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2027 Medicare Physician Fee Schedule
Final Rule Summary

On Wednesday, November 4, 2026, the Centers for Medicare & Medicaid Services (CMS) issued the 2027 Medicare Physician Fee Schedule (MPFS) final rule, with an estimated positive 2% impact to radiation therapy physician services overall, and a 4% impact to non-facility (freestanding) practices and negative 2% impact for facility practices. The final rule updates the payment policies, payment rates, and quality provisions for services furnished under the MPFS effective January 1, 2027.[1]

Despite the overall positive impact estimated by CMS, ASTRO is disappointed that CMS did not properly increase the MPFS RVUs for 77407 based on its hospital APC reassignment, and the significant cuts to important radiation oncology codes, including planning, management and SBRT.

Proposed Rule Takeaways for Radiation Oncology

- MPFS Conversion Factor
- Radiation Oncology Treatment Delivery (CPT codes 77402, 77407, and 77412)
- Proton Beam Treatment Delivery
- Practice Expense Methodology Changes
- Efficiency Adjustment
- Image-guided Robotic Linear Accelerator Stereotactic Radiosurgery (HCPCS code G0339
- and G0340)
- Strategies to Improve Payment Transparency, Accuracy, and Congruency Across Payment Systems
- Accounting for E/M Resource Overlap Between Stand-Alone Visits and Global Periods
- Supporting Beneficiaries Planning for Future Medical Decisions
- Evaluation and Management (E/M) Visit Complexity Add-on (HCPCS code G2211)
- Remote Monitoring Services
- Current Procedural Terminology (CPT) Request for Information (RFI)
- Comment Solicitation on Payment for Physician-Patient Clinical Trial Discussions

Go deeper on these issues in the summary below.

MPFS Conversion Factor

Beginning in CY 2026, there are two separate conversion factors (CF): one for qualifying alternative payment model (APM) participants and another for non-qualifying APM participants as defined under the Medicare Access and CHIP Reauthorization Act (MACRA). The CY 2027 CF for a qualifying APM participant will be $32.9548 and the CF for a non-qualifying APM participant will be $32.6286. The charts below show the CF

[1] The MPFS pays for services furnished by physicians and other practitioners in all sites of service. These services include visits, surgical procedures, diagnostic tests, therapy services, specified preventative services and more. Payments are based on the relative resources typically used to furnish the service. Relative value units (RVUs) are applied to each service for physician work, practice expense and malpractice. These RVUs become payment rates through the application of a Conversion Factor, which is updated annually.

calculations.

Both 2027 CFs are a cut compared to 2026. The 2026 CFs included a one-year, 2.50% increase that Congress provided for 2026 only, and that increase expires on December 31, 2026. As a result, the 2027 CFs are approximately 1.8% lower (qualifying) and 2.3% lower (non-qualifying) than the 2026 CFs, which has a negative impact on all radiation oncology codes.

Table D-B1: Calculation of the CY 2027 PFS Qualifying APM Conversion Factor

2026 Conversion Factor		$33.5675
Conversion Factor without One Year 2.50% Increase		$32.7488
CY 2027 Qualifying APM Participant	0.75% (1.0075)	
CY 2027 RVU Budget Neutrality Adjustment	-0.12% (0.9988)	
CY 2027 Conversion Factor		**$32.9548**

Table D-B2: Calculation of the CY 2027 MPFS Non-Qualifying APM Conversion Factor

2026 Conversion Factor		$33.4009
Conversion Factor without One Year 2.50% Increase		$32.5863
CY 2027 Non-Qualifying APM Participant	0.25% (1.0025)	
CY 2027 RVU Budget Neutrality Adjustment	-0.12% (0.9988)	
CY 2027 Conversion Factor		**$32.6286**

Impact on Radiation Oncology

According to the MPFS Total Allowed Charges Impact Table, the estimated impact on total allowed charges for radiation oncology services for 2027 is negative 2%, but the estimated impact on nonfacilities (i.e., freestanding centers) is positive 4%.

Medicare pays for each service by multiplying its total RVUs by the CF, so the CF reduction lowers payment for every radiation oncology code, regardless of how its RVUs change. The code-level table below shows this effect: for each listed code, the change in payment rate is roughly 1.5 to 2 percentage points worse than the change in RVUs. For example, the RVUs for CPT 77427 drops 2.72%, but its payment rate declines 4.97%, and the large RVU increase for CPT 77412 (23.89%) translates into a somewhat smaller payment increase (21.03%). **For services already facing RVU reductions, including planning, management, and SBRT, the CF cut compounds those declines, resulting in payment reductions of roughly 4% to 6% for the frequently billed codes shown below.** Because the loss of the 2.50% increase results from the expiration of a statutory provision rather than a CMS policy choice, only Congress can reverse it. This reinforces the need for Congress to address the CF this year and for comprehensive payment reform via the ROCR Act.

CY 2027 PFS Estimated Impact on Total Allowed Charges by Specialty

Specialty	Allowed Charges (mil)	Impact of Work RVU Changes	Impact of PE RVU Changes	Impact of MP RVU Changes	Combined Impact
Radiation Oncology and Radiation Therapy Centers	$ 1,603	0%	2%	0%	2%

CY 2027 PFS Estimated Impact on Total Allowed Charges by Specialty

Specialty	Total/Nonfacility/Facility	Allowed Charges (mil)	Combined Impact
Radiation Oncology and Radiation Therapy Centers	Total	$1,603	2%
	Nonfacility	$1,082	4%
	Facility	$521	-2%

The table below shows the distribution of radiation oncology practitioners based on how their total RVUs would change under the 2027 rule, rather than the average change for the specialty in the tables above.

Distribution of Practitioners by % Change in Total RVUs and IMPACT Specialty NPRM2027 (Unweighted)

Impact Specialty	Practitioners (thousands)	% Change in Total RVUs *per practitioner*										
		< -20%	-20% to < -10%	-10% to < -5%	-5% to < -2%	-2% to < -1%	-1% to < 1%	1% to < 2%	2% to < 5%	5% to < 10%	10% to < 20%	>=20%
Total	**1,442**	**Share of Total Practitioners in Specialty**										
RADIATION ONCOLOGY AND RADIATION THERAPY CENTERS	5	2%	0%	0%	2%	56%	13%	3%	15%	8%	1%	1%

The table below shows the code-level impact of the final rule on some of the most frequently billed radiation oncology codes.

Frequently Billed Radiation Oncology Codes Impact Table

CPT Code	2027 Short Descriptor	MOD	2026 Total RVUs	2026 Payment Rate	2027 Total NF RVUs	2027 Payment Rate	RVU % Difference	Payment Rate % Difference
77402	Radiation tx delivery lvl 1		2.38	$79.49	2.98	$97.23	25.21%	22.32%
77407	Radiation tx delivery lvl 2		9.51	$317.64	10.43	$340.32	9.67%	7.14%
77412	Radiation tx delivery lvl 3		11.72	$391.46	14.52	$473.77	23.89%	21.03%

77427	Radiation tx management x5		5.89	$196.73	5.73	$186.96	-2.72%	-4.97%
77431	Radiation therapy management		3.21	$107.22	3.14	$102.45	-2.18%	-4.45%
77301	Radiotherapy dose plan imrt	26	12.63	$421.85	12.32	$401.98	-2.45%	-4.71%
77263	Ther radiology tx plng cplx		5.07	$169.34	4.95	$161.51	-2.37%	-4.62%
77334	Radiation treatment aid(s)	26	1.82	$60.79	1.77	$57.75	-2.75%	-5.00%
99205	Office/outpatient new high mdm 60 minutes		7.09	$236.81	6.91	$225.46	-2.54%	-4.79%
77338	Design mlc device for imrt		14.34	$478.97	13.74	$448.32	-4.18%	-6.40%
77338	Design mlc device for imrt	26	6.78	$226.46	6.61	$215.68	-2.51%	-4.76%
77435	Sbrt management		19.31	$644.97	18.84	$614.72	-2.43%	-4.69%
77300	Radiation therapy dose plan		2.02	$67.47	1.93	$62.97	-4.46%	-6.66%
77300	Radiation therapy dose plan	26	0.98	$32.73	0.96	$31.32	-2.04%	-4.30%

Radiation Oncology Treatment Delivery (CPT codes 77402, 77407, and 77412)

Beginning in 2026, CMS has valued the practice expense and malpractice RVUs for the radiation treatment delivery codes (CPT 77402, 77407, and 77412) based on the relationship between the relative weights of those codes under the Hospital Outpatient Prospective Payment System (OPPS). Under the OPPS, each code is assigned to an Ambulatory Payment Classification (APC), and each APC has a relative weight. As a result, a code's APC assignment under the OPPS directly drives its RVUs under the MPFS, and a change in APC assignment under the OPPS should be reflected in the MPFS RVUs.

ASTRO is pleased to see increases relative to 2026 across the treatment delivery code family, but disappointed that the Agency didn't take additional steps to help freestanding centers dig out of a massive hole. Most notably, in the 2027 OPPS final rule, CMS reassigned CPT 77407 to the same APC as CPT 77412 (APC 5623); however, this reassignment did not result in increased MPFS RVUs for 77407. ASTRO is concerned that CMS is failing to properly implement its own policy by not updating the RVUs for 77407. ASTRO has engaged the Agency on this critical issue, which has the effect of widening the disparity between hospital and freestanding reimbursement for this high-volume code. ASTRO will advocate strongly for a solution for freestanding centers, as this issue could lead to further closures and consolidation.

Proton Beam Treatment Delivery

CMS finalized national practice expense RVUs for proton therapy delivery codes 77520, 77522, 77523, and 77525 beginning in CY 2027, despite ASTRO's recommendation to retain MAC pricing for another year and transition to national pricing in 2028 after more stakeholder input. CMS did, however, modify its methodology in response to ASTRO and other stakeholder concerns. It will now use Q1 and Q2 2026 MAC claims to establish the overall proton PE RVU pool, which better reflects the current coding structure in which image guidance is bundled into proton delivery. CMS then allocated that pool among the four codes using their relative OPPS payment relationships, with 77520 linked to APC 5623 and 77522, 77523, and

77525 linked to APC 5625. CMS stated that this approach preserves the overall level of spending reflected in MAC-priced claims while establishing consistent national rates (although payments may shift among individual proton services and providers).

Go deeper
Proton beam treatment delivery services are currently priced by local MACs. CMS has historically avoided assigning national RVUs for these services because proton therapy involves unusually high capital costs that are not well captured by the standard practice expense (PE) methodology. CMS noted that contractor pricing has resulted in substantial geographic variation in payment rates, raising concerns about payment consistency. In response to stakeholder requests for greater uniformity, CMS proposed a methodology similar to the one adopted for radiation treatment delivery services in 2026. CMS believes this approach balances the need for nationally consistent payment rates with the challenges of valuing highly specialized, capital-intensive proton therapy services.

Practice Expense Methodology Changes
Elimination of the Indirect Practice Cost Index (IPCI)
CMS finalized its proposal to eliminate the IPCI from the practice expense methodology (PE) over a two-year transition. CMS concluded that the IPCI, which is rooted in specialty-level cost data from the 2007 AMA Physician Practice Information Survey, can override more current code-level inputs and produce unpredictable or counterintuitive payment effects. Importantly, CMS is not eliminating all specialty-specific cost data from the PE methodology; rather, it is eliminating the IPCI's additional re-scaling of indirect PE RVUs. CMS declined to provide a longer transition (ASTRO requested a four-year transition, in-line with historical MPFS policy phase-ins), stating that its separate 5% annual PE stabilization adjustment will limit significant year-to-year changes at the code level and, for services experiencing large changes, could effectively phase in the impact over a period longer than four years.

Go deeper
Today, PE RVUs are first calculated at the code level using direct inputs (clinical labor, supplies, equipment) and indirect allocators. CMS then applies a specialty-level adjustment, known as the IPCI, that is tied to specialty survey data from the Physician Practice Information Survey (PPIS), most of which dates back to 2006-2007. CMS believes the IPCI is effectively allowing old specialty survey information to override more recent code-level resource information.

New Indirect PE Allocation Formula
CMS also finalized a new methodology for allocating indirect practice expense that gives greater weight to the resources directly associated with furnishing each service. Under the new formula, CMS will allocate indirect PE using both work RVUs and direct clinical labor PE RVUs, rather than relying primarily on work RVUs, better recognizing services that are clinical-labor intensive but have relatively low physician work. The change is intended to more accurately distribute indirect costs such as administrative staff, rent, and other overhead based on the resources needed to provide individual services and is part of CMS's broader effort to make the PE methodology more responsive to current code-level inputs.

Go deeper
CMS will now use Work RVUs + Clinical Labor RVUs as part of the indirect cost allocation for nearly all services (excepting certain 10- and 90-day global surgical services). This is instead of only applying that methodology to those services that can be reported using technical, professional, and global components

(typically diagnostic and imaging services). Services with substantial clinical labor but relatively low physician work may receive more indirect PE allocation than under the existing methodology, while other services could lose allocation.

Current Methodology	New Methodology
Generally: Indirect Allocator = Indirect % × (Direct PE RVUs ÷ Direct %) + greater of: • Work RVUs • Clinical labor PE RVUs Special modifications exist for global services.	Indirect Allocator = Indirect % × (Direct PE RVUs ÷ Direct %) + Work RVUs + Clinical Labor RVUs For essentially all services except 010- and 090-day global surgery codes.
Why this matters: several radiation oncology codes (e.g., treatment delivery) have significant clinical labor but little or no physician work. These codes benefit when both physician work and clinical labor are included.	

Updates to Practice Expense (PE) Methodology – Site of Service Differential
CMS is continuing to evaluate the significant PE methodology change finalized for 2026, which reduced the amount of indirect PE allocated to services furnished in the facility setting to 50% of the amount allocated in the non-facility setting. The policy was intended to better reflect modern physician practice patterns, particularly the growth of hospital-employed physicians who may incur fewer overhead costs than physicians maintaining their own offices. No changes to this policy have been made for 2027, but CMS will consider comments it received in future rulemaking.

Efficiency Adjustment
There was no efficiency adjustment applied for 2027 as it was just implemented in 2026 and runs on a three-year cycle.

Go Deeper
In the CY 2026 PFS final rule, CMS finalized a policy to apply an efficiency adjustment to work RVUs and the intraservice portion of physician time inputs every three years. The policy is intended to account for improvements in medical practice efficiency and better reflect the resources required to furnish services. Although recent Bureau of Labor Statistics productivity data would have supported a 3.6% adjustment, CMS adopted a more conservative 2.5% reduction. CMS also exempted certain services from the adjustment, including time-based services, services on the Medicare telehealth list, and codes that were new for CY 2026.

Image-guided Robotic Linear Accelerator Stereotactic Radiosurgery (HCPCS code G0339 and G0340)
CMS retained codes G0339 and G0340 for CY 2027 rather than deleting them, citing continued utilization and concerns about disrupting current billing practices. ASTRO recommended that CMS address the larger valuation issue by linking these codes, as well as codes for SRS/SBRT, to OPPS data beginning in 2028, similar to the OPPS-informed methodology used for other radiation treatment delivery services. CMS acknowledged this recommendation and indicated it may consider using OPPS payment rates to inform valuation of these services in future rulemaking, leaving the door open to ASTRO's proposed approach.

Go deeper

In the proposed rule, CMS discusses the future of HCPCS G-codes G0339 and G0340, which are used to report image-guided robotic linear accelerator-based stereotactic radiosurgery (e.g., CyberKnife). The RUC Relativity Assessment Workgroup (RAW) identified G0340 for review because it had more than 10,000 Medicare services in 2023 and is contractor-priced. In September 2025, the RAW recommended deleting both G-codes because CPT 77373 can be used to describe these services. However, CMS noted that the G-codes remain widely used, with approximately 3,000 claims for G0339 and 12,000 claims for G0340 in 2024. Because of this utilization, CMS is not deleting these codes.

Strategies to Improve Payment Transparency, Accuracy, and Congruency Across Payment Systems

Professional and Technical Components

CMS is continuing its effort to make MPFS payments more transparent and comparable across sites of care by showing how payment for a service can conceptually be divided between professional and technical resource components, including for services that do not currently use modifiers 26 and TC. CMS developed a public-use file displaying these components to facilitate comparison between PFS technical payments and facility payments and to provide a foundation for possible future payment reforms. CMS emphasized that this initiative itself does not change payment or billing policy, but it could ultimately support greater alignment of payment across settings. CMS continues to examine global surgical packages separately because their bundled structure makes the underlying components difficult to identify and compare, and it is considering ways to "right-size" those payments based on current resource costs and actual services furnished.

Global Surgical Packages

CMS finalized a pause in the mandatory reporting of CPT 99024 (*Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) related to the original procedure*), which has been used to collect data on postoperative visits included in 10- and 90-day global surgical packages. CMS continues to believe that its existing data indicate that fewer postoperative visits are being furnished than are assumed in current global package valuations, potentially resulting in payment for visits that do not occur. However, commenters raised concerns that 99024 may be underreported and does not capture other postoperative work occurring outside of formal visits. CMS agreed that pausing the reporting requirement will reduce provider burden and provide additional time to assess these limitations. CMS is not revaluing global packages for CY 2027 based on these data; instead, it published a public-use file illustrating the potential RVU implications of removing unreported postoperative visits and will consider potential approaches to revaluing global surgical packages in future rulemaking.

Telehealth Flexibilities and Modifiers

Congress extended the major Medicare telehealth flexibilities originally established during the COVID-19 public health emergency through December 31, 2027, including removal of geographic restrictions, expansion of permissible originating sites, and the broader range of practitioners eligible to furnish telehealth services. Congress also extended audio-only telehealth through January 1, 2028, and delayed the in-person visit requirements for tele-mental health services until that date. Beginning January 1, 2027, CMS will also require two new informational modifiers: BB for telehealth furnished through a virtual platform where the practitioner has a contractual or payment arrangement with the platform owner, and BC for telehealth furnished incident to a physician's or practitioner's professional service. The new modifiers are intended to provide CMS with additional information about how telehealth is delivered and do not affect Medicare payment.

Accounting for E/M Resource Overlap Between Stand-Alone Visits and Global Periods

CMS finalized a narrower and less severe version of its proposed payment reduction for separately identifiable office/outpatient E/M visits furnished on the same day as a global procedure. Rather than applying the policy to 0-, 10-, and 90-day global procedures, CMS will apply it only to 0-day global procedures. In addition, instead of reducing payment for the lower-cost service to 50% as proposed, CMS will pay the highest-cost service at 100% and other same-day procedures or separately identifiable E/M visits at 80%. CMS continues to believe that efficiencies exist when E/M and procedural services are furnished together, but it modified the policy substantially in response to stakeholder concerns.

Supporting Beneficiaries Planning for Future Medical Decisions

CMS finalized two new HCPCS codes, G0572 and G0573, to separately recognize advance care planning (ACP) performed by clinical staff under the direction of a treating physician or other qualified health care professional. G0572 covers the first 20 minutes of clinical staff ACP time and G0573 covers each additional 20 minutes, allowing clinical staff contributions to be recognized separately from practitioner ACP services, which will still be reported with CPT 99497 and 99498. CMS also finalized adding both new codes to the Medicare Telehealth Services List beginning in CY 2027, allowing these services to be furnished via an interactive telecommunications system when applicable.

Evaluation and Management (E/M) Visit Complexity Add-on (HCPCS code G2211)

For CY 2027, CMS is finalizing two changes to G2211:

1. Transition HCPCS code G2211 to a modifier that can be appended to the associated E/M base code modifier B1). This modifier will increase the payment of the associated E/M code by 16%, instead of a flat rate, maintaining an equal percentage increase across all levels of E/M codes. CMS believes this will result in more streamlined billing that will be easier for beneficiaries to understand.
2. CMS also is recognizing additional resource costs incurred by practitioners in Accountable Care Organizations (ACOs) when providing longitudinal care, such as maintaining total cost of care accountability and reporting quality measures that can align with providing longitudinal care and care coordination. This modifier (modifier B2) will be available only for practitioners participating in a Shared Savings Program ACO or Participant Providers in a Long-term Enhanced ACO Design (LEAD) Model ACO and would increase payment of the associated E/M visit by 32%.

Go deeper

CMS proposed to replace HCPCS code G2211 (*Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established))* with a new billing modifier beginning in 2027. G2211 was created to recognize the additional work involved in providing longitudinal, relationship-based care, such as serving as the continuing focal point for a patient's overall health care needs or managing an ongoing serious or complex condition.

Since implementation of G2211 in 2024, CMS has concluded that this complexity is not truly a separate service but rather an inherent feature of the underlying E/M visit. As a result, CMS believes it would be more accurately and efficiently reported as a modifier attached to the E/M code rather than as a separate add-on

code requiring its own claim line. The new modifier will be used in the same circumstances currently eligible for G2211, including office/outpatient and home/residence E/M visits. The policy does not change the underlying purpose of recognizing the added resources associated with ongoing patient-practitioner relationships.

Remote Monitoring Services

CMS finalized several changes to remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM). Beginning in CY 2027, RTM will be limited to established patients, and practitioners billing RPM or RTM must furnish a separately reportable initiating visit when services begin. CMS also finalized a requirement that clinical staff furnishing RPM or RTM be direct employees of the billing practitioner or practice, rather than contracted personnel, but it delayed implementation of that requirement until January 1, 2029, two years later than proposed. CMS did not move forward with consolidating the existing RPM and RTM code families into four new G-codes.

Current Procedural Terminology (CPT) Request for Information (RFI)

CMS asked stakeholders whether the Agency should continue relying so heavily on the current CPT coding framework and whether there are opportunities to modernize coding and valuation under the PFS. CMS noted that CPT plays a central role in describing physician services and forming the basis for payment, but the Agency was interested in feedback on whether the current structure is keeping pace with changes in healthcare delivery, technology, and value-based care.

Specifically, CMS sought feedback on:

1. What, if any, evidence is there for CMS to consider regarding the harms or challenges associated with AMA's monopoly over CPT-4 licenses for health care entities? Please cite potential improvements to patient care diverted or delayed due to AMA's monopoly over CPT codes, including inhibited innovations and acquisition or maintenance costs of CPT® licensure.
2. What, if any, evidence is there that the generation of CPT-4 codes follows a process of identification of medical necessity? What opportunities or examples from other populations, sites of care, or international health systems could instruct a process of identification of medical necessity in the CPT-4 code development process?
3. A combination of CPT-4 and HCPCS codes were formally adopted by HHS as the legal standard for national coding for physician and other services as part of implementing HIPAA (45 CFR 162.1002(a)(5)). If CMS were to revisit this standard in future rulemaking, which if any alternatives exist to CPT-4 for CMS to consider as part of the national coding standard for physician services? Would CMS need to specify a separate legal standard, or could CMS allow for private competition to supplement the existing CPT-4 coding standard?
4. What objective alternatives exist, or could be developed, to maintain a more objective process to the current AMA CPT and RUC committee processes? How would these alternatives support or inhibit innovation?
5. What are the benefits and drawbacks of paying for physician procedural services on the basis of the underlying International Classification of Diseases, 10th Revision (ICD-10) procedure code, as an alternative to CPT-4 code? How could the International classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) services be grouped or bundled into payment categories, similar to Medicare Severity Diagnosis Related Groups (MSDRGs), or Outpatient Prospective Payment System (OPPS) Ambulatory Payment Classifications (APCs)? What other alternatives exist for bundling or grouping procedural services?

CMS received many comments that it will take into consideration in future rulemaking.

Comment Solicitation on Payment for Physician-Patient Clinical Trial Discussions

Despite the U.S. investing over $50 billion annually in biomedical research, fewer than 7 percent of adult cancer patients enroll in clinical trials. A central and modifiable reason is that physicians rarely initiate conversations about clinical trials with their patients. For example, national survey data show that 70 percent of oncologists discuss trials with less than a quarter of their patients, yet more than 50 percent of eligible patients enroll when actively offered a clinical trial.

Time and administrative burden are documented as the top barrier to conversations between physician and patients about participation in clinical trials in virtually every survey. The current valuation of existing visit codes does not account for the additional time and resource costs associated with the structured physician counseling regarding clinical trial eligibility, options, risks and benefits associated with counseling a beneficiary on whether to enroll in a clinical trial.

CMS sought comment on whether it should effectuate payment for these resource costs through the creation of a HCPCS G-code describing a minimum of 20 minutes of physician or other QHP time spent on clinical trial counseling. CMS also sought comment on accurate valuation for this service, including inputs for work and practice expense, and whether the service should be available as a Medicare telehealth service. Interested parties suggested a work RVU value between 1.00 and 1.50 RVUs would accurately account for the physician work associated with this service. CMS also sought comment on what documentation requirements they might consider for such a service, such as the trial(s) discussed and the patient's decision.

The Agency received many comments and will take them into consideration in future rulemaking.

Quality Payment Program

A more thorough summary of the changes to the Quality Payment Program will be included in a subsequent summary document.

For a copy of the rule: https://public-inspection.federalregister.gov/2026-22743.pdf

For a fact sheet on the proposed rule: https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2027-medicare-physician-fee-schedule-final-rule