

American College of Radiology Preliminary 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).

Conversion Factor and CMS Overall Impact Estimates

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. Services provided by non-APM participants have a conversion factor of \$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 recent 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.

Physician Practice Information (PPI) Survey

In the proposed rule (PR), CMS expressed concerns with the AMA's PPI and CPI survey data, citing missing data, small sample sizes and low response rates, among other things. Despite stakeholder comments addressing many of those concerns, for CY 2026, CMS is finalizing their proposal to not implement the PE/HR data or cost shares from the AMA survey data. CMS will continue their contract with the RAND Corporation to analyze and develop alternative methods for measuring PE and related inputs for implementation of updates to payment under the PFS.

Beginning CY 2026, CMS is finalizing their proposal to reduce the portion of the facility practice expense (PE) RVUs allocated based on work RVUs to half the amount allocated to non-facility PE RVUs. Staff will continue to review and provide a detailed report in the coming weeks.

New and Revised Codes

For CY 2026 CMS finalized the RUC-recommended values for all of the Radiology-pertinent CPT codes, including two of the Endovascular Therapy codes that they initially proposed to refine. Other codes that were finalized for CY 2026 include CT Cerebral Perfusion, CTA Head & Neck, Prostate Biopsy, Transrectal Ultrasound, Irreversible Electroporation of Tumors, Coronary Atherosclerotic Plaque Assessment, and Percutaneous Decompression of Median Nerve.

Potentially Misvalued Services

CMS finalized their proposal to *not* nominate the fine needle Aspiration (FNA) codes as potentially 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.

Efficiency Adjustment

CMS is finalizing the -2.5% efficiency adjustment to non-time based codes and will be applying these efficiency adjustments every three years. They will be using the MEI productivity adjustment over a 5-year lookback period. Based on stakeholder feedback, CMS has agreed to exempt time-based services and services on the CMS telehealth list, as well as new codes for 2026.

Direct Supervision via Use of Two-way Audio/Video Communications Technology

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

In the CY 2026 PFS PR, CMS stated that for services provided within MSAs, physicians must maintain physical presence during critical portions of all resident-furnished services to qualify for Medicare payment, not just in-person services, ensuring consistent oversight standards. In the CY 2026 PFS PR, 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).

After consideration of public comments, CMS is finalizing to permanently allow teaching physicians to have a virtual presence in all teaching settings, only in clinical instances when the service is (a 3-way telehealth visit, with the teaching physician, resident, and patient in different locations). This will continue to permit teaching physicians to have a virtual presence during the key portion of the Medicare telehealth service for which payment is sought, through audio/video real-time communications technology, for all residency training locations.

Medicare Shared Savings Program

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.

CMS finalized policy 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 finalized 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 finalized policy 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 a new agreement period to have at least 5,000 assigned beneficiaries in BY3, while allowing the ACO to have fewer than 5,000 assigned beneficiaries in BY1, BY2, or both.
- Require ACOs that enter a new agreement period with fewer 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 finalizing policies to expand the application of MSSP 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.

Quality Payment Program (QPP)

MIPS Value Pathways (MVPs) (p.1441)

In this final rule, CMS finalized six new MVPS that that will become available for reporting in 2026. In addition to **the Diagnostic Radiology and Interventional MVPs**, it also includes Neuropsychology, Pathology, Podiatry, and Vascular Surgery MVPs. CMS has organized the Diagnostic Radiology MVP into three clinical groups: 1) General Diagnostic Radiology, 2) Body Imaging (Thoracic/Abdominal), and 3) Advancing Health and Wellness. The proposed Interventional Radiology MVP has been arranged into four clinical groups: 1) Vascular, 2) Dialysis-related, 3) Neurological Intervention, and 4) General Interventional Radiology. Depending on the clinical groups in both MVPs, CMS has assigned measures and activities it considers attributable to these radiologists.

Requests for Information (RFIs) (p. 1454)

CMS sought feedback on several RFIs focused on MVPs.

- *The Core Elements in an MVP.* CMS asked how it may encourage MVP reporting that provides patients with more directly comparative clinician performance data. CMS determined it would continue the use of decile-based benchmarking and maintain 75% data completeness threshold and 20-case minimum. It is also introducing dynamic cohort-based scoring to better reflect specialty performance.
- *Well-being and Nutrition Measures.* CMS inquired about how it may provide a more comprehensive approach to disease prevention and health promotion. In the final rule, it decided to retain measures like BMI Screening (Q128) and nutrition/physical activity risk assessments (e.g., G0136, once every 6 months), support functional status surveys to prompt lifestyle discussions, and retain Social Determinants of Health (SDOH) risk assessment measures.
- *Procedural Codes for MVP Assignment.* Sought information on an approach that would facilitate specialty reporting of MVPs relevant to their scope of care. CMS confirmed its use of CPT/HCPCS codes for episode-based cost measure (EBCM) attribution, deferred specialty assignment changes to CY 2027, and committed to a public comment process for specialty override requests.
- *Transition Toward Digital Quality Measurement.* CMS has previously included this RFI in past proposed rules to gain insights on advancements when making the shift to digital quality measurement. In the final rule, CMS determined it would continue to support electronic Clinical Quality Measures (eCQMs) and allow choice between CQM and eCQM reporting.

CMS also emphasizes its ongoing updates to the Practice Expense (PE) database for transparency and consistency and encourages digital reporting but did not make it mandatory.

- *Performance-Based Measures in Public Health and Clinical Data Exchange Objective.* CMS evaluated measures to assess the degree to which MIPS-eligible clinicians exchange data specified for each measure. It is also prioritizing Patient-Reported Outcome Performance Measures (PRO-PMs), requiring annual attestation for improvement activities like primary care connection and collaborative care, is maintaining CEHRT requirements for interoperability, and supporting measures for health information exchange (HIE), e-prescribing, and public health data exchange.
- *Data Quality.* CMS solicited information on clinicians' exchange of health information. In this final rule it determined it would retain the 2007–2008 AMA PPIS data as the primary PE data source to adopt the 2024 AMA PPI/CPI survey data due to low response rates and representativeness concerns, declined to adopt the 2024 AMA PPI/CPI survey data due to low response rates and representativeness concerns, and reaffirmed the 75% data completeness threshold and 20-case minimum for measure scoring.

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 finalized its proposal to maintain the performance threshold at 75 points through the 2028 performance year.** (p. 1439)

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 Performance 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. CMS also finalized its proposal to extend this policy to MVPs, noting that many MVPs are affected by the same issue as the specialty sets. (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 finalized its new benchmarking methodology for scoring administrative claims-based quality measures beginning with the 2025 MIPS performance period. 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. This new scoring methodology, which is based on standard deviation, median, and a point value derived from the performance threshold, was established with the intention of improving the scores of physicians reporting claims-based measures. (p. 1614)

Improvement Activities Performance Category

CMS has finalized its proposal to remove the Achieving Health Equity subcategory. Many of the activities previously included in this category were removed from the program in early 2025. CMS also finalized 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. 2255)

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 last activity, “Patient Safety Use of Artificial Intelligence,” is intended to address adverse patient events attributed to the use of AI in healthcare. (p. 2250)

Cost Performance Category (p. 1485)

While several changes to the Total Per Capita Cost (TPCC) measure were proposed, CMS decided to exclude candidate events initiated by advanced care practitioners based on group specialty exclusions deciding it will maintain the current TPCC specifications, methodology, and valuation, citing the need for stability, relativity, and a data-driven approach.

CMS also confirmed the two-year informational feedback period for newly implemented MIPS cost measures, which allows for stakeholder input, data collection, and measure refinement before the measures are used in scoring. CMS also rejected requests to shorten or extend the feedback period, emphasizing the importance of consistent evaluation and robust data before impacting payment adjustments.

Advanced Alternative Payment Models

For the Advanced APM track, if an eligible clinician participates in an Advanced APM and achieves Qualifying APM Participant (QP) or Partial QP status, they are excluded from the MIPS reporting requirements and payment adjustment (though eligible clinicians who are Partial QPs may elect to participate in MIPS and be subject to the MIPS reporting requirements and payment adjustment). Under current law, eligible clinicians who are QPs for the 2024 performance period and beyond will receive an increased physician fee schedule update of 0.75 percent based on the QP conversion factor in the corresponding payment year. QPs will continue to be excluded from MIPS reporting and payment adjustments for the applicable year.

CMS stated they plan to continue developing policies for the QPP that more effectively reward high-quality of care for patients and increase opportunities for Advanced APM participation.

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

ACR staff will review the entire MPFS final rule in the coming weeks and will provide a comprehensive summary of the rule.