

2026 Medicare Physician Fee Schedule Final Rule Summary

On Friday, October 31, 2025, the Centers for Medicare & Medicaid Services (CMS) issued the 2026 Medicare Physician Fee Schedule (MPFS) final rule, with an estimated -1% cut to radiation therapy physician services; however, due to statutory increases not reflected in the specialty impact table, radiation oncology will see a net positive impact. The proposed rule updates the payment policies, payment rates, and quality provisions for services furnished under the MPFS effective January 1, 2026.¹

Final Rule Takeaways for Radiation Oncology

- **Final Rule's estimated impact on radiation oncology: -1%; however, due to statutory increases not reflected in the specialty impact table, radiation oncology actually will see a net positive impact;**
- **2026 conversion factor increase of 3.77% for qualifying APM participants and 3.23% for non-qualifying APM participants;**
- **Revised radiation treatment delivery and superficial radiation therapy (SRT) code set valuations informed by hospital outpatient payment system (OPPS) data;**
- **New efficiency adjustment implemented, cutting many radiation oncology codes; and**
- **Use of existing practice expense survey data avoids potential 40% cut;**
- **Flexibility to provide direct supervision using two-way audio/visual communication made permanent.**

Go deeper on these issues in the summary below.

MPFS Conversion Factor

According to the MPFS Total Allowed Charges Impact Table below, the estimated impact on total allowed charges for radiation oncology services for 2026 is -1%. **The 0.75% and 0.25% updates to the CY 2026 qualifying APM and APM and nonqualifying APM conversion factors (CF), respectively, as well as the single year increase of 2.50% to the conversion factor for CY 2026, are statutory changes that take place outside of**

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.

budget neutrality, and therefore, are not captured in the specialty impacts displayed in the table below. A code-level analysis of key radiation oncology codes shows that many services will see an increase in 2026.

Table D-B7: CY 2026 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	TOTAL	\$1,507	-1%	-1%	0%	-1%
	Non-Facility	\$1,009	0%	-1%	0%	-1%
	Facility	\$498	-1%	-1%	0%	-2%

Beginning in CY 2026, there will be two separate CFs, 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 2026 CF update for qualifying APM participants is 0.75%, while the CF update for non APM participants is 0.25%.

CMS estimates that the CY 2026 CF for a qualifying APM participant will be \$33.5675 and the CF for a non-qualifying APM participant will be \$33.4009. In addition to the MACRA designated updates, the CFs also reflect a 0.49% budget neutrality adjustment, and a 2.50% increase associated with the passage of the HR 1 reconciliation package in July. The charts below depict the CF calculations:

Table DB-3: Calculation of the CY 2026 PFS Qualifying APM Conversion Factor

2025 Conversion Factor		\$32.3465
CY 2026 Qualifying APM Participant	0.75% (1.0075)	
CY 2026 RVU Budget Neutrality Adjustment	0.49% (1.0049)	
CY 2026 2.50% Increase	2.50% (1.0250)	
CY 2026 Conversion Factor		\$33.5675

Table DB-4: Calculation of the CY 2026 MPFS Non-Qualifying APM Conversion Factor

2025 Conversion Factor		\$32.3465
CY 2026 Non-Qualifying	0.25% (1.0025)	

APM Participant

CY 2026 RVU Budget

0.49% (1.0049)

Neutrality Adjustment

CY 2026 2.50% Increase

2.50% (1.0250)

CY 2026 Conversion**Factor****\$33.4009**

The table below reflects the impact of the proposed *non-qualifying* APM Conversion Factor on key radiation oncology services (excluding revised codes).

CPT Code	MOD	CPT Descriptor	2025 National Rate	2026 National Rate	2026 Impact
77427		Radiation tx Management x5	\$187.93	\$196.73	5%
77301		Radiotherapy Dose Plan IMRT	\$1,797.82	\$1,978.00	10%
77523		Proton Treatment Delivery	Carrier Priced	Carrier Priced	Carrier Priced
77263		Radiation Therapy Planning	\$164.97	\$169.34	3%
77301	26	Radiotherapy Dose Plan IMRT	\$411.12	\$421.85	3%
77373		SBRT Delivery	\$949.37	\$988.00	4%
77334	26	Radiation Treatment Aid(s)	\$58.87	\$60.79	3%
99205		Office o/p new hi 60-74 minutes	\$215.75	\$236.81	10%
77336		Radiation Physics Consult	\$88.63	\$93.19	5%
77338		Design Mlc Device for IMRT	\$461.58	\$478.97	4%
77338	26	Design Mlc Device for IMRT	\$220.28	\$226.46	3%
77435		SBRT Management	\$629.46	\$644.97	2%
77300	26	Radiation Therapy Dose Plan	\$32.02	\$32.73	2%
77300		Radiation Therapy Dose Plan	\$65.34	\$67.47	3%

Use of OPFS Data for MPFS Rate Setting***Radiation Therapy Treatment Delivery Codes***

In the Final Rule, CMS is finalizing its proposal to utilize the relationship between the OPFS

APC relative weights for APCs 5621, 5622, and 5623 to inform the valuation of PE-only CPT codes 77402, 77407, and 77412. Additionally, it is modifying the utilization crosswalk to 35% for CPT code 77412 and 55% for 77407. ASTRO had supported the RUC recommended utilization rates of 45% for 77412 and 50% for 77407. The total nonfacility RVUs for 2026 for the revised delivery codes are listed in the table below.

ASTRO was supportive of the Agency's proposal to use OPPS data to establish PE RVUs in the MPFS for the revised radiation treatment delivery codes but recommended adjustments. See [ASTRO's 2026 MPFS Proposed Rule comment letter](#) for more detailed information.

Go Deeper

In the proposed rule, CMS proposed to update the PE RVUs associated with the revised Radiation Therapy Treatment Delivery codes and the Superficial Radiation Treatment codes based on the relative relationship between the proposed OPPS Ambulatory Payment Classification (APC) relative weights. This would align underlying cost data and billing units across settings paid under both the MPFS and OPPS. According to the Agency, the resources involved in furnishing radiation treatment delivery and superficial radiation treatment delivery services are driven by capital costs that aren't as likely to vary greatly between facilities, like hospitals, and freestanding centers. Additionally, because the billing codes for the services are already stratified into professional and technical services, these services have obvious characteristics that make use of OPPS data particularly appropriate.

Radiation Treatment Delivery and Image Guidance

In the Final Rule, CMS is accepting the revisions to radiation treatment delivery codes 77402, 77407, and 77412 and is deleting the 17 G codes that were previously used to report these services under the Fee Schedule (G6001-G6017).

Go Deeper

In 2023 the radiation treatment delivery and image guidance codes were identified by the RUC's relativity assessment workgroup (RAW) in a potentially misvalued services screen, citing 2014 as the last time the inputs for these services had been reviewed. The codes were sent to the CPT Editorial Panel to develop a new code set to reflect how the services are currently performed. As engaged participants of the CPT process, ASTRO and ACRO collaborated to modernize the codes, and later surveyed members and submitted data to the RUC to support appropriate reimbursement. These recommendations were forwarded to CMS for the 2026 rulemaking cycle.

The simple, intermediate, and complex delivery codes (77402, 77407, 77412) were revised into Levels 1, 2 and 3, and the IMRT codes (77385 and 77386) were deleted since IMRT will be consolidated into the three levels of treatment delivery. Because the technical component of image guidance has been bundled into the revised delivery codes, 77014

(*CT guidance for placement of radiation therapy fields*) also will be deleted. The professional component of image guidance will be reported separately using 77387.

ASTRO is pleased that the Agency made refinements to the NF RVUs for the treatment delivery codes from the proposed rule that better reflect the costs of providing these services.

Radiation Treatment Delivery Code Family

CPT Code	Procedure Code Status	CPT Descriptor	2026 Total Nonfacility RVUs	2026 National Rate
77402	A	Radiation treatment delivery, Level 1 (eg, single electron field, multiple electron fields, or 2D photons), including imaging guidance, when performed	2.38	\$79.49
77407	A	Radiation treatment delivery, level 2, single isocenter (eg, 3D or IMRT), photons, including imaging guidance, when performed	9.51	\$317.64
77412	A	Radiation treatment delivery, level 3 multiple isocenters with photon therapy (eg, 2D, 3D, or IMRT) OR a single isocenter photon therapy (eg, 3D or IMRT) with active motion management, OR total skin electrons, OR mixed electron/photon field(s), including imaging guidance, when performed	11.72	\$391.46
77417	B	Therapeutic radiology port image(s)	0.12	\$0.67
77387	26	Guidance for localization of target volume for delivery of radiation treatment, includes intrafraction tracking, when performed	1.10 (0.68 work RVUs)	\$36.74

The Agency is finalizing a physician work RVU of 0.68 for CPT code 77387 *Guidance for localization of target volume for delivery of radiation treatment, includes intrafraction tracking, when performed*, the only code in the family that has a physician work component. CMS accepted the RUC-recommended 0.70 RVUs, but applied the new efficiency adjustment (described later in this summary) to the code, establishing a value of 0.68 RVUs. ASTRO argued that since 77387 was recently revalued by the RUC, it should be exempt from the efficiency adjustment; however, the Agency reiterated its concerns about RUC recommendations and the surveys used for those recommendations.

Billing 77387

Typically, when services have separately billable PC and TC components, the payment for the global services equals the sum of the payment for the PC and TC. In the case of CPT

code 77387, CMS isn't proposing that the PE and total RVU for the global service will equal the PE and total RVU for the professional component because the technical component is not separately payable under the PFS since the relative resources are included in the valuation of the treatment delivery codes.

CMS will apply Procedure Status "B" (not separately payable) to the technical component of CPT code 77387 to maintain consistency with the OPPS payment for this code, which is packaged into payment for the treatment delivery codes (77402, 77407, and 77412). The Agency sought comments on ways it can mitigate billing confusion since displaying the global service equal to the professional component could be problematic, or if it would be preferable to eliminate the global code and display only the professional and technical components in the OPPS Addendum B.

ASTRO recommended that CMS display only the professional component for CPT Code 77387 and not display the global code to attempt to mitigate billing confusion. However, the Agency does not believe that a change to billing guidance is needed at this time, especially given the lack of consensus regarding the best approach to this novel circumstance. It will revisit this once a consensus approach to reporting this service under the new coding construct emerges.

Similarly, for PE only CPT Code 77417 *Therapeutic radiology port image(s)*, the Agency will assign Procedure Status "B" to align with OPPS payment for this code, which is also packaged into the treatment delivery codes (77402, 77407, and 77412) and therefore not separately reportable under the MPFS.

Superficial Radiation Therapy

Similar to the radiation therapy treatment delivery codes, CMS is finalizing its proposal to use OPPS data for MPFS rate setting for superficial radiation treatment (SRT) (CPT codes 77436, 77437, 77438, and 77439). The new SRT codes and their descriptors are in the table below. CMS is finalizing the RUC-recommended work RVUs for the two codes in the family that have physician work (77436: 0.77 RVUs and 77439: 0.30 RVUs). 77437 and 77438 (PE-only) and the technical component of 77436 will utilize the relationship between OPPS APCs 5621 and 5732 to inform their valuation. Furthermore, CMS will assign procedure status "B" to the technical component of 77439 (not separately payable) because under OPPS, this is packaged into payment for the treatment delivery codes 77437 and 77438.

Some commenters argued that the new SRT coding will create barriers to the use of orthovoltage radiation treatment for non-malignant musculoskeletal disorders, but CMS stated that unlisted codes may be reported if a service is not described by an existing CPT code.

CPT	CPT Descriptor	2026 Total	2026 National
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Code		Nonfacility RVUs	Rate
77436	Surface radiation therapy; superficial or orthovoltage, treatment planning and simulation-aided field setting	2.40	\$80.16
77437	Superficial, delivery, <150 kV, per fraction (eg, electronic brachytherapy)	3.56	\$118.91
77438	Orthovoltage, delivery, >150-500 kV, per fraction	3.60	\$120.24
77439	Surface radiation therapy; superficial or orthovoltage, image guidance, ultrasound for placement of radiation therapy fields for treatment of cutaneous tumors, per course of treatment (List separately in addition to the code for primary procedure)	0.48	\$16.03

Go Deeper

In response to high utilization, CPT code 0394T was referred by the RUC to CPT to be converted from a Category III code to a Category I. Additionally, CPT code 77280 (*simulation-aided field setting, simple*) was originally established for radiation oncology, but in recent years had become predominantly used by dermatologists, which drew RUC scrutiny. This code was also flagged for being frequently billed together with the superficial radiation therapy code 77401.

These new codes went through the RUC process for recommended valuation, which was submitted to CMS. In the final rule, CMS accepts the new codes, but it is basing their respective rates on OPPS data, as it is doing with the radiation therapy treatment delivery codes.

ASTRO has long expressed concern regarding the inappropriate use of radiation therapy codes for the treatment of skin cancer, particularly image guidance. Superficial treatment of skin cancers does not meet the requirements associated with the use of many existing codes. The introduction of this revised code set will address these concerns by establishing codes that are specifically associated with the work of superficial radiation therapy.

Proton Beam Treatment Delivery

CMS received many comments in response to its comment solicitation on establishing national payment rates for proton beam treatment delivery under the MPFS and will consider them in future rulemaking.

Go Deeper

PFS payments for proton beam treatment delivery services are currently determined by local Medicare Administrative Contractors (MACs). In the 2021 MPFS proposed rule, CMS did not establish RVUs for these services due to the significant equipment costs involved that would have distorted the relativity of the MPFS. CMS sought comment on whether it should adopt a similar approach to establish RVUs for proton beam treatment delivery as with the radiation treatment delivery and superficial radiation therapy codes, described above. Proton beam treatment delivery services are assigned to APCs 5623 and 5625 under the OPPTS with established Medicare payment rates.

Specifically, the Agency asked for comment on establishing national pricing and total RVUs for proton beam treatment delivery codes to maintain relativity within the PFS. The Agency provided two examples for consideration: 1) use the overall ratio between OPPTS and PFS payment for radiation oncology treatment services to establish initial year RVUs for proton beam treatment delivery services that accurately reflect the relative resources involved in furnishing the service or 2) consider the overall difference between the OPPTS and Medicare payment as currently determined by the MACs for these services. CMS also welcomed alternative approaches.

Efficiency Adjustment

CMS is finalizing its proposed efficiency adjustment, which reduces the work RVUs and corresponding intraservice time for certain services. As explained in more detail below, the efficiency adjustment for 2026 will be 2.5%, and this adjustment will be repeated every three years. ASTRO opposed the efficiency adjustment as proposed and asked that any adjustments be based on robust, specialty-specific data that truly reflects efficiencies gained, rather than a generalized application that penalizes essential services.

The efficiency adjustment is intended to reflect productivity gains in medical practice, as measured by the Medicare Economic Index (MEI) over the last five years. The adjustment applies specifically to non-time-based services, but CMS has excluded several categories from the adjustment:

- Evaluation and Management (E/M) services
- Telehealth services
- Time-based codes (such as drug administration)
- Care management and behavioral health services
- Maternity services (those with MMM global periods)
- Any new codes introduced in CY 2026

Generally, specialties that bill more often for timed codes, such as family practice, will see an increase in RVUs. Specialties that bill more often for procedures, like diagnostic imaging and radiology services (such as radiation oncology, radiology, and some surgical specialties), will see a decrease in RVUs. ASTRO is working with affected medical

specialties to pursue legislation this year to stop the efficiency adjustment from taking effect.

CMS also noted that it may consider corresponding updates to the direct PE inputs for clinical labor and equipment costs in the future.

TABLE A-E1: EFFICIENCY ADJUSTMENT FOR CY 2026

CY	MEI Productivity Adjustment (%)
2022	0.2
2023	0.5
2024	0.4
2025	0.6
2026*	0.8*
Efficiency Adjustment	2.5%

Go Deeper

CMS has relied on the AMA RUC to estimate practitioner time, work intensity, and practice expense for the purpose of establishing RVUs for codes used for payment under the PFS. In the 2025 MPFS, CMS received comments expressing concern with using RUC data as a source of valuation and identifying a need for empirical data in the context of valuing advanced primary care management services. Additionally, CMS has expressed concern in prior years about not accounting for efficiencies gained in work RVUs for non-time based services included in codes describing procedures, radiology services, and diagnostic tests.

In 2018, MedPAC recommended three options to offset distortions in valuing physician work 1) an automatic reduction to the prices of new services, and services with high growth rates; 2) an extension of the annual numeric target for CMS to reduce the prices of overpriced services; and 3) an across the board reduction to all fee schedule services other than ambulatory E&M services. CMS is proposing a modified version of the third option in this proposed rule.

To consider changes in medical practice and better reflect the resources involved in furnishing services paid under the PFS, the Agency is proposing an efficiency adjustment to the work RVUs, as well as corresponding updates to the intraservice portion of physician time inputs for non-time-based services. The initial approach is designed to be “conservative” in nature; however, in the future the Agency may consider making additional corresponding updates to the direct PE inputs for clinical labor and equipment costs.

The efficiency adjustment sums all productivity adjustment percentage values included in the final MEI updates from the most recent five-year period. That summed amount is then

deducted from the work RVU values of all CPT codes that were reviewed by the RUC and CMS during that look back period. For CY 2026, CMS will apply the efficiency adjustment to CPT Codes reviewed during the look-back period CY 2022 through 2026. According to the rule, this would result in a reduction of 2.5% to the work RVU of those codes. The efficiency adjustment will occur every 3 years.

Updates to Practice Expense (PE) Methodology – Site of Service Differential

In the 2026 MPFS proposed rule, CMS is finalizing its proposal to reduce the portion of the facility PE RVUs allocated based on the work RVUs to half the amount allocated to nonfacility PE RVUs for 2026 for each service valued in the facility setting. This will lead to an increase in PE RVUs for specialties that practice primarily in the nonfacility setting and a decrease to those that primarily practice in the facility setting.

Go Deeper

Under the MPFS, many services have a site of service payment differential between the facility and non-facility settings. In the facility setting, the payment rate includes physician work RVUs and indirect practice expense allocated based on the physician work RVU. The direct costs in the facility are paid under a different system than the PFS, such as the OPPS. Indirect costs allocated to services furnished in the facility setting are meant to reflect typical costs associated with practice expenses in that setting.

Data suggests that fewer than half of physicians currently own their practices. However, the underlying assumption embedded within the MPFS payment methodology assumes that physicians generally maintain office practices and incur associated indirect costs. The current methodology presumes equal indirect costs incurred by physicians across sites of service. Due to the significant shift in practice, CMS will reduce the portion of the facility PE RVUs allocated based on work RVUs to half the amount allocated to non-facility PE RVUs beginning in CY 2026.

Commenters, including ASTRO, criticized CMS's assumption that employed physicians in facility settings incur insignificant administrative and overhead costs, arguing that this view is disconnected from the reality of modern health care. They emphasized that, despite the trend toward physician employment by larger systems, physicians in facility settings still face substantial indirect costs for functions like coding, billing, and scheduling, which are often charged back to their departments as practice expenses (e.g., rent, staffing, and administrative support). Commenters pointed to the AMA's Physician Practice Information (PPI) survey, which quantifies these indirect costs at approximately \$57 to \$62 per hour for hospital-based medicine and surgery, respectively. The commenters concluded that CMS's proposed flat 50% reduction to the work Relative Value Unit (RVU) allocator is an oversimplification that fails to account for these varied and complex practice arrangements, urging CMS to collect more accurate, up-to-date data on the true cost of practice before implementing such an assumption.

CMS acknowledged the complexity and variation in physician practice arrangements and the criticism that its assumptions about employed physician costs were simplistic. Even so, it defended its decision to retain an adjusted allocation of indirect PE RVUs, stating the new policy is a more accurate reflection of facility indirect PE than the prior assumption of near-equality. Furthermore, CMS expressed concern about the reliability of the AMA's PPI survey data due to its low response rate, suggesting those cost estimates may not accurately reflect the typical indirect PE faced by physicians who predominantly work in the facility setting.

Technical Corrections to Direct PE Input Database and Supporting Files

In response to the 2025 MPFS, the RUC requested that CMS update the names of several supplies and equipment items in the CMS rate setting database to remove specific product or brand names and more accurately describe items. CMS agreed with the RUC recommendations, which included renaming ER089 *IMRT Accelerator* to *ER089 Radiation Treatment Delivery Linear Accelerator*.

Practice Expense Per Hour and Medicare Economic Index

In the 2023 proposed MPFS, CMS proposed implementing the finalized 2017-based Medicare Economic Index (MEI) cost share weights associated with Physician Fee Schedule rate setting. Ultimately, the Agency agreed to delay implementation of the proposal so that the AMA could collect practice cost data via the Physician Practice Information Survey (PPIS).

The AMA completed the PPIS in July 2024 and issued a report to CMS in February 2025 to inform updates to the Practice Expense per hour (PE/HR) data. In the 2026 MPFS proposed rule, CMS expressed concern about the accuracy and suitability of the PPIS data, stating it has “substantive concerns about its accuracy, utility, and suitability as an immediate replacement for the current PE/HR data and cost shares for use in allocating nearly \$91 billion in payments across PFS.” Instead of implementing PE/HR data or cost shares from the PPIS, CMS will maintain the current PE/HR data and cost shares for CY 2026 PFS ratesetting.

ASTRO had expressed concerns regarding the use of the AMA PPIS, which recommended bundling radiation oncology services into a broader radiology category of diagnostic radiology, interventional radiology, and nuclear medicine. This would have resulted in an almost 40% reduction from the existing PE/HR rate of \$291.30.

Updates to Prices for Existing Direct PE Inputs – Radiation Treatment Vault Pricing Maintained

In the 2026 MPFS proposed rule, CMS proposed to update the price of 35 supplies and seven equipment times in response to the public submission of invoices following the CY 2025 PFS final rule. Among the submissions was the *Radiation treatment vault (ER056)*.

After consideration of the invoice submitted, CMS has chosen to keep the current price of \$773,104 for the vault. According to the Agency, the pricing information contained numerous costs associated with building construction, including surveying, plumbing, and HVAC expenses, which are not included in a traditional invoice. Furthermore, the Agency does not believe that construction costs should be included as a form of direct PE because they are not individually allocable to a particular patient or for a particular service.

Medicare Telehealth Services

CMS is finalizing its proposal to remove the distinction between provisional and permanent services on the Medicare Telehealth Services List. All services listed or added to the List will be considered included on a permanent basis, but the Agency reserves the right to remove services included on the Medicare Telehealth Services List based on internal review or feedback received from interested parties.

What This Means for Radiation Oncology

CPT code 77427, *Radiation tx management x5*, was added to the Medicare Telehealth List on a temporary basis during the COVID-19 Public Health Emergency (PHE), and through various regulatory actions, this was continued through the end of 2024. It is now on the List permanently. It remains ASTRO's position that the OTV component of radiation treatment management should always be conducted in-person by the radiation oncologist.

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

In the 2026 final rule, CMS is permanently adopting a definition of "direct supervision" that allows immediate availability of the supervising practitioner using audio/video real-time communications technology (excluding audio only) for all services, excluding those with a global surgery indicator of 010 or 090. The Agency asserts in the rule that this does not mean it is appropriate to allow virtual presence for every service for every Medicare beneficiary in every clinical scenario. The physician should use his or her complex professional judgment to determine the appropriate supervision modality on a case-by-case basis.

Office/Outpatient (O/O) Evaluation and Management (E/M) Visit Complexity Add-on

In the 2026 MPFS final rule, CMS is finalizing its proposal to allow O/O E/M visit complexity add-on code (HCPCS code G2211) to be billed as an add-on code with the home or residence evaluation and management visits code family. In prior rule making, CMS finalized its proposal to allow payment of the O/O E/M base code (CPT 99202-99205, 99211-99215) when it is reported by the same practitioner on the same day as an annual wellness visit, vaccine administration, or any Medicare Part B preventive service. This would extend that provision to the following home or residency E/M codes: 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350.

Payment for Dental Services Inextricably Linked to Other Specific Covered Services

In the 2026 MPFS final rule, CMS is not making any additions to dental services that are inextricably linked to other specific covered services. In prior rule making, CMS established two policies related to the billing of dental services inextricably linked to covered services. Effective July 1, 2025, CMS required the submission of the KX modifier on claims for dental services that clinicians believe to be inextricably linked to covered medical services. The Agency also finalized the required submission of a diagnosis code on 837D dental claims format beginning July 1, 2025.

Quality Payment Program

Additional information regarding proposed changes to the Quality Payment Program will be included in a subsequent summary document.

For a copy of the final rule: <https://public-inspection.federalregister.gov/2025-19787.pdf>

For a fact sheet on the proposed rule: <https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2026-medicare-physician-fee-schedule-final-rule-cms-1832-f>