medical items or services that can be utilized for comparison purposes to determine clinical and resource similarity. Lastly CMS stated that while there has been a rapid increase in the development and coding of services incorporating these technologies in recent years, there is a very limited amount of Medicare claims data for these services.

CMS expressed interest in paying accurately for the management of chronic disease and primary care services. CMS is seeking to understand how the use of SaaS and artificial intelligence (AI) technology affects those services and how to incorporate these costs into their current strategy for paying for evolving models of care delivery, such as the Advanced Primary Care Management and risk-based payment arrangements generally. CMS is requesting public comments on how they should consider paying for SaaS under the PFS, including:

- What factors should they consider when paying for SaaS?
- What has the experience been of risk-based payment arrangement participants with incorporating SaaS under their payment arrangements?
- Have risk-based payment arrangements reflected the underlying value of SaaS to the practice of medicine?
- Given the limitations of the PE methodology to account for this kind of technology, what alternative pricing strategies should CMS use to accurately pay for SaaS and AI devices

under the PFS? For example, should CMS continue its current practice of crosswalking values from the OPPS established payment amounts for the technical components of services incorporating SaaS and AI? Or should CMS integrate OPPS geometric mean costs for these devices into CMS's ratesetting methodology as CMS is proposing to do in this proposed rule for RPM and RTM services, or set payment rates relative to OPPS rates as they are proposing to do for radiation oncology services?

- How should CMS value the physician work associated with utilizing and interpreting the clinical outputs associated with SaaS and AI devices?
- Is there an alternative data source outside of the limited Medicare claims data currently available and hospital invoices provided by manufacturers, which may not fully depict total hospital acquisition costs, that can accurately reflect the costs of the SaaS?
- How are these technologies used in the treatment of chronic disease?
- How may CMS best evaluate the quality and efficacy of SaaS and AI technologies? CMS welcomes input from interested parties on these questions as well as any additional suggestions that would enhance CMS's ability to provide accurate and consistent payment for procedures incorporating SaaS.

CMS notes that there is a comment solicitation in the CY 2026 OPPS proposed rule regarding SaaS devices furnished in hospital outpatient departments and ASCs.

Medicare Shared Savings Program (Page 745)

As of January 1, 2025, the Medicare Shared Savings Program (MSSP) has 477 accountable care organizations (ACOs) with over 650,000 healthcare providers and organizations providing care to over 11.2 million assigned beneficiaries. Eligible groups of providers and suppliers, such as physicians, hospitals, and other healthcare providers, may participate in the Shared Savings Program by forming or joining an ACO and in so doing agree to become accountable for the total cost and quality of care provided under Traditional Medicare to an assigned population of Medicare FFS beneficiaries. Under the MSSP, providers and suppliers that participate in an ACO continue to receive Traditional Medicare FFS payments under Parts A and B, and the ACO may be eligible to receive a shared savings payment if it meets specified quality and savings requirements, and in some instances may be required to share in losses if it increases healthcare spending.

Summary of Shared Savings Program Proposals

CMS is proposing to modify requirements for determining ACO's eligibility for MSSP participation options, for agreement periods beginning on or after January 1, 2027, to limit participation in a one-sided model to an ACO's first agreement period under the BASIC track's glide path (if eligible) and require ACOs inexperienced with performance-based risk Medicare ACO initiatives (defined at § 425.20) to progress more rapidly to higher levels of risk and potential reward under Level E of the BASIC track or the ENHANCED track.

CMS is proposing to modify eligibility requirements to require ACOs to make certain changes to their ACO participant list when an ACO participant experiences a change of ownership (CHOW) where the surviving Taxpayer Identification Number (TIN) is newly enrolled in the Provider Enrollment, Chain, and Ownership System (PECOS) with no prior Medicare billing claims

history, during the performance year and outside of the annual change request cycle, and similarly allow for changes during the performance year to the ACO's Skilled Nursing Facility (SNF) affiliate list if a SNF affiliate undergoes a CHOW resulting in change to the Medicare enrolled TIN.

CMS is proposing to modify MSSP eligibility requirements and financial reconciliation requirements in connection with the statutory requirement that ACOs have at least 5,000 assigned Medicare FFS beneficiaries to:

- Require ACOs applying to enter into a new agreement period to have at least 5,000 assigned beneficiaries in BY3, while allowing the ACO to have under 5,000 assigned beneficiaries in BY1, BY2, or both.
- Require ACOs that enter a new agreement period with less than 5,000 assigned beneficiaries in BY1, BY2, or both to enter the BASIC track.
- Cap shared savings and shared losses at a lesser amount for ACOs with fewer than 5,000 assigned beneficiaries in any of the three BYs, to help ensure the amounts reflect the ACO's performance in the program rather than normal variation in expenditures.
- Exclude ACOs that fall below 5,000 assigned beneficiaries in any benchmark year from being eligible to leverage existing policies that provide certain low revenue ACOs participating in the BASIC track with increased opportunities to share in savings.

CMS is proposing to revise the quality performance standard and other quality reporting requirements, including the following:

- Revise the definition of a beneficiary eligible for Medicare CQMs at § 425.20 for performance year 2025 and subsequent performance years so that the population identified for reporting within the Medicare CQM collection type would have greater overlap with the beneficiaries that are assignable to an ACO.
- Remove the health equity adjustment applied to an ACO's quality score beginning in performance year 2025 and revise the terminology used to describe the health equity adjustment and other related terms for performance years 2023 and 2024.
- Update the APP Plus quality measure set for Shared Savings Program ACOs including the removal of Quality ID: 487 Screening for Social Drivers of Health.
- Require CMS-approved survey vendors to administer the CAHPS for MIPS Survey via a web-mail-phone protocol beginning with 2027.

CMS is proposing to expand the application of the Shared Savings Program quality and finance extreme and uncontrollable circumstances (EUC) policies to an ACO that is affected by an EUC due to a cyberattack, including ransomware/malware, as determined by the Quality Payment Program, for performance year 2025 and subsequent performance years.

CMS is proposing to revise the definition of a beneficiary eligible for Medicare Clinical Quality Measures (Medicare CQMs) for ACOs participating in MSSP, for performance year 2025 and subsequent performance years, so that the population identified for reporting within the Medicare CQM collection type would have greater overlap with the beneficiaries that are assignable to an ACO, and thereby reduce ACOs' burden in the patient matching necessary to report Medicare CQMs.

For alignment with CMS' quality programs, CMS is proposing to update the Alternative Payment Model (APM) Performance Pathway (APP) Plus quality measure set for Shared Savings Program ACOs, including to remove Quality ID: 487 Screening for Social Drivers of Health, and to expand the survey modes for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for Merit-based Incentive Payment System (MIPS) Survey from a mail-phone administration protocol to a web-mail-phone administration protocol beginning with performance year 2027.

CMS estimates that these proposals would reduce program spending by $20 million in total through the end of the 10-year period 2026 through 2035.

Drugs and Biological Products Paid Under Medicare Part B (Page 1200)
Requiring Manufacturers of Certain Single-dose Container or Single-use Package Drugs to Provide Refunds with Respect to Discarded Amounts pg. 451
By statute, manufacturers are required to pay Medicare a refund for specified discarded amounts of certain single-dose container or single-use package drugs under Part B. In this proposed rule, CMS reviewed two applications for increased applicable percentage for specific products for CY 2026, but CMS is not proposing increased applicable percentages for either drug.

Updates to the Quality Payment Program (QPP)
CMS proposed changes to policies for the tenth year of the Quality Payment Program (QPP) and its component participation methods – the Merit-Based Incentives Payment System (MIPS) and Advanced Alternative Payment Models (APMs).

MIPS Value Pathways (MVPs) – Proposed Additions and Structure

CMS is proposing six new MVPs for the 2026 performance year, which would become available for voluntary reporting. These additions are part of CMS's broader strategy to simplify quality reporting and align performance measures more closely with clinical practice. The proposed MVPs include Diagnostic Radiology, Interventional Radiology, Neuropsychology, Pathology, Podiatry, and Vascular Surgery. (p. 900)

The *Diagnostic Radiology MVP i*s divided into three clinical categories:

1. General Diagnostic Radiology – This category encompasses a wide range of imaging services across various organ systems.
2. Body Imaging (Thoracic/Abdominal) – This grouping focuses on advanced imaging techniques such as CT, MRI, and ultrasound, specifically for thoracic and abdominal conditions.
3. Advancing Health and Wellness – This category emphasizes preventive imaging, screening, and population health initiatives.

The *Interventional Radiology MVP* includes four clinical groups:

1. Vascular – This group involves procedures such as angioplasty, stenting, and embolization.
2. Dialysis-related – This involves interventions related to vascular access for dialysis patients.
3. Neurological Intervention – This group focuses on image-guided procedures for conditions like stroke, aneurysms, and other neurovascular issues.
4. General Interventional Radiology – This is a broad category that includes procedures not included in the other groups.

Each clinical category is associated with a set of quality measures, cost measures, and improvement activities that the CMS considers most relevant to the services provided by radiologists and interventionalists. These measures assess the appropriateness of imaging, patient safety, care coordination, and participation in clinical data registries. (p. 1724)

CMS aims to enhance attribution accuracy, reduce administrative burdens, and support continuous quality improvement. CMS is requesting feedback on the clinical relevance of the categories, the alignment of proposed measures, and the overall value of these MVPs for encouraging specialty engagement and improving patient outcomes.

Requests for Information (RFIs) Related to MVPs

CMS is also seeking input on several RFIs that could inform the future direction of MVP development: (p. 901)

- *Core Elements in an MVP*: CMS is evaluating whether standardizing specific components—such as population health measures, patient-reported outcomes, or interoperability requirements—across all MVPs could enhance transparency and enable patients to compare clinician performance more effectively. Feedback is requested on how to structure MVPs to support this goal.
- *Well-being and Nutrition Measures*: CMS is considering how to incorporate broader public health priorities into MVPs, including preventive care, nutrition, and lifestyle interventions. The agency is particularly interested in how these measures could support chronic disease prevention and address social determinants of health.
- *Procedural Codes for MVP Assignment*: CMS is examining the use of procedural codes (e.g., CPT, HCPCS) to automatically assign clinicians to MVPs, reflecting their scope of practice. This could streamline reporting and ensure that clinicians are evaluated using relevant measures. Comments are being requested on how CMS should define procedural thresholds or assessment logic.
- *Transition Toward Digital Quality Measurement*: CMS continues to pursue a shift toward digital quality measurement (dQM). The agency is requesting feedback on the use of FHIR-based APIs, EHR integration, and automated data capture to support real-time, interoperable reporting. Stakeholders are encouraged to share insights on barriers to adoption and system readiness.

- *Performance-Based Measures in Public Health and Clinical Data Exchange:* CMS is considering new performance-based measures under the Promoting Interoperability category. These would assess not just participation in data exchange, but the quality, frequency, and completeness of that exchange, such as bidirectional sharing and timeliness.

Data Quality: Recognizing the importance of reliable data, CMS is seeking input on how to assess and improve the quality of health information exchanged across systems, including identifying common sources of error, establishing validation standards, and understanding how data quality affects the performance of measures.

MIPS Scoring Overview

The category weights for the 2026 performance year will remain unchanged: **Quality – 30%, Cost – 30%, PI – 25%, and IAs – 15%.** Previously established reweighting formulas for non-patient-facing clinicians and small practices are set to continue with no proposed changes. **CMS proposes maintaining the performance threshold at 75 points through the 2028 performance year. (p. 906)**

CMS finalized the payment adjustment of +/- nine percent for performance years 2020 and beyond. No changes have been proposed to the MIPS adjustment. CMS will maintain the small practice bonus of 6 points for the Quality performance category score and all previously finalized considerations for small practices.

Quality Category

CMS proposes to maintain the measure scoring policy established in 2025 which identifies certain measure sets affected by limited measure choice and adjusts the benchmarks of point-capped measures to allow for a maximum score of 10 points. This policy reset the benchmarks for several Diagnostic Radiology measures, allowing physicians to once again achieve 10 points on measures which had been capped at 7 points in previous years. CMS proposes extending this policy to MVPs, noting that many MVPs are affected by the same issue as the specialty sets. CMS will identify certain MVPs as "at-risk" if participants would not be able to meet or exceed the 75-point performance threshold using measures available within the MVP. (p. 1063)

The diagnostic radiology measures previously identified for this scoring adjustment will continue to receive an adjusted benchmark in 2026. These measures include:

- #143: Oncology: Medical and Radiation – Pain Intensity Quantified
- #360: Count of Potential High Dose Radiation Imaging Studies: CT and Cardiac Nuclear Medicine Studies
- #364: Appropriateness: Follow-up CT Imaging for Incidentally Detected Pulmonary Nodules
- #405: Appropriate Follow-up Imaging for Incidental Abdominal Lesions
- #406: Appropriate Follow-up Imaging for Incidental Thyroid Nodules (p. 1064)

CMS has also amended the definition of "high priority measure" to remove references to health equity. The relatively new health equity measure, #487: Screening for Social Drivers of Health, has been proposed for removal. No other measures relevant to diagnostic or interventional radiology have been proposed for removal in 2026. (p. 1407)

Lastly, CMS has proposed a new benchmarking methodology for scoring administrative claims-based quality measures beginning with the 2025 MIPS performance period. This change, if finalized, will not affect measures submitted through Qualified Registries or Qualified Clinical Data Registries. CMS notes that performance scores for claims-based measures have historically been lower than their registry-based counterparts, likely due to their use of performance period benchmarks rather than established historical benchmarks. Because of this difference in benchmarking, physicians reporting claims measures to CMS have been unable to accurately gauge their performance on measures over the course of the year.

This new scoring methodology, which is based on standard deviation, median, and a point value derived from the performance threshold, is proposed with the intention of improving scores of physicians reporting claims-based measures. (p. 1072)

Improvement Activities

CMS has proposed the removal of the Achieving Health Equity subcategory. Many of the activities previously included in this category were removed from the program in early 2025. CMS also proposed the addition of a new subcategory titled Advancing Health and Wellness, as well as the addition of three new IAs into the subcategories of Population Management and Patient Safety and Practice Assessment. (p. 984)

The improvement activities proposed for removal are:

- **IA_AHE_5: MIPS Eligible Clinician Leadership in Clinical Trials or CBPR**
- **IA_AHE_8: Create and Implement an Anti-Racism Plan**
- **IA_AHE_9: Implement Food Insecurity and Nutrition Risk Identification and Treatment Protocols**
- **IA_AHE_11: Create and Implement a Plan to Improve Care for Lesbian, Gay, Bisexual, Transgender, and Queer Patients**
- **IA_AHE_12: Practice Improvements that Engage Community Resources to Address Drivers of Health**
- **IA_PM_26: Vaccine Achievement for Practice Staff: COVID-19, Influenza, and Hepatitis B**
- **IA_PM_6: Use of Toolsets or Other Resources to Close Health and Health Care Inequities Across Communities**
- **IA_ERP_3: COVID-19 Clinical Data Reporting with or without Clinical Trial**

The three IAs proposed for addition to the program are:

- **IA_PM_XX: Improving Detection of Cognitive Impairment in Primary Care**
- **IA_PM_XX: Integrating Oral Health Care in Primary Care**

- **IA_PSPA_XX: Patient Safety Use of Artificial Intelligence**

The activity "Patient Safety Use of Artificial Intelligence" was proposed with the intent of addressing adverse patient events attributed to the use of AI in healthcare. (p. 990)

Cost Performance Category

CMS is proposing changes to the Total Per Capita Cost (TPCC) measure to refine how candidate events are identified and attributed. Specifically, the proposal would allow for the exclusion of candidate events initiated by advanced practice providers (APPs), like nurse practitioners or physician assistants, when all other non-APP clinicians (i.e., physicians) within the same TIN-NPI group are excluded based on existing specialty exclusion criteria. This change is intended to improve the accuracy of attribution by ensuring that APPs are not inappropriately assigned responsibility for cost measures when their collaborating or supervising physicians are excluded from the measure due to their specialty. (p. 1800)

CMS also proposes to implement a two-year informational feedback period for any newly adopted MIPS cost measures. During this period, clinicians would receive performance feedback on the new measures, but the results would not be factored into their MIPS final score. This approach is designed to give clinicians time to understand the measure specifications, assess their performance, and make any necessary adjustments before the measures are used for scoring purposes. (p. 904)

APM Performance Pathway
CMS is proposing to update some quality measures in the APM Performance Pathway (APP), original quality measure set and the APP Plus quality measure set to reflect the proposed changes to measures specified for the quality performance category. CMS is proposing to incorporate the updated versions of MIPS quality measures used in the APP quality measure set.

Advanced APMs pg. 1098
CMS is proposing to add an individual level calculation to Qualifying APM Participant (QP) determinations, as set forth in proposed regulation text at §§ 414.1425(b)(3 and (c)(3), for all eligible clinicians participating in an Advanced APM, such that each eligible clinician would receive both APM Entity level calculation and an individual level calculation.

CMS is also proposing to expand the scope of the services in the sixth criterion of the definition of "attribution-eligible beneficiary" at § 414.1305 to use covered professional services (section 1848(k)(3)(A) of the Act). CMS believes these proposals would modernize and improve the QP determination approach across Advanced APMs.

CMS is proposing to sunset the Advanced APM criterion at § 414.1415(c)(7), which currently limits Medical Home Model participants to 50 clinicians. Lastly, CMS is proposing to modify §§ 414.1455(a)(b)(3)(ii) and (b)(3)(vi) pertaining to the QP Targeted Review process to align with

MIPS Targeted Review process set forth at § 414.1385 to ensure that the QP and MIPS Targeted Reviews occur concurrently.

The ACR will submit comments to CMS by the September 12 comment period deadline.

Additional Resources: CMS Press Release / Physician Payment Schedule Fact Sheet / Medicare Shared Savings Program Fact Sheet / Quality Payment Program Fact Sheet