CY 2027 Medicare Physician Fee Schedule Final Rule Summary

On November 4, the Centers for Medicare & Medicaid Services (CMS) released the Medicare Physician Fee Schedule (MPFS) final rule and fact sheet for CY 2027 (CMS-1848-F). This rule updates policies and payment rates for Part B services furnished under the MPFS. The data files including Addendum B, which lists the final RVUs for each CPT® code can be found here.

Note that the page numbers listed in this document refer to the display copy of the proposed rule.

Conversion Factor and Regulatory Impact Analysis
Highlight: Payment for services paid under Medicare will decrease for some specialties while increasing for others.

Conversion Factor for 2027 – p. 1,972
For the second year, there are two separate conversion factors, one for qualifying practitioners participating in an advanced alterative payment model (APM) and the other for those not participating in a qualifying APM. The qualifying APM conversion factor is $32.95, a decrease of 1.83%, and the non-qualifying APM conversion factor is $32.63, a decrease of 2.31%.

The CY 2027 final rule increased the projected reduction in the conversion factors. This is primarily attributable to a change in the budget neutrality adjustment, which shifted from a proposed positive 0.53% adjustment to a finalized negative 0.12% adjustment to account for changes in work RVUs. As a result, the qualifying practitioner conversion factor decreases 1.83% and the non-qualifying practitioner conversion factor decreases 2.31% compared with CY 2026.

Specialty Level Impact of the Finalized Policy Changes – p. 1,154
CMS attributes the impact of the finalized policies to changes in relative value units (RVUs) redistribution resulting in changes to work RVUs for new and revised codes. CMS's finalized policy to delete HCPCS code G2211 (complex patient care) and replace it with a modifier, updated payment policy for services performed on the same day as 0-day global procedure, and other code-level updates impact the increases or decreases to Medicare payments by specialty. **For the specialty of endocrinology, there is an expected 1% increase to total Medicare payments**. Note that the impact of the final rule policies on group practices and individual physicians varies based on practice type, the patient mix, and services provided to those patients.

New this year, the agency did not publish, within the rule text, the specialty level impacts of the policies included in the final rule. Instead, the agency has created a public use file available here: Estimated Specialty Impact. The agency's rationale for doing is "*we believe that posting this table as a separate file will make it easier for interested parties to access the data within the table as well as making the data more readable outside of a text-based format*."

Practice Expense Relative Value Unit (RVU) Methodology - p. 19
Highlight: CMS finalizes removal of the Indirect Practice Cost Index (IPCI) from the payment methodology calculation, which CMS believes relies on outdated data.

CMS simplified the methodology used to calculate practice expense (PE) RVUs, a change that meaningfully redistributes Medicare payments across specialties. Currently, PE RVUs are determined through an 18-step process that includes the IPCI, which adjusts indirect practice expenses based on specialty-level survey data. CMS removed the IPCI entirely, eliminating steps 12 through 17 of the payment formula methodology.

The IPCI adjusts indirect practice PE RVUs based on specialty-level overhead data derived primarily from the 2007 AMA Physician Practice Information Survey (PPIS). CMS determined that the IPCI relies on outdated data and may result in indirect PE valuations that do not accurately reflect the resources required to furnish individual services. Under the final policy, CMS will phase in the change over a two-

year period. In 2027, CMS will reduce the IPCI's portion of the payment formula by 50% and eliminate it entirely beginning in CY 2028. The revised methodology will rely more heavily on service-level indirect PE allocators rather than adjustments based on historical specialty-level cost distributions.

Many commenters argued that CMS should incorporate the AMA's updated PPIS data, stating that this new data is a more accurate reflection of the cost of providing services. Some comments suggested that an entirely new survey be conducted to determine indirect practice costs. Comments were divided on the removal with some arguing to maintain it, while still others commented that the phase-in of removing the IPCI should be over a four-year period, as opposed to two years. CMS outright rejected calls for a new specialty-level indirect cost survey or to use the updated AMA PPIS, citing historically low response rates, non-random practice selection, and inconsistent specialty groupings that would limit the reliability of the data. Additionally, CMS believes the IPCI does not reliably capture specialty-specific cost differences because it adjusts a service's indirect PE based on the mix of specialties billing that service, rather than the actual indirect costs associated with furnishing it. CMS maintains that eliminating the IPCI will result in PE RVUs that more accurately reflect the indirect resources required to furnish individual services. Finally, CMS maintained its proposal to phase in the IPCI removal over a two-year period, while also finalizing a 5% PE stabilization adjustment to limit annual changes in individual services' PE RVUs and mitigate payment disruptions during the transition.

Updates to Practice Expense Methodology – Site of Service Payment Differential – p. 73
In the proposed rule, CMS sought stakeholder feedback on additional changes to the physician practice expense (PE) methodology following its CY 2026 final policy reducing indirect facility PE relative value units (RVUs) to 50% of the non-facility allocation. CMS described the CY 2026 change as an initial step to address longstanding distortions in indirect PE payments across sites of care, and the agency indicates it is considering further refinements for rulemaking. CMS also requested comments on potential approaches to better identify hospital-employed physicians, including whether a new HCPCS modifier could distinguish services furnished by employed clinicians and allow more accurate allocation of indirect PE RVUs. The agency did not address any comments received on this topic and will consider comments for future rulemaking.

Payment for Medicare Telehealth Services under Section 1834(m) of the Act – p. 89
Highlight: CMS implements telehealth flexibilities and revises policy for virtual presence for teaching physicians.

Changes to the Medicare Telehealth Services List
CMS did not receive any requests to add or remove services from the Medicare Telehealth Services List for CY 2027. Any requests for changes for CY 2028 must be submitted to and received by CMS by February 10, 2027.

Addition of New Codes to the Telehealth List
CMS finalized adding the following codes to the Medicare Telehealth Services List:

- G0572: *Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), first 20 minutes of clinical staff time with the patient, family member(s), directed by the treating physician or other treating qualified health professional.*
- G0573: *Advanced care planning including the explanation and discussion of advanced directives such as standard forms (with completion of such forms, when performed), each additional 20 minutes of clinical staff time with the patient, family member(s), directed by the treating physician or other treating qualified health professional.*
- G0686: *Group-based medical session involving multiple patients with common medical condition(s) and receiving medical care in a group setting. The voluntary session is billed and led by a physician or other qualified healthcare professional (QHP) and may include services provided by other QHPs, clinical staff, or auxiliary personnel under the direction of the supervising physician or QHP. The voluntary session integrates group education, counseling, and peer support with individualized patient clinical assessment and care, includes 2–10 patients, billed once per patient, first 60 minutes.*

- G0687: *Group-based medical session involving multiple patients with common medical condition(s) and receiving medical care in a group setting. The voluntary session is billed and led by a physician or other qualified healthcare professional (QHP) and may include services provided by other QHPs, clinical staff, or auxiliary personnel under the direction of the supervising physician or QHP. The voluntary session integrates group education, counseling, and peer support with individualized patient clinical assessment and care, includes 2–10 patients, billed per patient, each additional 30 minutes (list separately in addition to code for primary service).*
- G0903: *Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual; for the pediatric population age 21 and under.*
- G0576: *Office or other outpatient evaluation and management service(s) for the diagnosis and treatment of vaccine adverse effects, new or established patient, each 15 minutes personally performed by the physician or qualified healthcare professional.*

Telehealth Flexibilities and Modifiers
Congress recently extended Medicare telehealth flexibilities through Section 6209(a) of the Consolidated Appropriations Act (CAA), which removed the geographic restrictions, expanded the list of acceptable originating sites and expanded the providers eligible to furnish telehealth services until December 31, 2027.

Section 6209(g) of the CAA required CMS to establish modifiers for telehealth services in certain instances, starting on January 1, 2027. While these modifiers do not affect payment, they are required for telehealth service claims furnished through a telehealth platform with whom the physician has a contractual relationship, or when telehealth services are furnished incident to a physician or practitioner's professional service. To implement this provision, CMS created modifiers BB and BC; further guidance on utilization of the modifiers will be available on the CMS website at www.cms.gov/medicare/coverage/telehealth.

Telehealth Critical Care Consultations
In the CY 2026 MPFS final rule, CMS permanently removed the frequency limitation of one critical care consultation service furnished by telehealth per day. To align the code descriptors with this policy, CMS finalized the proposal to revise the descriptors to remove "initial" from G0508 and "subsequent" from G0509. The new code descriptors are as follows:
- G0508: Telehealth consultation, critical care; first 30 to 74 minutes.
- G0509: Telehealth consultation, critical care; each additional 30 minutes (List separately in addition to code for primary service).

Changes to Teaching Physicians' Billing for Services Involving Residents or Teaching Physicians with Virtual Presence
Current CMS policy allows teaching physicians to have a virtual presence in all teaching settings, only in clinical instances when the service is a three-way telehealth visit, with the teaching physician, resident, and patient in distinct locations. The agency revised this policy to allow teaching physicians to bill for services involving residents when either the teaching physician or the resident is in the same physical location as the patient, with "same physical location" meaning the same room. This policy only applies to services on the Medicare Telehealth Services List.

Telehealth Originating Site Facility Fee Payment Amount Proposed Update
CMS finalized the payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) at $32.68. This change is based on a 2.6 MEI increase.

Valuation of Specific Codes – p. 103
Each year, CMS receives work and practice expense RVU recommendations from the AMA RUC for new and revised CPT codes. The agency reviews these recommendations for inclusion in the fee schedule. Additionally, with this rule CMS has reviewed and revised code valuations that were not a part of the RUC recommendations for this rule cycle, including remote therapeutic monitoring and remote physiologic monitoring.

Fine Needle Aspiration (FNA) (10005, 10006) – p. 123
Beginning on January 1, 2027, payment for FNA services described CPT codes 10005 (*Fine needle aspiration biopsy, including ultrasound guidance; first lesion*) and 10006 (*Fine needle aspiration biopsy, including ultrasound guidance; each additional lesion* will increase approximately 20%. CMS finalized a new practice expense equipment item, ER130 (*Fine Needle Aspiration portable ultrasound*), with an input price of $83,750. CMS also finalized work relative value units (RVUs) 1.35 for CPT code 10005 and 1.00 for 10006.

Remote Monitoring (CPT codes 98975, 98976, 98977, 98978, 98980, 98981, 98984, 98985, 98986, 98979, 99091, 99453, 99454, 99457, 99458, 99473, 99474, 99445, and 99470) – p. 272
At the September 2024 CPT Editorial Panel meeting, several revisions were made to the remote monitoring services code set to increase flexibility in reporting these services and to better align with current clinical practice. The revisions created new codes while clarifying descriptors and coding requirements for others. Payment amounts and practice expense inputs were finalized and implemented beginning January 1, 2026. However, due to agency's concern with the lack of data to inform accurate valuation of Remote Patient Monitoring (RPM) and Remote Therapeutic Monitoring (RTM) services, and per comments submitted by the AMA, all 19 RPM and RTM codes will once again undergo a RUC survey, focusing only on the practice expense inputs for these services. The recommendations from this survey will be presented at the January 2027 AMA RUC meeting.

CMS finalized three significant policy changes delaying one policy for RPM and RTM services. The policy changes, per CMS are intended to strengthen clinical oversight, reinforce the practitioner-patient relationship, and address program integrity concerns identified by the Office of Inspector General (OIG).[1]

1. Initiating Visit: CMS finalized a requirement for practitioners to conduct a separate reportable initiating visit prior to starting RTM and RPM. The initiating visit may be conducted either in-person or via telehealth and the use of RTM and RPM must be discussed with the patient who must consent to beginning RTM or RPM. The agency also clarified that the initiating visit does not have to be for the sole purpose of discussing remote monitoring services.
2. Established Patients: CMS finalized policy limiting RTM services to established patients, consistent with its existing RPM policy. The agency believes practitioners should have an existing clinical relationship with the patient, including knowledge of the patient's medical history and current health status, before ordering RTM services and then using the collected data to guide treatment.
3. Supervision Requirements: CMS proposed to limit payment for RPM and RTM services to those furnished by clinical staff directly employed by the billing practitioner or practice. However, CMS will delay the policy until January 1, 2029. At that time, practitioners cannot bill Medicare for RPM or RTM services performed by staff employed by third-party companies.

The agency received many comments on its third-party contracting policy. Considering the comments, CMS finalized a two-year delay in implementing the requirement that clinical staff furnishing RPM and RTM services must be directly employed by the billing practitioner or practice. **Practices may continue contracting with third-party companies through December 31, 2028**. Until then, practitioners must maintain appropriate oversight and clinical integration with third-party vendors to meet existing billing requirements. CMS also plans to issue sub-regulatory guidance clarifying permissible clinical staff arrangements.

Finally, CMS did seek comment on creating just four HCPCS G codes to replace all nineteen RTM and RPM codes. The agency thanked commenters for their valuable input and may consider changes to this coding family in the future.

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[1] HHS-OIG: *Additional Oversight of Remote Patient Monitoring in Medicare Is Needed*: https://oig.hhs.gov/reports/all/2024/additional-oversight-of-remote-patient-monitoring-in-medicare-is-needed/

Revision of G2211 with Modifier MOD1 – p. 326
Highlight: Despite comments requesting CMS maintain G2211, the agency finalized deletion of G2211 and will replace it with modifiers B1 and B2(for use in ACOs).

The agency finalized deletion of code G2211 (*Visit complexity inherent to evaluation and management associated with medical care services)* and create a modifier to take its place.[2] The new modifier, B1, will have the exact same descriptor as G2211, and per the agency should be reported and billed in the same way as the G-code, except the B1 modifier is placed on the same claim-line as the CPT code for the evaluation and management (E/M) service.

The modifier, when appended to an appropriate E/M code, will increase payment by 16% of the value of the reported E/M CPT code. CMS believes the clinical resources associated with providing longitudinal, relationship-based care are inherent to the provided E/M service rather than as distinct service requiring a separate add-on code. CMS states that using a modifier instead of a separate code will more accurately reflect the work associated with this care and will also simplify billing by eliminating the need for an additional claim line, thereby reducing administrative burden.

Commenters warned that replacing standalone HCPCS code G2211 with modifiers B1 and B2 (see discussion below on modifier B2), which have no independent work RVU value, could negatively affect physician compensation under productivity-based models. Despite these concerns, CMS finalized the policy. CMS acknowledged the potential operational and compensation challenges but maintained that the change is consistent with other payment adjustments the agency has made in the past. In response to commenters' concerns regarding productivity-based compensation models, CMS published a public use file mapping the B1 and B2 modifier values to comparable RVUs at each E/M level. Appendix A: *Work RVU Values Associated with B1 and B2 Modifiers* of this summary show the work RVU when modifier B1 or B2 is appended to a qualifying E/M service. The values are derived by applying 16% to the work RVU of each E/M service to generate a total work RVU. **Again, the modifier does not have an associated RVU. CMS simply published this file to help practitioners**, who are employed under RVU target compensation models, understand the RVU values when B1 is appended to an E/M service.

CMS clarified that Modifiers B1 and B2 (used in place of G2211 in accountable care organizations) may be used when office/outpatient or home/residence E/M visits are furnished via telehealth, provided all other requirements are met, because both these services and HCPCS code G2211 are on the Medicare telehealth services list.

G2211 in Medicare Accountable Care Organizations – p. 331
CMS finalized replacing HCPCS G2211 office visit complexity add-on code, when used in the Shared Savings Program ACOs, with a new modifier B2that would pay 32% of the associated evaluation and management (E/M) visit (twice the payment of B1) to better account for the added complexity of caring for patients in the ACO setting. The enhanced payment is intended to recognize the additional time and effort required to provide coordinated, longitudinal, whole-person care.

Shared Medical Appointments (HCPCS codes G0686 and G0687) – p. 348
Highlight: New codes to report shared medical appointments are effective January 1, 2027.

CMS established two new HCPCS codes, G0686 (first 60 minutes) and G0687 (each additional 30 minutes) to recognize and separately pay for Shared Medical Appointments (SMAs) under the MPFS. [3]

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[2] HCPCS code G2211 full description: *Visit complexity inherent to new or established office/outpatient or home or residence evaluation and management service, associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition.*
[3] HCPCS code G0686 and G0687 full description - *Group-based medical session involving multiple patients with common medical condition(s) and receiving medical care in a group setting. The voluntary session is billed and led by a physician or other qualified healthcare professional (QHP) and may include services provided by other QHPs,*

CMS states that shared medical appointments have become an increasingly common model for delivering care to patients with chronic conditions and therefore created codes to describe these services. The new codes are intended to recognize services furnished by a physician or other qualified health care professional in a group setting while still providing individualized E/M services to each patient.

CMS finalized a work RVU of 1.73 for G0686. **Note that the code is billed per patient**, recognizing the individualized E/M service furnished to each beneficiary during a shared medical appointment, rather than as a single payment for the group session. The RVU for G0687, each additional 30 minutes, is 0.87. Practitioners may bill up two units of G0687, thus an additional 60 minutes if needed and medically necessary. Additionally, CMS finalized adding this new service to the Medicare Telehealth list to improve access to remote and rural areas, and to expand access to those who lack access to transportation.

According to CMS, shared medical appointments can improve the management of chronic diseases by combining individualized medical care with group education, counseling, and peer support. The agency believes this model may enhance patient engagement, promote healthy behavior changes, reduce social isolation, and improve practice efficiency by allowing clinicians to deliver education and self-management support to multiple patients with similar conditions at the same time. CMS believes that conditions such as diabetes, obesity, hypertension, and other chronic diseases are particularly well suited to this care model.

Accounting for E/M Resource Overlap Between Stand-Alone Visits and Global Periods – p. 391
Highlight: While some comments called for CMS NOT to implement policy reducing payment for same-day services when coupled with an E/M visit, CMS finalized the policy but did make some modifications.

CMS revised its proposal to reduce payment for an office/outpatient (O/O) E/M visit reported with modifier -25 when the physician also performs a procedure on the same day. Effective January 1, 2027, CMS will limit the policy to procedures with a 0-day global period, rather than the proposed 0-, 10-, and 90-day global periods. When a physician furnishes an E/M visit and one or more procedures on the same day, Medicare will pay 100% of the higher-valued service and 80% of the lower-valued service. CMS initially proposed a 50% reduction for the lower-valued service. The policy applies only to O/O E/M services (CPT codes 99202–99204, 99025, and 99211–99215) furnished on the same day as a 0-day global procedure. CMS will not extend the reduction to other E/M services, including inpatient, emergency department, or critical care visits.

CMS received many comments on the modifier -25 policy. Most opposed the proposal, questioning CMS's evidence that same-day E/M visits and procedures involve duplicative resources. Specialty societies, the RUC, and the AMA all argued that the existing CPT/RUC valuation process already accounts for overlapping physician work and practice expenses when procedures are frequently reported with an E/M visit, and that this overlap is measured during the RUC survey process. The Medicare Payment Advisory Commission (MedPAC) an independent, non-partisan legislative branch agency of the U.S. government, supported the policy, citing unrecognized efficiencies in physician work and practice expenses.[4] AHIP, a D.C.-based political advocacy and trade association representing health insurance providers across the U.S., also supported the proposal, citing it's study of Medicare claims data estimating that overlapping resources exist when performing an E/M and a surgical procedure on the same day and may account for approximately $1.5 billion annually in duplicative Medicare payments.

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clinical staff, or auxiliary personnel under the direction of the supervising physician or QHP. The voluntary session integrates group education, counseling, and peer support with individualized patient clinical assessment and care, includes 2–10 patients, billed once per patient, first 60 minutes. G0687 has the exact same descriptor but is for each additional 30 minutes.

[4] The Medicare Payment Advisory Commission (MedPAC) is an independent congressional agency established by the Balanced Budget Act of 1997 (P.L. 105-33) to advise the U.S. Congress on issues affecting the Medicare program. In addition to advising the Congress on payments to private health plans participating in Medicare and providers in Medicare's traditional fee-for-service program, MedPAC provides information on access to care, quality of care, and other issues affecting Medicare. https://www.medpac.gov/what-we-do/

Commenters also raised concerns that the proposed 50% reduction would further strain practice finances, potentially leading to staffing cuts and reduced capacity to accept Medicare patients. Most opposed any reduction, while others suggested a smaller reduction of 20% or 25%. AHIP supported the 50% reduction but recommended phasing it in over three years. While CMS acknowledged these concerns, the agency finalized the policy anyway, but finalized a 20% reduction, rather than the proposed 50%, stating that this payment reduction better reflects payment accuracy and will hopefully reduce the monetary impact on physicians and their practices.

Several commenters also questioned applying the policy to physicians in different specialties within the same group practice, noting that patients may schedule appointments with multiple specialists on the same day. **CMS agreed and revised the policy to apply only when the same physician or another physician of the same specialty within the same group practice provides the services.**

CMS outlined several comments which stated that the payment reduction could encourage practices to schedule procedures on separate days to avoid reduced reimbursement. Other comments noted that the policy would increase beneficiary cost sharing, create additional transportation and scheduling burdens, particularly for rural and underserved populations. **CMS clarified that the policy does not prohibit same-day E/M visits and procedures and stated that it will monitor utilization for potentially inappropriate scheduling practices through claims edits, comparative billing reports, and medical review.** CMS also disagreed with concerns about increased beneficiary cost-sharing, stating that separating services into separate visits could increase patients' out-of-pocket costs.

Comment Solicitation on Payment for Physician-Patient Clinical Trial Discussions – p. 434
Highlight: To help improve clinical trial participation, CMS requested feedback on developing a code to pay for patient and physician discussions regarding clinical trials

In the proposed rule, CMS sought comments on the potential development of a HCPCS G-code to capture the time, effort, work, and resources associated with physician/patient conversations regarding participation in clinical trials. CMS stated that, despite significant federal investment in biomedical research, adult cancer patient enrollment in clinical trials remains below 7 percent. Since the agency did not propose a new code and only sought comments, the agency thanked commenters for the suggestions and will consider comments for future rulemaking.

Commenters supported establishing payment for physician-patient clinical trial counseling, noting that uncompensated counseling time can discourage physician participation in clinical trial enrollment. Some comments recommended a modifier or add-on to an E/M visit rather than a standalone HCPCS G-code. Additional comments included expanding billing eligibility to RNs and advanced practice providers, allowing the service delivered via telehealth. Commenters also recommended that documentation requirements not be overly burdensome, stating the minimum documentation needed includes the clinical trial(s)/names of the trials discussed, time spent, and the substance of the counseling conversation.

Request for Information: Redesigning Primary Care to Make America Health Again – p. 506
Highlight: CMS sought feedback on potential approaches to modernizing primary care payment, including adjustments to primary care valuation, technology-enabled care, and prospective payment models.

In the final rule, CMS reiterated its interest in evaluating how Medicare payment policies can better support primary care as part of HHS' Make America Healthy Again priorities. The agency emphasized concerns that primary care services may be undervalued under the current Physician Fee Schedule and noted that advances in digital health technologies and artificial intelligence are changing how beneficiaries access care and how clinicians deliver services.

Through this request for information (RFI), CMS sought stakeholder feedback on three broad areas: (1) whether and how Medicare should reconsider the valuation of primary care services under the Physician Fee Schedule; (2) how payment policies should account for technology-enabled care, including the use of artificial intelligence and other digital health tools, and (3) how prospective primary care payment models

could be incorporated into the Medicare Shared Savings Programs and potentially expanded more broadly across Original Medicare.

CMS indicated that stakeholder feedback will help inform future policy development related to primary care payment and delivery. The final rule **does not** adopt any specific payment changes associated with this RFI.

Reconsidering Relative Primary Care Payment in the Medicare Physician Fee Schedule – p. 509
Highlight: Stakeholders agreed that primary care is undervalued under the Physician Fee Schedule, and CMS indicated it will consider the feedback in future rulemaking.

CMS discussed stakeholder feedback on potential approaches to better recognizing and valuing longitudinal primary care services under the PFS. The agency had requested input on whether current office/outpatient (O/O) evaluation and management (E/M) coding and payment policies adequately reflect the complexity and resources required to provide ongoing, relationship-based care.

Comments from stakeholders agreed that clinicians serving as the patient's ongoing focal point for care should be identified through the existence of a longitudinal care relationship and clinical responsibility for patient care rather than through additional documentation requirements. Stakeholders also emphasized that payment should prioritize and support longitudinal care, while expressing mixed views on whether specialists billing HCPCS code G2211 should be required to coordinate with primary care clinicians to ensure preventive services and risk factor reduction are addressed.

In response to CMS' questions regarding potential future distinctions among longitudinal, acute, and consultative visits, commenters broadly acknowledged that longitudinal care is not adequately distinguished under the current E/M framework. While some stakeholders supported reconsideration of consultative visit codes, others noted that existing tools, including E/M visits, HCPCS code G2211, and Advanced Primary Care Management (APCM) services, may already provide flexibility to account for diverse types of physician work. Some stakeholders commented on broader payment reform, including simplified E/M coding combined with per-beneficiary-per-month prospective payments through a hybrid payment model.

Additionally, commenters further noted the difficulty of accurately measuring and differentiating the resource costs associated with longitudinal, acute, and consultative care. In response to CMS' request for information on resources that could inform future categorization of O/O E/M services, commenters suggested potential empirical data sources and methodologies to identify gaps in the resource requirements currently captured under existing payment policies.

More broadly, commenters agreed that the PFS structurally undervalues primary care services. Primary care organizations, payers, and policy groups supported moving toward prospective or hybrid payment models, while specialty organizations cautioned against increasing primary care payment through reductions to specialty organizations cautioned against increasing primary care payment through reductions to specialty payments. These commenters argue that many specialties also furnish longitudinal and cognitive care services and warned that payment redistribution could adversely affect patient access to specialty care. Hepatology and cardiology organizations specifically highlighted concerns that changes focused exclusively on primary care could undermine access to specialty services for patients with complex chronic conditions. CMS did not respond to these concerns substantively, stating only that it would consider stakeholder feedback in future rulemaking. Several commenters also emphasized the importance of incorporating behavioral health and lifestyle support services into primary care payment models.

CMS did not finalize any policy changes related to these issues. Instead, the agency stated throughout the discussion that it will consider the feedback received as it evaluates potential future changes to primary care payment and valuation.

Care Management Code 'Family' – p. 514
Highlight: Commenters broadly supported simplifying Medicare's care management code structure but opposed creating separate payment pathways for technology-enabled care management services.

CMS reviewed stakeholder feedback on potential changes to the care management code family, including CCM, PCM, TCM, and APCM services. Commenters argued that underutilization of care management services is a greater concern than fraud, waste, and abuse, and pointed to beneficiary cost-sharing and documentation requirements as significant barriers to adoption.

Stakeholders also noted substantial overlap among existing care management codes and broadly supported greater alignment of requirements across services, including consent, supervision, and documentation standards. Commenters highlighted significant resources required to deliver advanced primary care, including care team staffing, health IT infrastructure, and population health management tools.

Commenters opposed creating separate "technology-first" and "traditional" care management pathways, emphasizing that technology is increasingly integrated into all models of care delivery. CMS did not finalize any policy changes and stated it will consider the feedback in future rulemaking.

Service	Description
Care Management Services	
Chronic Care Management (CCM) (CPT Codes 99487, 99489, 99490, 99491, 99439, 99437)	Management of all care for patients with two or more serious chronic conditions, timed, per month.
Principal Care Management (PCM) (CPT Codes 99424, 99425, 99426, 99427)	Management of all care for patients with one serious chronic condition, timed, per month.
Transitional Care Management (TCM) (CPT Codes 99495, 99496)	Management of transition from acute care or certain outpatient stays to a community setting, with face-to-face visit (bundled into payment for the code), once per patient within 30 days post-discharge.
Advanced Primary Care Management (APCM) (HCPCS G0556, G0557, and G0558)	Management of all care for patients with or without chronic conditions, not timed, per month.
Communication Technology-Based Services	
Remote Physiologic Monitoring (RPM) and Remote Therapeutic Monitoring (RTM) (CPT codes 99453, 99445, 99454, 99470, 99457, 99458, 99091)	Remote monitoring and assessment of physiologic data or adherence and response to therapeutic treatment, timed, per month.

Payment Implications of Technology Enablement of Primary Care – p. 518
Highlight: Commenters supported AI tools that reduce administrative burden and improve clinical decision-making, while cautioning that future Medicare payment policies should be tied to demonstrated clinical value.

CMS summarized stakeholder feedback on the growing use of technology and artificial intelligence (AI) in primary care. Commenters supported AI-enabled tools that help clinicians synthesize patient information, identify screening and vaccination gaps, flag risk factors, and automate administrative tasks such as documentation and questionnaire administration. Many stakeholders noted that these tools could free clinicians to spend more time on direct patient care, care planning, and shared decision-making.

At the same time, commenters expressed concerns about the current limitations of AI technologies and emphasized that any future Medicare payment policies should be supported by evidence demonstrating improvements in clinical outcomes. Several stakeholders also stressed that technology should support, rather than replace, physician judgment and patient-clinician relationships.

Regarding privacy and oversight, commenters stated that existing HIPAA and HITECH requirements already provide a framework for governing AI-enabled tools, while others called for improved data infrastructure and interoperability standards to support broader adoption.

CMS **did not** finalize any payment changes in response to the RFI and stated that it will consider stakeholder feedback in future rulemaking.

Current Procedural Terminology (CPT) Request for Information (RFI) – p. 573
Highlight: While CMS requested comments specifically on the AMA CPT process which most commenters supported, the agency also received many comments on the AMA RUC process.

CMS requested stakeholder feedback on whether the current physician coding and valuation system, centered on the AMA's CPT coding system and the AMA Relative Value Scale Update Committee (RUC) continues to be the best option for payment Medicare services. CMS acknowledged that CPT codes have formed the foundation of physician payment under the MPFS for many years, but the agency also has longstanding concerns about reliance on a private organization, the AMA, to develop and value codes that directly influence physician reimbursement.

CMS acknowledged that the RFI initially focused on potential harms associated with the AMA's CPT-4 licensing monopoly and alternative coding standards, but most comments addressed the AMA RUC process. In response, CMS is considering potential changes to the RUC process, including improving transparency and the data used to develop payment recommendations, modifying committee composition, increasing CMS independence in valuing physician services, and evaluating whether to retire low-value services.

In response to comments, CMS emphasized that physician input remains important to understanding the resources required to furnish services but reiterated that the agency maintains sole authority to establish Medicare physician payment rates. CMS encouraged the RUC and other organizations that submit recommendations for the values of physician services, to support recommended values with empirical and market-based data, including statistically valid clinician surveys, auditable practice cost reports, market prices, and negotiated rates between clinicians and private payers.

Importantly, CMS also wants organizations to provide information on the clinical outcomes expected from physician services, including the distribution and variation in those outcomes. CMS views incorporating clinical outcomes into physician service valuation to better assess the value of services, align Medicare spending with the value of care delivered, and advance its longstanding priority of outcomes-based payment and more accountable, value-based care. **CMS is signaling that future physician payment recommendations may need to demonstrate not only the resources required to furnish a service but also the clinical outcomes that patients can reasonably expect.**

In the rule, CMS used the procedure of total knee arthroplasty as an example to educate stakeholders on the type of information the agency may find valuable to determine the pricing of a service. This information includes data on improvements in pain and range of motion, typical recovery times, complication rates, and the proportion of patients who eventually require revision surgery may help the agency to determine the value of a service. CMS expects this information to help establish typical clinical outcomes and distinguish commonly accepted practice from variations in outcomes.

Limiting Medicare Coverage of Certain Individuals – p. 840 ALL
Highlight: CMS finalized Medicare enrollment policy changes to implement new statutory citizenship and immigration eligibility requirements enacted by the Working Families Tax Cut (WFTC) legislation.

CMS finalized policies implementing section 1899C of the Social Security Act, which was added by the Working Families Tax Cut (WFTC) legislation enacted on July 4, 2025. Under the law, Medicare eligibility is limited to four categories of individuals: U.S. citizens or nationals, lawful permanent residents (LPRs), Cuban and Haitian entrants (CHEs), and individuals lawfully residing in the United States under a Compact of Free Association (COFA).

CMS explained that, prior to enactment of the WFTC legislation, Medicare relied on the same lawful presence verification framework used by the Social Security Administration (SSA) for Title II benefits. That framework permitted Medicare eligibility for a broader range of lawfully present noncitizens, including refugees, asylees, and certain parolees. Because the WFTC legislation narrowed Medicare eligibility without changing Title II eligibility requirements, CMS stated that continued reliance on the prior verification process would no longer comply with statute.

Accordingly, CMS finalized Medicare-specific definitions and enrollment policies related to citizenship, nationality, and immigration status to ensure Medicare eligibility determinations align with the new statutory requirements.

Medicare Prescription Drug Inflation Rebate Program – p. 899
Highlight: CMS finalized policies to implement the Medicare Prescription Drug Inflation Rebate Program.

Overview of the Medicare Prescription Drug Inflation Rebate Program
Sections 11101 and 11102 of the Inflation Reduction Act established requirements that drug manufacturers must pay inflation rebates if they raise their prices for certain drugs payable under Part B and/or covered under Part D faster than the rate of inflation.

Summary of the Finalized Policies for the Medicare Prescription Drug Inflation Rebate Program
CMS finalized the following new policies to implement the Medicare Part B Drug Inflation Rebate Program:

- Clarify the definition of "first marketed date" to clarify the data sources that the agency will use to identify the first marketed date when relevant Average Sales Price (ASP) data is not available.
- Modify the skin substitutes excluded product category for Part B rebatable drugs to only apply to certain skin substitutes; and
- Clarify the CPI-U data that would be used to determine the benchmark period CPI-U in place of the month when CPI-U data is not available.

CMS finalized the following new policies to implement the Medicare Part D Drug Inflation Rebate Program:

- Clarify definitions of applicable period CPI-U and what CPI-U data would be used when data from the first month is not available;
- Clarify what CPI-U data would be used to determine the benchmark period CPI-U in place of the month for which CPI-U data are unavailable; and
- Require providers and suppliers who are covered entities to submit Part D 340B data to the 340B repository beginning with claims with a date of service on or after January 1, 2027.

Request for Information on Duplicate Laboratory Testing, Imaging, and Result Sharing and Interoperability – p. 1,546
Highlight: CMS received feedback on how to address concerns with duplicate laboratory testing and diagnostic imaging.

Purpose of the RFI
CMS recognizes that both diagnostic imaging and laboratory testing are critical components of patient care and is concerned that the imaging data and laboratory test results are often siloed within EHRs and often is inaccessible to treating physicians. The agency believes that these silos can result in incomplete or delayed care management and duplicative testing and requested information for future policy aimed at addressing the interoperability and duplicate testing concerns.

The agency considered the following mechanisms to address duplicative payments:

- Clarifications to billing instructions to laboratories and imaging centers on parameters of duplicate laboratory or imaging tests;

- Local MAC edits that would result in non-payment or reduced payment for duplicate laboratory or imaging tests;
- Payment integrity levers to recoup payments for duplicate testing from providers and suppliers; and
- Application of frequency limitations to certain tests where clinically appropriate.

CMS wants to ensure that any policies that are implemented do not restrict beneficiary access to necessary care, particularly when more frequent clinical testing may be clinically justified. The agency also sought feedback on specific questions related to interoperability for diagnostic laboratory testing and imaging services.

Commenters supported the agency's efforts to reduce costs associated with duplicative testing and imaging, although some commenters noted that duplicate testing may often be clinically necessary and providers should not be penalized if access to the prior results is not available. The agency will consider the comments for future rulemaking.

Appendix A: RVU Values Associated with B1 and B2 Modifiers

CPT Code	Total RVU**	Total RVU w/B1	Total RVU w/B2
99202	2.27	2.63	3.00
99203	3.48	4.04	4.59
99204	5.21	6.04	6.88
99205	6.91	8.02	9.12
99211	0.74	0.86	0.98
99212	1.77	2.05	2.34
99213	2.82	3.27	3.72
99214	4.02	4.66	5.31
99215	5.62	6.52	7.42
99341	1.49	1.73	1.97
99342	2.42	2.81	3.19
99344	4.41	5.12	5.82
99345	6.19	7.18	8.17
99347	1.42	1.65	1.87
99348	2.40	2.78	3.17
99349	3.88	4.50	5.12
99350	5.69	6.60	7.51

*Modifier B1 increases the total RVU by 16%, Modifier B2 increases the total RVU by 32%.

**Total RVU includes the work, practice expense, and malpractice RVU.

Example: E/M CPT code 99202 total RVU is 2.27. 16% of 2.27 = 0.36.
2.27 + 0.36 = 2.63.