American College of Radiology

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

The Centers for Medicare and Medicaid Services (CMS) released the calendar year (CY) 2026 Medicare Physician Fee Schedule (MPFS) final rule on Friday, October 31, 2025. In this rule, CMS describes changes, effective January 1, 2026, to payment provisions and to policies for the ninth 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). There is no formal comment period associated with the final rule.

Conversion Factor and CMS Overall Impact Estimates (Page 1735)
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 a qualifying APM participant is finalized at $33.5675, inclusive of a .75% annual update. The conversion factor for services provided by non-APM participants is finalized at $33.4009, 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 budget reconciliation bill as well as a 0.49% budget neutrality adjustment.

CMS estimates an overall impact of the MPFS changes to be -2 percent for radiology, -1 percent for nuclear medicine, 2 percent for interventional radiology and -1 percent for radiation oncology under the finalized fee schedule.

Medicare Economic Index (MEI) (Page 25)
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 (the "2017-based MEI") to reflect the current market conditions that physicians are facing. However, after receiving stakeholder feedback, CMS decided to delay implementation until the American Medical Association (AMA) concluded their data collection efforts for the Physician Practice Information (PPI) and Clinician Practice Information (CPI) surveys. In the final rule, CMS expressed their concerns with the data and its accuracy, choosing not to use the practice expense per hour (PE/HR) or cost shares data from the AMA survey at this time. For CY 2026, CMS will maintain the current PE/HR and the 2006-based MEI cost shares.

Efficiency Adjustment (Page 182)
The CMS has relied on the AMA's Relative Value Scale Update Committee (RUC) data to estimate physician time, work intensity, and PE and uses this information to establish RVUs in the MPFS. However, CMS has concerns about potential response bias, as well as the low response rate of the RUC data and the infrequency of how often most codes are revalued by the RUC.

The Agency also believes that non-time-based codes (procedures, radiology services, and diagnostic tests) should become more efficient over time, but that these efficiency gains have not been reflected in the work RVUs for these services. Therefore, beginning CY 2026, CMS is

implementing an efficiency adjustment of negative 2.5% to the work RVUs and intra-service time for non-time-based codes. This efficiency adjustment would be applied every three years. CMS is not making corresponding updates to direct practice expense at this time, but may consider it for future rulemaking.

CMS is moving forward with this efficiency adjustment despite stakeholder concerns about the broad application to all non-time-based procedures, reduced patient access to care, and financial stability of practices. However, CMS acknowledges that technological changes may impact services differently and they will welcome empiric data for consideration in future rulemaking. The Agency was also persuaded by stakeholder feedback that it would not be appropriate to apply the efficiency adjustment to new services, as there has not been time for efficiencies to be gained. Codes that are new for CY 2026 will be exempt, along with time-based services, services on the CMS telehealth list, time-based physical medicine and rehabilitation services, remote therapeutic monitoring services, and also time-based drug administration codes.

Practice Expense Data Collection and Methodology (Page 53)
The AMA PPI survey was introduced in 2007 to collect comprehensive and reliable data on direct and indirect PEs incurred by physicians. 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.

For consideration in the CY 2026 MPFS, the AMA shared their updated PPI and CPI survey data with CMS. In reviewing the data, while CMS acknowledges that the 2024 survey design is an improvement over the 2007 PPI survey, they continue to express concerns about the accuracy of the data due to low response rates, the small sample size and sampling variation, the lack of comparability to previous survey data, potential measurement error, and also missing and incomplete data submission. For these reasons, CMS is not incorporating the new PPI and CPI data and will continue to use the current PE/HR data and cost shares for CY 2026 rate setting.

Alternatives Considered for Adjusting RVUs to Match PE Share in the AMA's PPI and CPI Surveys (Page 1803)
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 proposed three 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 these alternatives yield significant redistributive effects, which CMS displays in the MPFS. The cost shares derived by CMS and from the PPI and CPI surveys result in very different PE shares, and the current 2006-based MEI cost shares are in the middle. Therefore, CMS will continue to delay the implementation of any alternative cost share weights, citing their efforts to balance payment stability and predictability with incorporating new data through routine updates.

PE Methodology – Site of Service Payment Differential (Page 68)
CMS states that due to the shift of physicians from private practice offices (non-facility) into hospitals (facility), indirect costs may now be overstated for physicians who no longer maintain an office. An overstatement of PE in the facility affects the allocation of indirect costs in the non-facility setting, which could result in additional costs for payers and obstacles for physicians who maintain independent practices. Therefore, CMS proposed 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 received responses both in support of, and against, the proposal. Some individuals felt the 50% was arbitrary, others suggested a multi-year transition, and others pointed out that professional contracts between independent medical groups and hospitals often vary. A commenter also suggested working toward a more precise process for adjusting the payments over time, including a facility-based physician modifier, which CMS may consider in future rulemaking. **CMS also shared that services billed with the 26 modifier will not be impacted by this proposal.**

CMS believes that their estimate of 50% is conservative and is finalizing the reduction of facility PE RVUs allocated based on work RVUs to half the amount allocated to non-facility PE RVUs beginning CY 2026.

Determination of Malpractice (MP) RVUs (Page 547)
Three factors comprise the MP 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.

MP RVUs are calculated using specialty-specific MP premium data. For CY 2026, CMS was able to obtain the data for all 50 states and the District of Columbia, although distinct premium data was not available for all specialties. CMS is not proposing any major methodological refinements to the development of MP premium data but aims to rely less on imputed data for

specialties such as geriatric medicine, hospitalist, internal medicine, medical oncology, pain management, and preventative medicine.

For CY 2026, CMS will map the MP RVUs for technical component (TC)-only services to allergy/immunology, with a risk index value of 0.427.

Alternatives Considered for the PE Geographic Practice Cost Index (GPCI) (Page 1811)
The four components of the 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. Given that the AMA's PPI and CPI surveys do not contain the breakdown of PE needed for CMS to weight the four components of the PE GPCI for CY 2006, they will continue to use the 2006- based MEI cost share weights.

Potentially Misvalued Services Under the PFS (Page 85)
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 by a stakeholder. 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 expressed concern that the reduction in work RVU impacts patient care and accessibility to the procedure. They encouraged CMS to revisit the valuation of these codes.

CMS reiterated that they do not believe these codes are misvalued. However, the RUC submitted comment that, due to interest from a specialty society to re-review CPT codes 10005 and 10006, these codes will be placed on the Level of Interest for review for CY 2027.

Valuation of Specific Codes for CY 2026 (Page 173)

Lower Extremity Revascularization (CPT codes 37254, 37255, 37256, 37257, 37258, 37259, 37260, 37261, 37262, 37263, 37264, 37265, 37266, 37267, 37268, 37269, 37270, 37271, 37272, 37273, 37274, 37275, 37276, 37277, 37278, 37279, 37280, 37281, 37282, 37283, 37284, 37285, 37286, 37287, 37288, 37289, 37290, 37291, 37292, 37293, 37294, 37295, 37296, 37297, 37298, and 37299) - (Page 235)

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 expressed some concern about the survey data and methodology, including the use of a full RUC survey for only 11 codes and abbreviated surveys for the remaining 35 codes. However, based on stakeholder feedback, CMS is finalizing the RUC recommendations for all 46 Lower Extremity Revascularization codes for 2026. See table below.

CPT CODE	LONG DESCRIPTOR	CY 2026 WORK RVU
37254	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
37255	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
37256	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
37257	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
37258	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
37259	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, each additional vessel (List separately in addition to code for primary procedure)	4.00
37260	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	12.69

	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	
37261	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
37262	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
37263	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
37264	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
37265	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, initial vessel	10.50
37266	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
37267	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
37268	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
37269	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including	14.75

	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	
37270	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, each additional vessel (List separately in addition to code for primary procedure)	5.00
37271	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
37272	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
37273	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
37274	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
37275	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, initial vessel	11.00
37276	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
37277	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory,	15.00

	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	
37278	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
37279	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
37280	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, initial vessel	9.80
37281	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
37282	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
37283	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
37284	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
37285	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	3.34

	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)	
37286	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
37287	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
37288	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
37289	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 to code for primary procedure)	4.75
37290	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
37291	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
37292	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
37293	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with	6.50

	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)	
37294	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
37295	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
37296	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
37297	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
37298	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, initial vessel	13.70
37299	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 received detailed comments from stakeholders regarding the PE refinements that were proposed, specifically those related to the supply inputs. After reviewing stakeholders' comments CMS has finalized all of the PE recommendations set forth at the RUC. See table below.

Supplies & Equipment	Refinement	CPT Codes
ED053 (professional PACS workstation)	Apply the standard equipment formula 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)	Finalize the RUC-recommended two stents.	37263, 37265, 37271 & 37273
SD379 (drug eluting stent, tibial)	Finalize the RUC-recommended two stents.	37286, 37287, 37294 & 37295
NEW – SA142 (pack, angiography)	Approved the creation of a new pack with 20 supply components	37254, 37256, 37258, 37260, 37263, 37265, 37267, 37269, 37271, 37273, 37275, 37277, 37280, 37282, 37284, 37286, 37288, 38290, 37292, 37294, 37296, 37298

CMS received numerous comments from stakeholders in support of the creation of G-codes for high-cost disposable supplies, stating that it could improve billing accuracy and ensure appropriate reimbursement for expensive medical devices and supplies used in patient care. Stakeholders also stated that if CMS intends to use the OPPS cost data to establish pricing for services and supplies in the MPFS, a comprehensive proposal should be shared in future rulemaking. CMS indicated that they appreciate the feedback. They believe the OPPS cost data may be useful and will consider it for future rulemaking.

Irreversible Electroporation of Tumors (CPT codes 47384 and 55877) - (Page 246)

CPT codes 47384 and 55877 were created for reporting of percutaneous irreversible electroporation ablation of one or more tumors.

CMS finalized the RUC-recommended work RVUs for both codes. See the table below.

CPT CODE	LONG DESCRIPTOR	CY 2026 WORK RVU
47384	Ablation, irreversible electroporation, liver, 1 or more tumors, including imaging guidance, percutaneous	9.41
55877	Ablation, irreversible electroporation, prostate, 1 or more tumors, including imaging guidance, percutaneous	13.50

CMS, with stakeholders' support, finalized the RUC-recommended PE inputs for CPT code 55877.

For CPT code 47384, CMS continues to disagree with the use of the standard 90-day global pre-service clinical labor times in the Facility setting since it is a 0-day global procedure. Instead,

CMS finalized the standard 000/010 global day extensive pre-service clinical labor times in the Facility setting. See the table below.

Clinical Activity	Refinements	CPT Code
CA002 (Coordinate pre-surgery services (including test results))	Reduced from 20 minutes to 10 minutes	47384
CA003 (Schedule space and equipment in facility)	Reduced from 8 minutes to 5 minutes	47384
CA004 (Provide pre-service education/obtain consent)	Reduced from 20 minutes to 7 minutes	47384
CA005 (Complete pre-procedure phone calls and prescription)	Reduced from 7 minutes to 3 minutes	47384

Prostate Biopsy Services (CPT codes 55705, 55706, 55707, 55708, 55709, 55710, 55711, 55712, 55713, 55714, 55715, and 76872) – (Page 262)

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, with stakeholders' support, finalized the RUC-recommended work RVUs and PE for all 12 Prostate Biopsy Services codes without refinement.

CPT CODE	LONG DESCRIPTOR	CY 2026 WORK RVU
55705	Biopsy, prostate; any approach, nonimaging-guided	1.88*
55706	Biopsies, prostate, needle, transperineal, stereotactic template guided saturation sampling, including imaging guidance	4.16*
55707	Biopsy, prostate, transrectal,ultrasound-guided (ie, sextant), ultrasound-localized	2.63
55708	Biopsy, prostate, transrectal, ultrasound-guided (ie, sextant) with MRI-fusion guidance	3.39
55709	Biopsy, prostate, transperineal, ultrasound-guided (ie, sextant), ultrasound-localized	3.23
55710	Biopsy, prostate, transperineal, ultrasound-guided (ie, sextant) with MRI-fusion guidance	3.81
55711	Biopsy, prostate, transrectal, MRI-ultrasound-fusion guided, targeted lesion(s) only	2.61
55712	Biopsy, prostate, transperineal, MRI-ultrasound-fusion guided, targeted lesion(s) only, first targeted lesion	3.10
55713	Biopsy, prostate, in-bore CT- or MRI-guided (ie, sextant), with biopsy of additional targeted lesion(s), first targeted lesion	4.00
55714	(Biopsy, prostate, in-bore CT- or MRI-guided targeted lesion(s) only, first targeted lesion	3.62
55715	(Biopsy, prostate, each additional, MRI-ultrasound fusion or in-bore CT- or MRI-guided	1.05

	targeted lesion (List separately in addition to code for primary procedure	
76872	Ultrasound, transrectal	0.65*

*Note that the efficiency adjustment has been applied to the RUC-recommended RVU

Endovascular Therapy with Imaging (CPT codes 61624, 61626, 75894, and 75898) – (Page 266)

Based on action plans developed in correspondence with the April 2022 RUC meeting, CPT codes 61624, 61626, 75894, and 75898 were sent to the CPT editorial panel to evaluate the potential for code bundling.

In the proposed rule, CMS expressed some concerns about the survey data and RUC-recommended RVUs for CPT codes 75894 and 75896 due to variations in the intraservice times and work values in the responses collected. However, CMS proposed to accept the RUC-recommended values for these codes. CMS proposed refinements to the value of CPT codes 61624 and 61626, from 20.00 RVU to 17.06 RVU and 15.31 RVU to 13.46 RVU, respectively. CMS believed the lower RVUs reflect the significant decrease in both the intraservice and total time for CPT codes 61624 and 61626.

After reviewing stakeholders' feedback that detailed the complexity differences between CPT codes 61624 and 61626 and the crosswalk codes CMS proposed, CMS reversed their position and finalized the RUC-recommended values for all four codes. See table below.

CPT CODE	LONG DESCRIPTOR	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]	19.50*
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]	14.93*
75894	Transcatheter therapy, embolization, any method, radiological supervision and interpretation)	2.19*
75898	Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion, other than for thrombolysis	1.80*

*Note that the efficiency adjustment has been applied to the RUC-recommended RVU

In the proposed rule, CMS requested clarification on the clinical activity CA021 (Perform procedure/service—NOT directly related to physician work time) for CPT codes 75894 and 75898, as the involvement of additional vascular interventional technologists were unclear. Based on stakeholder feedback and the additional information provided, about how the vascular interventional technologist works closely with the physician to ensure appropriate imaging, adequate contrast, and proper documentation of images, CMS agrees that the 60 minutes for CPT code 75894 and 45 minutes for CPT code 75898 is appropriate for CA021.

CMS finalized the RUC-recommended PE inputs for CPT codes 61624, 75984 and 75898 without refinement.

Following stakeholder feedback, CMS revised some of their PE refinements for CPT code 61626. See the table below.

PE Inputs	Refinements	CPT Code
CA011 (Provide education/obtain consent)	Approved 5 minutes due to the explanation provided by stakeholders as to the complexity of this exam.	61626
SD172 (guidewire, cerebral (Bentson)	CMS disagreed with stakeholders that this cerebral guidewire is typical for a non-central nervous system procedure. Instead, CMS has agreed to add a second SD089 guidewire (guidewire, hydrophilic) to the direct PE inputs instead.	61626
ED053 (Professional PACS workstation)	151.5 minutes is appropriately rounded up to a total time of 152 minutes.	61626
EL011 (Angiography room)	Finalized at total of 127 minutes, to incorporate the 3 minutes from CA024 (clean room/equipment by clinical staff) missing from the room time formula.	61626

Percutaneous Decompression of Median Nerve (CPT code 64728) – (page 280)

The CPT Editorial Panel created new CPT code 64728 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 many stakeholders support CMS's finalization of the RUC-recommended value of 2.70 for CPT Code 64728, some commenters stated that this value would not adequately reimburse practitioners for the time, effort, complexity, and expertise for providing this service. See table below.

CPT CODE	LONG DESCRIPTOR	CY 2026 WORK RVU
64728	Decompression; median nerve at the carpal tunnel, percutaneous, with intracarpal tunnel balloon dilation, including ultrasound guidance	2.70

CMS accepted the RUC-recommended direct PE inputs for CPT code 64728.

Cerebral Perfusion & CT Angiography-Head & Neck (CPT codes 70496, 70498, 70471, 70472, and 70473) – (Page 291)

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 and stakeholders were in alignment on the valuation of Cerebral Perfusion & CT Angiography-Head & Neck. The Agency has finalized the RUC-recommended work RVUs for all five codes. See table below.

CPT CODE	LONG DESCRIPTOR	CY 2026 WORK RVU
70496	Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing	1.71*
70498	Computed tomographic angiography, neck, with contrast material(s),including noncontrast images, if performed, and image postprocessing	1.71*
70471	Computed tomographic angiography (CTA), head and neck, with contrast material(s), including noncontrast images, when performed, and image postprocessing	2.50
70472	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
70473	Computed tomographic (CT) cerebral perfusion analysis with contrast material(s), including image postprocessing performed without concurrent CT or CT angiography of the same anatomy	1.00

*Note that the efficiency adjustment has been applied to the RUC-recommended RVU

CMS is finalizing the RUC-recommended direct PE inputs without refinements for the entire family.

Coronary Atherosclerotic Plaque Assessment (CPT code 75577) – (Page 292)

The CPT Editorial Panel created a new Category I CPT code, 75577, to describe coronary atherosclerotic plaque assessment and deleted four existing Category III CPT codes associated with the procedure.

CMS is finalizing the RUC-recommended work RVU of 0.85 for CPT code 75577. See table below.

CPT CODE	LONG DESCRIPTOR	CY 2026 WORK RVU
75577	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

CMS accepted the RUC-recommended direct PE inputs for CPT code 75577. However, they note 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. Since software analysis fees are not well accounted for in the direct PE methodology, CMS will be crosswalking the PE RVU for CPT code 75577 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 77436, 77437, 77438, and 77439), and Proton Beam Treatment Delivery (CPT codes 77520, 77522, 77523, and 77525) - (Page 294)

In the proposed rule, CMS detailed 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. In response to the proposed rule, 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 obtain.

The CPT Editorial Panel 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.

In the proposed rule CMS proposed using 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 also proposed 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.

CMS received comments that varied from support to fundamental opposition for the use of OPPS cost data to establish PE RVUS for the radiation treatment delivery codes. The agency states they have reviewed the feedback and reserve the authority to establish and adjust PE RVUs using various measures such as cost and data from suppliers and providers.

Stakeholder requested to delay the implementation to allow further data collection from non-facility practices. CMS responded that they do not believe it is prudent to delay implementation,

as they believe that the OPPS data is the best source for setting the relative rates for these types of services.

Radiation Oncology Treatment Delivery (CPT codes 77387, 77402, 77407, 77412, and 77417) (Page 304)

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 had been using 17 G-codes for payment of these services under the PFS but will be deleting those codes beginning CY 2026.

CMS is finalizing 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	CY 2026 WORK RVU
77387	Guidance for localization of target volume for delivery of radiation treatment, includes intrafraction tracking, when performed	0.68
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 finalizing their proposal to utilize the relationship between the OPPS APC relative weights for APCs 5621, 5622, and 5623 to inform the valuation of PE-only CPT codes 77402, 77407, and 77412.

Superficial Radiation Treatment (CPT codes 77436, 77437, 77438, and 77439) (Page 310)

The CPT Editorial Panel created four new codes, 77436, 77437, 77438, and 77439, to describe surface radiation therapy. These codes are replacing 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 77436 and 77439, CMS is finalizing the RUC-recommended RVUs. See table below.

CPT CODE	LONG DESCRIPTOR	CY 2026 WORK RVU
77436	Surface radiation therapy; superficial or orthovoltage, treatment planning and simulation-aided field setting	0.77
77437	Surface radiation therapy; superficial, delivery, <150 kV, per fraction (eg, electronic brachytherapy)	-
77438	Surface radiation therapy; orthovoltage, delivery, >150-500 kV, per fraction	-
77439	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 77439 in conjunction with 77437, 77438)	0.30

For PE RVUs, CMS is using a similar approach that they used for the radiation oncology treatment delivery codes. They are applying 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 finalizing the use of OPPS APCs 5621 and 5732 to value PE-only codes 77437 and 77438, and for the technical component of CPT code 77436 when paid under the MPFS.

Proton Beam Treatment Delivery (CPT codes 77520, 77522, 77523, and 77525) (Page 317)

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 solicited feedback in the proposed rule 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 specifically asked for stakeholder comments on how they can establish national pricing and total RVUs for these services to maintain relativity within the PFS. They posed 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?

While CMS did not share details, they indicated that they received "many thoughtful comments" and that they will consider it as part of future rulemaking.

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 supported CMS's extension of this policy.

CMS is finalizing their proposal 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 noted that the definition of direct supervision (allowing "immediate availability" of the supervising practitioner using audio/video real-time communications technology (excluding audio-only) for all services described at § 410.26, except for services that have a global surgery indicator of 010 or 090), does not mean that it is appropriate to allow virtual presence for every service for every Medicare beneficiary in every clinical scenario. CMS stated the physician, or practitioner should use his or her complex professional judgment to determine the appropriate supervision modality on a case-by-case basis.

Changes to Teaching Physicians' Billing for Services Involving Residents with Virtual Presence (Page 165)
In the CY 2026 MPFS proposed rule, CMS had proposed to not extend its policy to allow teaching physicians to have a virtual presence for purposes of billing for services furnished involving residents in all teaching settings except when the service is furnished virtually (e.g., a three-way telehealth visit, with the patient, resident, and teaching physician in separate locations).

However, after reviewing public comments, **CMS has finalized a policy to permanently allow teaching physicians to have a virtual presence in all teaching settings, but only in clinical scenarios where the service is furnished via telehealth in a three-way configuration (i.e., the teaching physician, resident, and patient are each in different locations).** This finalized policy ensures that teaching physicians may continue to be virtually present during the key portion of a Medicare telehealth service for which payment is sought, using real-time audio/video communication technology, across all residency training locations.

Policies to Improve Care for Chronic Illness and Behavioral Health Needs (Page 436)

Comment Solicitation on Payment Policy for Software as a Service (SaaS) (Page 449)
CMS acknowledged rapid advancements in software-based technologies supporting clinical decision-making, particularly in outpatient and physician office settings.

CMS expressed interest in accurately reimbursing chronic disease management and primary care services and sought public input on how SaaS and AI technologies should be considered under the MPFS. Key questions included:

- What factors should inform SaaS payment?
- How have risk-based payment models incorporated SaaS?
- Do current models reflect the value of SaaS?
- What alternative pricing strategies should CMS consider, given PE methodology limitations?
- How should CMS value physician work related to interpreting SaaS outputs?
- Are there better data sources to assess SaaS costs?
- How are these technologies used in chronic disease treatment?
- How can CMS evaluate the quality and efficacy of SaaS and AI tools?

CMS welcomed stakeholder feedback and may consider it in future rulemaking.

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 MSSP 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 fee-for-service (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
Beginning January 1, 2027, CMS is updating the eligibility requirements for ACOs participating in the Medicare Shared Savings Program. ACOs that are considered inexperienced with performance-based risk Medicare ACO initiatives will be allowed to participate in a one-sided risk model for up to five performance years during their first agreement period in the BASIC track's glide path. This is a reduction from the current allowance of up to seven years across two agreement periods. After the first agreement period, these ACOs must transition to a two-sided risk model more quickly. Specifically, they will be required to participate in either Level E of the BASIC track for all performance years of their second or subsequent agreement period, or in the

ENHANCED track—provided they have at least 5,000 assigned beneficiaries in benchmark year 1 (BY1), benchmark year 2 (BY2), or both.

For ACOs that CMS determines to be experienced with performance-based risk Medicare ACO initiatives, the participation options remain largely the same. These ACOs may enter either Level E of the BASIC track or the ENHANCED track for all performance years of the agreement period, again subject to the requirement of having at least 5,000 assigned beneficiaries in the relevant benchmark years. ACOs with fewer than 5,000 assigned beneficiaries are prohibited from participating in the ENHANCED track and will be limited to the BASIC track, with capped shared savings and losses and exclusion from enhanced savings opportunities available to low-revenue ACOs.

CMS is updating its beneficiary assignment requirements for ACOs entering MSSP beginning January 1, 2027. Historically, an ACO was deemed to meet the statutory requirement of having at least 5,000 assigned Medicare FFS beneficiaries if it had 5,000 or more beneficiaries assigned in each of the three benchmark years. This standard was designed to ensure reliable financial and quality performance assessments. However, based on program experience, CMS has determined that it can maintain the integrity of benchmark calculations and performance assessments even if an ACO has fewer than 5,000 beneficiaries in BY1, BY2, or both—provided additional safeguards are implemented.

Under the revised policy, ACOs applying for a new agreement period starting in 2027 must have at least 5,000 assigned beneficiaries in benchmark year 3 (BY3), but may fall below that threshold in BY1 or BY2. To mitigate risks associated with smaller beneficiary populations, CMS will require such ACOs to participate only in the BASIC track. Additionally, if an ACO has fewer than 5,000 assigned beneficiaries in any of the three benchmark years during the agreement period, its shared savings and losses will be capped at a lower amount. These ACOs will also be excluded from policies that offer enhanced savings opportunities to certain low-revenue ACOs in the BASIC track.

Revisions to the Quality Performance Standard and Reporting Requirements

Removal of the Health Equity Adjustment

CMS is finalizing a modified policy to remove the health equity adjustment from an ACO's quality score beginning in performance year 2026, rather than 2025 as initially proposed. This decision reflects the impact of other finalized policies that already support equitable quality scoring, including the Complex Organization Adjustment, the electronic clinical quality measure (eCQM)/Merit-based Incentive Payment System clinical quality measure (MIPS CQM) reporting incentive, and flat benchmarks for Medicare CQMs. These measures collectively help ACOs meet quality performance standards and maximize shared savings, making the health equity adjustment redundant. Its removal will simplify the quality scoring methodology and eliminate duplicative scoring factors.

Terminology Revisions Related to Health Equity Adjustment

CMS is also revising the terminology used in Shared Savings Program regulations to more accurately reflect the data used to calculate the health equity adjustment. These changes apply to

performance years 2023 through 2025, expanding the scope from the originally proposed 2023 and 2024.

Promoting Alignment with CMS's Quality Programs

Update the Alternative Payment Model (APM) Performance Pathway (APP Plus) Quality Measure Set

For performance year 2025 and subsequent performance years, MSSP ACOs are required to report the APP Plus quality measure set. CMS is finalizing several updates to the APP Plus quality measure set for Shared Savings Program ACOs, including the removal of Quality ID: 487 Screening for Social Drivers of Health.

Expansion of Extreme and Uncontrollable Circumstances (EUC) Policies

Under current regulations, the Shared Savings Program's EUC policies for quality and financial performance are aligned with the MIPS EUC policy, which provides relief for ACOs affected by natural disasters and public health emergencies. Beginning in performance year 2025, CMS will expand the EUC policy to include cyberattacks, such as ransomware or malware incidents, as qualifying events. If an ACO is impacted at the legal entity level by such an event and seeks relief from Shared Savings Program requirements, it must submit a MIPS EUC Exception application to the Quality Payment Program as an APM Entity for the affected year. If the application is approved, CMS will apply MSSP's EUC policies to exempt the ACO from certain quality reporting and financial performance requirements for that performance year. This expansion acknowledges the growing threat of cybersecurity incidents and ensures that ACOs have a pathway to maintain program participation and compliance during such disruptions.

Revisions to the Definition of Primary Care Services used in Shared Savings Program Beneficiary Assignment

CMS is finalizing changes to the definition of "primary care services" used for assigning Medicare fee-for-service beneficiaries to ACOs under the Shared Savings Program. Starting in performance year 2026, the definition will be updated to align with changes in the MPFS. This includes the addition of new behavioral health integration and psychiatric collaborative care management add-on services, when provided alongside advanced primary care management services. CMS also decided not to exclude code G0136 from the definition; instead, it will continue to be included with its updated descriptor for administering a standardized, evidence-based physical activity and nutrition assessment tool. These updates aim to reflect evolving care practices and improve the accuracy of beneficiary assignments.

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 (Page 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.

Quality Payment Program

MIPS Value Pathways (MVPs) CMS is introducing six new MVPs for the 2026 performance year, 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. These new MVPs include Diagnostic Radiology, Interventional Radiology, Neuropsychology, Pathology, Podiatry, and Vascular Surgery. (p.2272)

The *Diagnostic Radiology MVP* is 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, including CT, MRI, and ultrasound, 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 broad category 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.

Requests for Information (RFIs) Related to MVPs

CMS sought input on several RFIs that could inform the future direction of MVP development (p. 1454). Having received robust public comments, CMS plans to review all RFIs and use this feedback to inform future rulemaking.

- *Core Elements in an MVP*: CMS requested feedback on 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.
- *Well-being and Nutrition Measures*: CMS requested public comment on how to incorporate broader public health priorities into MVPs, including preventive care,

nutrition, and lifestyle interventions. The agency noted that it is particularly interested in how these measures could support chronic disease prevention and address social determinants of health.

- *Procedural Codes for MVP Assignment*: CMS examines the use of procedural codes (e.g., CPT, HCPCS) to automatically assign clinicians to MVPs based on their scope of practice, which could, in the future, streamline reporting and ensure that clinicians are evaluated using relevant measures. The agency requested comments on how CMS should define procedural thresholds or assessment logic.
- *Toward Digital Quality Measurement*: CMS is continuing to pursue a shift toward digital quality measurement (dQM). The agency solicited feedback on the use of FHIR-based APIs, EHR integration, and automated data capture to support real-time, interoperable reporting. Stakeholders were encouraged to share insights on barriers to adoption and system readiness.
- *Performance-Based Measures in Public Health and Clinical Data Exchange:* CMS sought feedback on new performance-based measures under the Promoting Interoperability category to assess not just participation in data exchange but also the quality, frequency, and completeness of that exchange, including bidirectional sharing and timeliness.
- *Data Quality*: Recognizing the importance of reliable data, CMS invited 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.

Quality Category

CMS will 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 that had been capped at seven points in previous years. CMS finalized its proposal to extend this policy to MVPs, noting that many MVPs face the same issue as specialty sets. CMS will identify specific MVPs as "at-risk" if participants do not meet or exceed the 75-point performance threshold using measures available within the MVP. (p. 1438)

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. 1594)

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 finalized for removal. It will not remove other measures relevant to diagnostic or interventional radiology 2026. (p. 1943)

Lastly, CMS finalized its proposal to establish a new benchmarking methodology for scoring administrative claims-based quality measures beginning with the 2025 MIPS performance period. This change 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 those for registry-based measures, likely because they use 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, based on standard deviation, median, and a point value derived from the performance threshold, is intended to improve the scores of physicians reporting claims-based measures. (p. 1614)

Improvement Activities

CMS has finalized its proposal to remove the Achieving Health Equity subcategory from the Improvement Activities (IA) performance category. Many of the activities previously included in this category were removed from the program in early 2025. CMS also finalized its proposal to add a new subcategory titled Advancing Health and Wellness, as well as three new IAs to the subcategories of Population Management, Patient Safety, and Practice Assessment. (p. 2255)

The improvement activities finalized 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 finalized 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 to address adverse patient events caused by AI in healthcare. (p. 2250)

Cost Performance Category

CMS finalized changes to the Total Per Capita Cost (TPCC) measure to refine attribution methodology. Specifically, CMS will now exclude candidate events initiated by advanced practice providers (APPs), such as nurse practitioners or physician assistants, when all other non-APP clinicians (e.g., physicians) within the same TIN-NPI group are excluded based on existing specialty exclusion criteria. This policy is intended to improve attribution accuracy and prevent inappropriate assignment of cost accountability to APPs when their collaborating or supervising physicians are excluded due to specialty designation. (P. 1800)

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

MIPS Promoting Interoperability
CMS will continue to automatically reweight the MIPS Promoting Interoperability (PI) category for "non-patient-facing clinicians" who do not report PI performance data.

CMS implemented a new "measure suppression" policy to enable a PI category participant to receive full credit for reporting a CMS-identified "suppressed" measure that is part of a cohort of required measures under an objective. Pursuant to the new policy, CMS will temporarily "suppress" the Electronic Case Reporting measure of the Public Health & Clinical Data Exchange objective for the CY 2025 performance period (2027 MIPS payment year).

CMS finalized proposed modifications to existing PI category measures. For the Security Risk Analysis measure, CMS will require PI participants to attest "Yes" to having conducted security risk management, and to attest "Yes" to having conducted or reviewed a HIPAA-required security risk analysis. CMS finalized changes to its High Priority Practices SAFER Guide measure by requiring an annual self-assessment using the 2025 version of the guide at any point during the calendar year. CMS also finalized a new (optional) bonus measure for Public Health Reporting using the Trusted Exchange Framework and Common Agreement (TEFCA).

Advanced Alternative Payment Models (Page 1098)
CMS individual QP determination calculation for all clinicians participating in an Advanced APM in addition to determinations at the APM entity level. CMS is also creating a uniform calculation methodology by using 2 sets of services for the QP calculations: Evaluation and Management services; and All Covered Professional Services. CMS will assign QP status based on the most favorable calculation.

CMS published Fact Sheets on the overall MPFS final rule, the Shared Savings Program, and a Press Release.