CY 2027 Medicare Physician Fee Schedule Proposed Rule Summary

On July 14, the Centers for Medicare & Medicaid Services (CMS) released the Medicare Physician Fee Schedule (MPFS) proposed rule and fact sheet for CY 2027 (CMS-1848-P). This rule updates payment policies and payment rates for Part B services furnished under the MPFS. The data files including Addendum B, which lists the proposed RVUs for each CPT® code can be found here. **Comments are due September 14.**

With the release of this rule, CMS signals the possibility of moving away from the AMA CPT and RUC process by creating or proposing several new HCPCS G code replacing CPT codes for payment in the Medicare program. Coinciding with the creation of new HCPCS G codes, the agency also outlines a request for information (RFI) asking stakeholders to provide information on the use of CPT codes for physician payment and if the use of CPT codes creates a payment system with contradictory incentives. This proposed rule also contains several other formal RFIs including ways to improve primary care and seeking improved payment methodologies for the global surgical package.

Throughout the rule, CMS seeks comments on many of its proposals. While not unusual to seek comment on specific topics, the CY 2027 rule offers many more opportunities for stakeholders to weigh in on proposed policies. Finally, the Make America Healthy Again initiative, a priority of the administration, is prominent throughout with discussions on primary care, improving chronic care management, and creation of new HCPCS codes to support such care.

Note that the page numbers listed in this document refer to the display copy of the proposed rule. Additionally, new CPT codes do not have final code numbers assigned. The complete code numbers will be provided when the final rule is released in early November.

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

Conversion Factor for 2027 – p. 1,144
For the second year, there are two separate conversion factors, one for practitioners participating in a qualifying advanced alterative payment model (APM) and the other for those not participating in a qualifying APM. The qualifying APM conversion factor is $33.17, a decrease of 1.19%, and the non-qualifying APM conversion factor is $32.84, a decrease of 1.68%. Decreases of the two conversation factors are due to Congress only providing a one-year conversion factor increase of 2.5% for CY 2026; therefore, current law requires a 2.5% reduction to Medicare payments in 2027.

Specialty Level Impact of the Proposed Policy Changes – p. 1,154
CMS attributes the impact of the proposed policies to be generally related to changes in relative value units (RVUs) redistribution resulting in changes to work RVUs for new and revised codes. Additionally, CMS's proposed change to HCPCS code G2211 (longitudinal, complex patient care), updates to payment for services when performed on the same day as 0-, 10, or 90-day global procedure, and other code-level updates impact the increases or decreases to Medicare payments per specialty.

Table D-B5, page 1,146 of the rule (**Appendix A of this summary**) estimates the specialty level impacts of the policies included in the proposed rule and includes impacts of rate-setting changes and changes to RVUs within the budget neutral system. The impact of the proposed rule's policies on group practices and individual physicians varies based on practice type and the mix of patients and services provided to those patients.

Updates to Practice Expense Methodology - p. 49
Highlight: CMS continues to tweak payment methodology by removing steps in the payment formula that CMS believes rely on outdated data.

CMS proposes to simplify the methodology used to calculate PE RVUs, a change that could meaningfully redistribute Medicare payments across specialties. Currently, PE RVUs are determined through an 18-step process that includes the Indirect Practice Cost Index (IPCI), which adjusts indirect practice expenses based on specialty-level survey data. CMS proposes removing the IPCI entirely, eliminating steps 12 through 17 of the payment formula methodology.

CMS believes the IPCI relies too heavily on outdated, specialty-specific survey data and can distort code-level valuations by overriding more current and precise resource inputs. The agency argues that eliminating the IPCI will produce more accurate PE valuations that better reflect the resources required to furnish individual services. To lessen the impact on physician payments, CMS proposes a two-year transition, with half of the IPCI adjustment removed in the first year and the remaining adjustment eliminated in the second year.

CMS also seeks 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 describes 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.

Specifically, CMS is requesting information on how indirect practice expenses differ across physician practice arrangements, particularly for physicians employed by hospitals or health systems. The agency questions whether hospital-employed physicians incur enough indirect practice expenses to justify the current 50% facility PE allocation and asks whether the appropriate allocation could be even lower—including potentially 0% if those costs are already reflected in hospital outpatient payments under the Hospital Outpatient Prospective Payment System (OPPS).

CMS also seeks comment 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. More broadly, CMS requests objective data on physician employment arrangements, practice costs, and payment relationships to inform future refinements to PE valuation and ensure Medicare payments more accurately reflect the resources required to furnish services across different sites of care.

Payment for Medicare Telehealth Services under Section 1834(m) of the Act – p. 60
Highlight: CMS implements telehealth flexibilities and revises policy for virtual presence for teaching physicians.

<u>Telehealth Flexibilities and Modifiers</u>
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.

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 different locations. The agency proposes to revise 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. The agency is assuming that "same physical location" means the same room and seek comment on if this is appropriate. This policy only applies to services on the Medicare Telehealth Services List.

Telehealth Originating Site Facility Fee Payment Amount Proposed Update

CMS proposes to set the payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) at $32.65. This change is based on the proposed percentage increase in MEI and will be updated in the final rule.

Revision of G2211 with Modifier MOD1 – p. 170

Highlight: G2211 slated to be replaced by a modifier, retaining the description of the service, but changing the payment rate.

The agency proposes to delete code G2211 (Visit complexity inherent to evaluation and management associated with medical care services) and create a modifier to take its place.[1] The modifier, MOD1, 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 new 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. Table A-D7 on page 172 provides an illustrative example of how payment levels will change when the new modifier is reported with an E/M code. For example, when a lower level E/M service is provided such as 99212 (established patient E/M service), payment will increase by 29%.

G2211 in Medicare Accountable Care Organizations (MOD2) – p. 173

CMS proposes to replace HCPCS G2211 office visit complexity add-on code, when used in the Shared Savings Program ACOs, with a new claims modifier (MOD2) that would pay 32% of the associated evaluation and management (E/M) visit (twice the payment of MOD1) 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.

Vaccine Adverse Effects Management (HCPCS Code GADV1) – p. 191

Highlight: Creation of new HCPCS G code will be used to pay for and track severe adverse events related to vaccines.

CMS proposes a new add-on code, HCPCS code GADV1 (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 (list separately in addition to CPT codes 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215,

[1] 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.*

99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350)), to address the diagnosis and management of rare and severe vaccine adverse effects.

The agency states that while typical E/M services cover standard, mild vaccine side effects, the intensive clinical decision-making involved in managing rare and severe reactions such as anaphylaxis, myocarditis, thrombotic events, and pneumonitis is not accurately captured under the standard E/M code set. These rare cases require additional practitioner resources that extend beyond a typical E/M visit. The proposed code is designed to capture the time spent listening to patient concerns, building trust, providing educational resources, and tailoring diagnostic and treatment strategies to a patient's specific cultural beliefs, religious beliefs, and literacy level.

To bill for this new add-on service, a physician or nonphysician practitioner (NPP) must personally perform the service in 15-minute increments in conjunction with an allowed primary office, outpatient, or home/residence E/M visit code. The billing practitioner is required to meet two strict documentation thresholds: they must establish and document a clear temporal relationship between the vaccination and the adverse reaction, and they must perform and document a medically appropriate assessment to rule out alternative causes for the symptoms.

For valuation, CMS proposes to crosswalk HCPCS code GADV1 directly to the prolonged services code HCPCS code G2212, which would value GADV1 at 0.61 work RVUs and apply the same direct practice expense inputs. Additionally, CMS proposes to add GADV1 to the Medicare Telehealth List.

Finally, CMS is seeking public feedback on whether to establish a second, stand-alone HCPCS code for scenarios where a practitioner evaluates a patient solely for a vaccine-related complaint, outside the context of a separate E/M visit. They are also welcoming comments on whether the work RVUs and practice expense inputs for such a stand-alone code should similarly crosswalk to HCPCS code G2212.

Accounting for E/M Resource Overlap Between Stand-Alone Visits and Global Periods and Changes to Payment When Modifier 25 is Used – p. 199
Highlight: CMS reduces payment for services performed on the same day.

CMS proposes to reduce payment when a separately identifiable office/outpatient evaluation and management (E/M) visit as indicated by modifier -25, is furnished by the same physician (or a physician in the same practice) on the same day as the procedure included in a 0-, 10-, or 90-day global. The most expensive service (either surgical procedure or E/M visit) would be paid at 100% and all other surgical procedure(s) or E/M visit furnished on the same day would be paid at 50%. This policy will affect physicians who provide an E/M service coupled with a same day procedure.

The agency seeks comment on whether a different reduction, such as 25%, would be more appropriate. CMS also requests feedback on whether this policy should be expanded beyond office/outpatient E/M visits to include other E/M services, such as inpatient visits. Finally, the agency also notes that they will monitor for abuse of the policy by tracking if providers are scheduling services on separate days solely to maximize payment.

Comment Solicitation on Payment for Physician-Patient Clinical Trial Discussions – p. 214 ALL
Highlight: To help improve clinical trial participation, CMS proposes code to pay for patient and physician discussions regarding clinical trials.

The agency seeks 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 states that, despite significant federal investment in biomedical research, adult cancer patient enrollment in clinical trials remains below 7 percent. Per the agency, major yet modifiable barrier to clinical trial enrollment is that physicians rarely initiate these discussions. As noted in the rule, "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."

The primary barrier to these discussions is the time and administrative burden on physicians, which is not currently captured as a specific element in the E/M CPT code family. To address this, CMS seeks comments on a possible solution that creates a new HCPCS G-code to reimburse physicians (or other qualified healthcare professionals) for spending a minimum of 20 minutes counseling patients on clinical trial eligibility, options, risks, and benefits. While the code has not been officially proposed, CMS does seek comment on a work RVU between 1.00 and 1.50, whether the service may be provided a telehealth service, and CMS requests suggestions as to the types of documentation that would be required to bill for the service.

Potentially Misvalued Services Under the Physician Fee Schedule – p. 232
Each year the agency reviews potentially misvalued services. The criteria to identify a misvalued service are applied at the code level, and refinements are proposed by CMS for each code deemed misvalued by the agency. Beginning in 2012, CMS finalized a process for the public to nominate potentially misvalued services. Nominations for potentially misvalued services are due to the agency by February 10 each year and requestors must submit documentation supporting the code nomination. For a complete list of the types of supporting documentation that is acceptable please see page 235 of the display copy of the proposed rule. Finally, the review of values for the CPT code set is required by law, and since 2009, CMS has reviewed more than 1,700 codes.

Allergy Immunotherapy (CPT Code 95165) – p. 247
CMS seeks comment on whether Medicare's longstanding definition of a "dose" for allergen immunotherapy (CPT code 95165) continues to reflect current clinical practice. Under a policy established in 2001, Medicare assumes that a standard 10 cc vial of allergen extract is divided into ten 1 cc doses, and the practice expense payment for CPT code 95165 is based on this methodology. The policy also recognizes that some allergens (such as mold and pollen) cannot be mixed, requiring separate vials for certain patients.

Specialty societies have informed CMS that this definition no longer aligns with modern allergy immunotherapy practice. They argue that the 1 cc aliquot dose standard is creating reimbursement-driven changes in treatment protocols rather than reflecting clinically appropriate care. They also note that the policy's influence has expanded beyond Medicare, as commercial insurers and Medicaid programs have increasingly adopted the same billing approach. In addition, per the requestors, Medicare beneficiaries now represent a much larger share of allergy immunotherapy patients, up to 20% of an allergy practice's total patient load, than when the policy was originally developed, increasing the policy's impact on clinical practice.

CMS requests evidence and stakeholder feedback on how allergy immunotherapy doses are currently defined and administered in clinical practice and whether Medicare's payment policy should be updated accordingly.

CMS also seeks comment on its current medically unlikely edit (MUE), which limits billing to 30 doses per claim as a safeguard against overutilization. Specialty societies contend that an annual dose limit would better reflect clinical practice, suggesting a maximum of approximately **160 doses during the first year of treatment** to accommodate the build-up phase, followed by **130 or fewer doses annually** during maintenance therapy. CMS is specifically requesting data and clinical evidence to determine whether an annual dose limit would be a more appropriate utilization policy for CPT code 95165.

Request for Information: Redesigning Primary Care to Make America Health Again – p. 252
Highlight: CMS seeks feedback on modernizing primary care payment to better support preventive care and technology-enabled services.

CMS requests stakeholder feedback on how Medicare should modernize the payment and valuation of primary care services under the PFS. The agency states that primary care is central to HHS's "Make America Healthy Again" (MAHA) priorities and emphasizes that current payment policies should better support preventive, high-value care while reducing long-term health care costs associated with chronic disease.

According to CMS, the current valuation of primary care services was established when care was primarily delivered through traditional office-based visits. The agency notes that advances in digital health technologies and artificial intelligence (AI) are changing how beneficiaries access medical information and how primary care clinicians deliver care. As a result, CMS is evaluating whether existing fee-for-service payment policies, including office/outpatient evaluation and management (E/M) visits, annual wellness visits, and care management services, continue to appropriately reflect the time, intensity, and value of primary care services.

CMS also highlights its continued interest in expanding prospective primary care payment models. Building on lessons learned from CMS Innovation Center demonstrations and the establishment of Advanced Primary Care Management (APCM) services in the CY 2025 PFS, the agency is considering whether prospective monthly payments could be more broadly incorporated into the Medicare Shared Savings Program and, potentially, original Medicare. CMS notes that any future payment model would need appropriate safeguards to prevent fraud, waste, and abuse, particularly as technology-enabled care becomes more common.

Given the broad scope of this discussion, CMS seeks comments on several overarching policy issues, including:

- Whether primary care services are appropriately valued under the current Physician Fee Schedule and how payment for office visits, annual wellness visits, and care management services could be improved.
- How Medicare should account for technology-enabled care, including digital health tools and AI, when determining payment, service valuation, and evidence of improved patient outcomes.
- How prospective primary care payment models should be implemented within the Medicare Shared Savings Program and whether they should be expanded more broadly across Medicare, including appropriate payment structures and program safeguards.

Reconsidering Relative Primary Care Payment in the Medicare Physician Fee Schedule – p. 255
Highlight: CMS considers restructuring evaluation and management (E/M) payments to better recognize longitudinal primary care.

CMS seeks feedback on whether the current office/outpatient (O/O) evaluation and management (E/M) visit structure appropriately reflects the resources and complexity involved in providing primary care, particularly for patients who require ongoing, coordinated care. The agency notes that traditional E/M codes do not distinguish between different types of visits, such as one-time acute visits, specialty consultations, and longitudinal care provided through an ongoing relationship between a patient and clinician.

According to CMS, the current payment structure may not fully account for the additional work associated with longitudinal primary care, including care coordination, preventive services, and activities that occur outside of face-to-face visits. The agency notes that specialties relying heavily on E/M services, including primary care, may receive different payment levels than specialties that routinely provide procedural services or diagnostic testing. CMS previously took steps to better recognize the complexity of longitudinal care through the adoption of HCPCS code G2211, an add-on payment for visits where the clinician serves as the continuing focal point for a patient's health care needs.

However, CMS states that the current E/M code set may still insufficiently reflect differences in the nature and intensity of care provided. As a result, the agency is considering whether future payment policies should establish separate categories of O/O E/M visits based on the purpose of the encounter, including:

- **Longitudinal care visits**, which involve an ongoing patient-clinician relationship and include care delivered during and between visits, such as chronic disease management, preventive care, and care coordination.
- **Acute care visits**, which focus on evaluating and treating a specific, short-term medical issue.

- **Consultative visits**, which are performed in response to a referral to address a specific clinical question and provide recommendations back to another practitioner.

CMS seeks feedback on how to better recognize the differences among longitudinal, acute, and consultative care within the MPFS. The agency requests input on whether existing coding structures should be modified or whether new codes should be created, how longitudinal care should be valued, whether care management services should be incorporated into payment, and what data should inform future valuation decisions.

Care Management Code Family – p. 258
Highlight: CMS seeks feedback on restructuring care management payments to improve utilization and account for technology-enabled care models.

CMS seeks feedback on how to improve the utilization and effectiveness of care management services, which are intended to support ongoing care coordination, chronic disease management, and other activities provided between patient visits. Over the past 14 years, CMS has expanded separate payment pathways for care management services that were previously considered part of evaluation and management (E/M) visits, including Transitional Care Management (TCM), Chronic Care Management (CCM), Principal Care Management (PCM), and Advanced Primary Care Management (APCM) services. See Table A-E1 below for additional details on current care management services paid under the Physician Fee Schedule.

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.

Despite these efforts, CMS notes that adoption of care management codes has been lower than anticipated. The agency states that stakeholders have identified cost-sharing requirements and documentation burdens as key barriers to broader use. CMS has previously taken steps to address these concerns, including simplifying certain documentation requirements for Chronic Care Management services, but continues to evaluate whether additional changes are needed to make care management services more accessible while maintaining appropriate program integrity safeguards.

CMS is considering whether the current care management code structure should be simplified or redesigned to better reflect the way primary care is delivered, including through team-based care, population health management, and technology-enabled services. The agency requests comment how to best improve the current care management code structure, and seeks feedback on whether new approaches, such as technology-enabled care management codes or a two-track payment model, may be appropriate as digital tools become increasingly integrated into primary care delivery.

Payment Implications of Technology Enablement of Primary Care – p. 261
Highlight: CMS requests feedback on how Medicare should account for technology-enabled primary care and clinical AI in future payment policies.

CMS requests stakeholder feedback on how advances in technology and clinical artificial intelligence (AI) are changing the delivery of primary care and how Medicare payment policies should evolve in response. The agency notes that AI tools are increasingly being used to reduce administrative burden and support clinical decision-making, with technologies such as AI documentation assistants and clinical decision-support tools becoming more widely adopted in physician practices. CMS believes these technologies have the potential to shift primary care from reactive, manual processes to more proactive, data-driven, and personalized care.

According to CMS, technology-enabled care may improve quality while reducing the resources required to deliver certain services. However, the agency notes that the rapidly evolving nature of these technologies, limited information on their costs, and uncertainty regarding their long-term impact present challenges for developing appropriate payment methodologies. As a result, CMS is exploring whether future payment policies should place greater emphasis on demonstrated clinical outcomes rather than traditional fee-for-service valuation.

CMS seeks feedback on the current use of AI and other technology-enabled tools in primary care, including their impact on clinical workflows, physician productivity, resource costs, patient outcomes, and beneficiary experience. The agency also requests input on how Medicare should evaluate the effectiveness of these technologies, protect patient privacy, monitor for fraud, waste, and abuse, and determine whether existing coding and payment policies adequately recognize technology-enabled care. In addition, CMS seeks comments on lessons learned from private payors, appropriate outcomes measures and data reporting approaches, and whether alternative payment models beyond fee-for-service, outcomes-based, or prospective payment may be better suited to support technology-enabled primary care.

Current Procedural Terminology (CPT) Request for Information (RFI) – p. 304
Highlight: Coupled with proposals throughout the rule to create HCPCS codes for services paid under the MPFS, CMS requests information on possible avenues to move away from the AMA CPT and RUC processes.

CMS requests 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 acknowledges that CPT codes and the RUC have formed the foundation of physician payment under the MPFS for many years, but the agency raises its longstanding concerns about reliance on a private organization, the AMA, to develop and value codes that directly influence physician reimbursement.

HIPAA regulations designated the combination of HCPCS and CPT codes as the national standard for reporting on claims, physician and other health care services. The agency believes that the HIPAA statute does not specifically mandate the use of CPT codes in HIPAA transactions stating that **"there is no specification in the HIPAA statute regarding the manner in which these national coding sets may be used or how they may be combined, and only HHS interpretation, not the Act itself, mentions CPT**, which suggests that the agency believes there may be flexibility to reconsider the current coding framework used in the Medicare program.

CMS also states in the rule "we note the historic reliance on the CPT and RUC process as a potential contributor to the development of US health care as a 'sick care' system with limited emphasis on prevention and lifestyle modifications and which may inhibit progress on the Secretarial priority to Make America Healthy Again." The agency suggests that the existing coding and valuation process may have contributed to a health care system that prioritizes treatment of illness over prevention and broader population health goals.

CMS seeks public comment on the following questions, copied directly from the proposed rule:

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 based on 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 (MS- DRGs), or Outpatient Prospective Payment System (OPPS) Ambulatory Payment Classifications (APCs)? What other alternatives exist for bundling or grouping procedural services?

This request for information represents one of CMS's broadest requests for information on the Medicare physician coding and payment processes. The RFI also coincides with CMS proposing changes to, or requesting feedback on, several CPT code families whereby the agency wants to create HCPCS G-codes to replace CPT codes for use in the Medicare program.

Limiting Medicare Coverage of Certain Individuals – p. 454 ALL
Highlight: CMS proposes Medicare enrollment changes to implement new statutory citizenship and immigration eligibility requirements.

CMS proposes to update Medicare enrollment policies to implement 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 new law, Medicare eligibility is limited to four categories of individuals: U.S. citizens or nationals, lawful permanent residents, Cuban and Haitian entrants, and individuals lawfully residing in the United States under a Compact of Free Association (COFA).

Prior to enactment of the WFTC legislation, Medicare generally relied on the same lawful presence verification process used by the Social Security Administration (SSA) for Title II benefits. Under that framework, a broader range of noncitizens who were lawfully present in the United States, such as refugees, asylees, and certain parolees, could qualify for Medicare if they met all other eligibility requirements. Since the WFTC legislation narrows Medicare eligibility without changing Title II eligibility requirements, the previous verification process is no longer sufficient for determining Medicare eligibility. Therefore, CMS proposes to establish Medicare-specific definitions and enrollment policies related to citizenship, nationality, and immigration status to ensure compliance with the new statutory eligibility requirements.

Medicare Prescription Drug Inflation Rebate Program – p. 480
Highlight: CMS proposes policies to implement the Medicare Prescription Drug Inflation Rebate Program.

<u>Overview of the Medicare Prescription Drug Inflation Rebate Program</u>
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 Proposed Policies for the Medicare Prescription Drug Inflation Rebate Program

CMS proposes 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 would use to identify the first marketed date when relevant ASP data is not available;
- Revise 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 proposes 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; and
- Require providers and suppliers who are covered entities to submit Part D 340B data to the 340B repository beginning with claims on or after January 1, 2027.

Appendix A: Table D-B5 CY 2027 PFS Estimated Impact on Total Allowed Charges by Specialty – p. 1,146

(A) Specialty	(B) Total: Non-Facility/Facility	(C) Allowed Charges (mil)				(D) Impact of Work RVU Changes	(E) Impact of PE RVU Changes	(F) Impact of MP RVU Changes	(G) Combined Impact
ALLERGY/IMMUNOLOGY	*TOTAL*	$154	0%	-1%	0%	0%			
	Non-Facility	$147	0%	-1%	0%	0%			
	Facility	$7	1%	0%	0%	1%			
ANESTHESIOLOGY	*TOTAL*	$1,656	0%	0%	0%	0%			
	Non-Facility	$332	0%	-1%	0%	-1%			
	Facility	$1,324	0%	0%	0%	0%			
AUDIOLOGIST	*TOTAL*	$81	1%	-4%	0%	-3%			
	Non-Facility	$78	1%	-4%	0%	-3%			
	Facility	$3	1%	-1%	0%	0%			
CARDIAC SURGERY	*TOTAL*	$146	1%	1%	0%	1%			
	Non-Facility	$30	0%	2%	0%	2%			
	Facility	$116	1%	0%	0%	0%			
CARDIOLOGY	*TOTAL*	$6,464	0%	0%	0%	1%			
	Non-Facility	$4,205	0%	1%	0%	1%			
	Facility	$2,259	0%	0%	0%	0%			
CHIROPRACTIC	*TOTAL*	$626	0%	2%	0%	2%			
	Non-Facility	$624	0%	2%	0%	2%			
	Facility	$2	0%	0%	0%	0%			
CLINICAL PSYCHOLOGIST	*TOTAL*	$729	3%	8%	0%	11%			
	Non-Facility	$593	3%	8%	0%	11%			
	Facility	$136	3%	5%	0%	8%			
CLINICAL SOCIAL WORKER	*TOTAL*	$974	4%	9%	0%	12%			

(A) Specialty	(B) Total: Non-Facility/Facility	(C) Allowed Charges (mil)				(D) Impact of Work RVU Changes	(E) Impact of PE RVU Changes	(F) Impact of MP RVU Changes	(G) Combined Impact
	Non-Facility	$857	3%	9%	0%		13%		
	Facility	$116	4%	7%	0%		11%		
COLON AND RECTAL SURGERY	*TOTAL*	$147	-1%	-3%	0%		-4%		
	Non-Facility	$57	-3%	-6%	0%		-9%		
	Facility	$90	0%	-1%	0%		-1%		
CRITICAL CARE	*TOTAL*	$348	0%	0%	0%		0%		
	Non-Facility	$65	1%	0%	0%		1%		
	Facility	$283	0%	-1%	0%		0%		
DERMATOLOGY	*TOTAL*	$3,881	-3%	-6%	0%		-9%		
	Non-Facility	$3,754	-3%	-6%	0%		-9%		
	Facility	$127	-3%	-4%	0%		-7%		
DIAGNOSTIC TESTING FACILITY	*TOTAL*	$999	0%	3%	0%		4%		
	Non-Facility	$997	0%	3%	0%		4%		
	Facility	$2	0%	1%	1%		2%		
EMERGENCY MEDICINE	*TOTAL*	$2,581	0%	0%	0%		1%		
	Non-Facility	$286	0%	0%	0%		0%		
	Facility	$2,294	0%	0%	0%		1%		
ENDOCRINOLOGY	*TOTAL*	$584	1%	1%	0%		2%		
	Non-Facility	$485	1%	1%	0%		2%		
	Facility	$99	1%	0%	0%		1%		
FAMILY PRACTICE	*TOTAL*	$5,976	1%	1%	0%		1%		
	Non-Facility	$4,927	1%	0%	0%		1%		
	Facility	$1,049	0%	2%	0%		3%		
GASTROENTEROLOGY	*TOTAL*	$1,327	0%	-1%	0%		-1%		
	Non-Facility	$538	0%	-1%	0%		-1%		
	Facility	$788	0%	-1%	0%		-1%		
GENERAL PRACTICE	*TOTAL*	$408	1%	1%	0%		2%		
	Non-Facility	$329	1%	0%	0%		1%		
	Facility	$79	1%	4%	0%		5%		
GENERAL SURGERY	*TOTAL*	$1,517	0%	0%	0%		0%		
	Non-Facility	$480	0%	1%	0%		0%		
	Facility	$1,037	0%	-1%	0%		-1%		
GERIATRICS	*TOTAL*	$203	1%	2%	0%		4%		
	Non-Facility	$131	1%	0%	0%		2%		
	Facility	$72	1%	6%	0%		7%		
HAND SURGERY	*TOTAL*	$278	-1%	-4%	0%		-5%		
	Non-Facility	$160	-2%	-4%	0%		-7%		
	Facility	$117	0%	-2%	0%		-3%		
HEMATOLOGY/ONCOLOGY	*TOTAL*	$1,571	1%	-1%	0%		0%		
	Non-Facility	$1,037	0%	0%	0%		0%		
	Facility	$534	1%	-1%	0%		1%		
INDEPENDENT LABORATORY	*TOTAL*	$380	0%	0%	0%		0%		

(A) Specialty	(B) Total: Non-Facility/Facility	(C) Allowed Charges (mil)				(D) Impact of Work RVU Changes	(E) Impact of PE RVU Changes	(F) Impact of MP RVU Changes	(G) Combined Impact
	Non-Facility	$371	0%	0%	0%		0%		
	Facility	$9	0%	0%	0%		0%		
INFECTIOUS DISEASE	*TOTAL*	$587	0%	0%	0%		0%		
	Non-Facility	$97	0%	-1%	0%		-1%		
	Facility	$490	0%	0%	0%		0%		
INTERNAL MEDICINE	*TOTAL*	$9,932	1%	1%	0%		1%		
	Non-Facility	$5,203	1%	0%	0%		1%		
	Facility	$4,728	0%	1%	0%		1%		
INTERVENTIONAL PAIN MGMT	*TOTAL*	$880	0%	-1%	0%		-2%		
	Non-Facility	$706	0%	-1%	0%		-2%		
	Facility	$174	0%	0%	0%		-1%		
INTERVENTIONAL RADIOLOGY	*TOTAL*	$545	0%	3%	0%		3%		
	Non-Facility	$361	0%	5%	0%		5%		
	Facility	$183	0%	1%	0%		1%		
MULTISPECIALTY CLINIC/OTHER PHYS	*TOTAL*	$164	-1%	-1%	0%		-2%		
	Non-Facility	$84	-2%	-2%	0%		-4%		
	Facility	$80	0%	0%	0%		0%		
NEPHROLOGY	*TOTAL*	$1,672	0%	0%	0%		0%		
	Non-Facility	$1,054	0%	0%	0%		1%		
	Facility	$619	1%	0%	0%		0%		
NEUROLOGY	*TOTAL*	$1,390	0%	-1%	0%		0%		
	Non-Facility	$923	0%	-1%	0%		-1%		
	Facility	$467	1%	-1%	0%		0%		
NEUROSURGERY	*TOTAL*	$652	0%	-2%	0%		-2%		
	Non-Facility	$128	0%	-1%	0%		-1%		
	Facility	$524	0%	-2%	-1%		-2%		
NUCLEAR MEDICINE	*TOTAL*	$50	0%	2%	0%		2%		
	Non-Facility	$21	0%	2%	0%		2%		
	Facility	$29	0%	1%	0%		2%		
NURSE ANES / ANES ASST	*TOTAL*	$1,130	0%	1%	0%		1%		
	Non-Facility	$19	0%	10%	0%		10%		
	Facility	$1,111	0%	1%	0%		1%		
NURSE PRACTITIONER	*TOTAL*	$7,775	0%	1%	0%		2%		
	Non-Facility	$5,263	0%	-1%	0%		0%		
	Facility	$2,512	0%	6%	0%		6%		
OBSTETRICS/GYNECOLOGY	*TOTAL*	$558	0%	-1%	0%		-1%		
	Non-Facility	$397	0%	-1%	0%		-1%		
	Facility	$162	0%	-1%	-1%		-2%		
OPHTHALMOLOGY	*TOTAL*	$4,548	0%	-3%	0%		-3%		
	Non-Facility	$3,373	0%	-3%	0%		-3%		
	Facility	$1,175	0%	-2%	0%		-2%		
OPTOMETRY	*TOTAL*	$1,498	0%	-2%	0%		-2%		

(A) Specialty	(B) Total: Non-Facility/Facility	(C) Allowed Charges (mil)				(D) Impact of Work RVU Changes	(E) Impact of PE RVU Changes	(F) Impact of MP RVU Changes	(G) Combined Impact
	Non-Facility	$1,457	0%	-2%	0%		-2%		
	Facility	$41	0%	-1%	0%		0%		
ORAL/MAXILLOFACIAL SURGERY	*TOTAL*	$34	0%	-1%	0%		-1%		
	Non-Facility	$24	0%	-1%	0%		-1%		
	Facility	$10	0%	-1%	0%		-1%		
ORTHOPEDIC SURGERY	*TOTAL*	$3,296	-3%	-4%	-1%		-7%		
	Non-Facility	$1,549	-2%	-4%	0%		-5%		
	Facility	$1,747	-4%	-4%	-1%		-8%		
OTHER	*TOTAL*	$39	0%	-2%	0%		-2%		
	Non-Facility	$29	0%	-3%	0%		-2%		
	Facility	$10	-1%	-1%	0%		-2%		
OTOLARYNGOLOGY	*TOTAL*	$1,199	-3%	-5%	0%		-9%		
	Non-Facility	$982	-4%	-6%	0%		-10%		
	Facility	$217	-1%	-2%	0%		-3%		
PATHOLOGY	*TOTAL*	$777	0%	-1%	0%		0%		
	Non-Facility	$412	0%	-1%	0%		-1%		
	Facility	$364	0%	0%	0%		0%		
PEDIATRICS	*TOTAL*	$61	1%	0%	0%		0%		
	Non-Facility	$42	0%	0%	0%		0%		
	Facility	$19	1%	0%	0%		1%		
PHYSICAL MEDICINE	*TOTAL*	$1,203	0%	1%	0%		1%		
	Non-Facility	$592	0%	-2%	0%		-2%		
	Facility	$611	0%	3%	0%		4%		
PHYSICAL/OCCUPATIONAL THERAPY	*TOTAL*	$4,372	0%	3%	0%		3%		
	Non-Facility	$4,370	0%	3%	0%		3%		
	Facility	$1	0%	0%	0%		0%		
PHYSICIAN ASSISTANT	*TOTAL*	$3,751	-1%	-2%	0%		-3%		
	Non-Facility	$2,699	-1%	-3%	0%		-5%		
	Facility	$1,052	0%	2%	0%		1%		
PLASTIC SURGERY	*TOTAL*	$268	0%	-2%	0%		-3%		
	Non-Facility	$131	-1%	-3%	0%		-4%		
	Facility	$138	0%	-1%	0%		-1%		
PODIATRY	*TOTAL*	$1,969	-2%	-2%	0%		-4%		
	Non-Facility	$1,762	-2%	-2%	0%		-4%		
	Facility	$207	-1%	1%	0%		0%		
PORTABLE X-RAY SUPPLIER	*TOTAL*	$76	0%	-2%	0%		-1%		
	Non-Facility	$72	0%	-2%	0%		-1%		
	Facility	$4	0%	-1%	0%		-1%		
PSYCHIATRY	*TOTAL*	$882	1%	1%	0%		3%		
	Non-Facility	$565	1%	2%	0%		3%		
	Facility	$317	1%	1%	0%		2%		
PULMONARY DISEASE	*TOTAL*	$1,266	1%	0%	0%		0%		

(A) Specialty	(B) Total: Non-Facility/Facility	(C) Allowed Charges (mil)				(D) Impact of Work RVU Changes	(E) Impact of PE RVU Changes	(F) Impact of MP RVU Changes	(G) Combined Impact
	Non-Facility	$599	1%	0%	0%	1%			
	Facility	$667	0%	0%	0%	0%			
RADIATION ONCOLOGY AND RADIATION THERAPY CENTERS	*TOTAL*	$1,541	0%	3%	0%	3%			
	Non-Facility	$1,054	0%	4%	0%	5%			
	Facility	$486	0%	-1%	0%	-1%			
RADIOLOGY	*TOTAL*	$4,706	0%	2%	0%	2%			
	Non-Facility	$2,075	0%	2%	0%	2%			
	Facility	$2,631	0%	1%	0%	1%			
RHEUMATOLOGY	*TOTAL*	$567	0%	-1%	0%	-1%			
	Non-Facility	$514	0%	-1%	0%	-1%			
	Facility	$53	1%	0%	0%	1%			
THORACIC SURGERY	*TOTAL*	$299	1%	1%	0%	1%			
	Non-Facility	$62	0%	2%	0%	2%			
	Facility	$237	1%	0%	0%	0%			
UROLOGY	*TOTAL*	$1,626	-1%	-1%	0%	-2%			
	Non-Facility	$1,178	-1%	-1%	0%	-2%			
	Facility	$448	0%	0%	0%	-1%			
VASCULAR SURGERY	*TOTAL*	$1,015	0%	3%	0%	3%			
	Non-Facility	$747	0%	4%	0%	4%			
	Facility	$268	0%	0%	0%	0%			
TOTAL	***TOTAL***	$91,355	0%	0%	0%	0%			
	Non-Facility	$59,028	0%	0%	0%	0%			
	Facility	$32,327	0%	1%	0%	1%			

* Column G may not equal the sum of columns D, E, and F due to rounding.