CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 13507	**Date: December 5, 2025**
	Change Request 14315

SUBJECT: Summary of Policies in the Calendar Year (CY) 2026 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, Computed Tomograph (CT) Modifier Reduction List, and Preventive Services List

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to provide a summary of the policies in the CY 2026 MPFS Final Rule and to announce the Telehealth Originating Site Facility Fee payment amount. The attached recurring update notification applies to publication 100-04, chapter 12, section 190.5, chapter 13, section 20.2.4, and chapter 18, section 240.

EFFECTIVE DATE: January 1, 2026
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 5, 2026

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
Recurring Update Notification

Attachment - Recurring Update Notification

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II. GENERAL INFORMATION

A. Background: The CR provides a summary of the policies in the CY 2026 MPFS. Section 1848(b)(1) of the Social Security Act (the Act) requires the Secretary to establish by regulation a fee schedule of payment amounts for physicians' services for the subsequent year. The CMS issued a final rule that updates payment policies and Medicare payment rates for services furnished by physicians and Nonphysician Practitioners (NPPs) that are paid under the MPFS in CY 2026. The final rule also addresses public comments on Medicare payment policies proposed earlier this year.

B. Policy: CMS issued regulation number CMS-1832-F Medicare and Medicaid Programs; CY 2026 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program. This CR provides a summary of the payment polices under the MPFS and makes other policy changes related to Medicare Part B payment. These changes are applicable to services furnished in CY 2026.

For additional information regarding the following policies, please contact:
MedicarePhysicianFeeSchedule@cms.hhs.gov

Telehealth Services

For CY 2026, we are finalizing our proposal to add several services to the Medicare Telehealth Services List, including multiple-family group psychotherapy, group behavioral counseling for obesity, the infectious disease add-on code, and auditory Osseo integrated sound processor services. The list of codes that are added to the telehealth services list can be found at: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.

For CY 2026, we are finalizing to streamline the process for adding services to the Medicare Telehealth Services List. We are simplifying our review process by removing the distinction between provisional and permanent services and limiting our review on whether the service can be furnished using an interactive, two-way audio-video telecommunications system.

We are finalizing to permanently remove frequency limitations for subsequent inpatient visits, subsequent nursing facility visits, and critical care consultations.

We are also finalizing, for services that are required to be performed under the direct supervision of a physician or other supervising practitioner, to permanently adopt a definition of direct supervision that allows the physician or supervising practitioner to provide such supervision through real-time audio and visual interactive telecommunications (excluding audio-only). Except for services that have a global surgery indicator of 010 or 090, we are finalizing that a physician or other supervising practitioner may provide such virtual direct supervision for applicable incident-to services under Subsection (§) 410.26, diagnostic tests under § 410.32, pulmonary rehabilitation services under § 410.47, cardiac rehabilitation and intensive cardiac rehabilitation services under § 410.49.

We did not propose to extend our current policy to allow teaching physicians to have a virtual presence for purposes of billing for services furnished involving residents in all teaching settings. However, in response to public comments highlighting the extent to which this flexibility has been integrated into clinical practice, we are finalizing this policy on a permanent basis, but only in clinical instances when the service is furnished virtually (a three-way telehealth visit, with the patient, resident, and teaching physician in separate locations).

Telehealth origination site facility fee payment amount update

Section 1834(m)(2)(B) of the Act establishes the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001, through December 31, 2002, at $20. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased by the percentage increase in the Medicare Economic Index (MEI) as defined in section 1842(i)(3) of the Act. The MEI increase for 2026 is 2.7 percent. Therefore, for CY 2026, the payment amount for Healthcare Common Procedure Coding System (HCPCS) code Q3014 (Telehealth originating site facility fee) is 80 percent of the lesser of the actual charge, or $31.85 (The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance).

Therapy Services

KX Modifier Thresholds

We are announcing that the KX-modifier threshold amounts for CY 2026 are $2,480 for physical therapy and speech-language pathology services combined and $2,480 for occupational therapy services.

Evaluation and Management (E/M) Visits

Complexity Add-on HCPCS Code G2211

In 2024, CMS began making separate payment of HCPCS code G2211 as an add-on code with the office/outpatient evaluation and management visits code family (Current Procedural Terminology (CPT) codes 99202-99205, 99211-99215). For CY 2026, we are finalizing payment of HCPCS code G2211 as an add-on code with the home or residence evaluation and management visits code family (CPT codes 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350). This would ensure that our E/M visit complexity add-on policy, which aims in part to make payment for previously unaccounted resources inherent in the complexity of all longitudinal primary care visits, is achieved. The visit complexity add-on code recognizes the inherent costs of building trust in the practitioner-patient relationship. We believe that trust-building in

the longitudinal practitioner-patient relationship may be particularly significant in the context of home and residence E/M visits.

Behavioral Health Services

For CY 2026, to further support access to behavioral health services, we are finalizing to expand our payment policies for HCPCS codes G0552, G0553, and G0554 to also make Medicare payment for Digital Mental Health Treatment (DMHT) devices cleared under section 510(k) of the Federal Food, Drug, and Cosmetic Act or granted de no novo authorization by the Food and Drug Administration (FDA) and classified under 21 Code of Federal Regulations (CFR) 882.5803 Digital therapy device for Attention Deficit Hyperactivity Disorder (ADHD), furnished incident to professional behavioral health services used as an adjunct to clinician supervised ongoing behavioral health care treatment under a behavioral health treatment plan of care. The § 882.5803 classification is for software intended to provide therapy for ADHD or any of its individual symptoms as an adjunct to clinician supervised treatment. HCPCS codes G0552, G0553, and G0554 describe these services. HCPCS code G0552, which describes "*Supply of digital mental health treatment device and initial education and onboarding, per course of treatment that augments a behavioral therapy plan"* continues to be assigned contractor-pricing. HCPCS code G0553 and G0554 continue being assigned national pricing. All HCPCS code G0552 billing requirements applicable to devices classified at 21 CFR 882.5801 will be applicable to devices classified at 21 CFR 882.5803, that is:

- the billing practitioner is incurring the cost of furnishing the DMHT device to the beneficiary as a supply,
- that furnishing of the DMHT device is incident to the billing practitioner's professional services in association with ongoing behavioral health treatment under a plan of care by the billing practitioner, and
- payment may only be made for DHMT devices for mental health treatment in accordance with the use indicated under their FDA classification.

G0136

We are finalizing a new code descriptor for HCPCS G0136 to focus on the essential patient behaviors of physical activity and nutrition with an aim to reduce chronic disease and improve health.

Advanced Primary Care Management Services

For CY 2026, we are finalizing the creation of optional add-on codes for Advanced Primary Care Management (APCM) services that would facilitate providing complementary Behavioral Health Integration (BHI) or psychiatric Collaborative Care Model (CoCM) services. We are finalizing the establishment of three new HCPCS codes (HCPCS codes G0568, G0569, and G0570) to be billed as add-on services when the APCM base code is reported by the same practitioner in the same month. The services of the proposed add-on codes are meant to be directly comparable to existing CoCM and BHI codes.

Efficiency Adjustment

For CY 2026, we are finalizing our proposal to use the MEI productivity adjustment percentage. The MEI productivity adjustment is calculated by the CMS Office of the Actuary (OACT) each year, and we are finalizing a look-back period of five years, which would result in a final efficiency adjustment of -2.5% for CY 2026. In response to public comments, we are finalizing an updated list of HCPCS codes that will be exempt from the efficiency adjustment. We are also finalizing that, going forward, CMS may give preference to empiric studies of time to incorporate into service valuation, compared to survey data, and solicit comment on the types of empiric data that CMS should consider. CMS expects that moving away from survey data would lead to more accurate valuation of services over time and help address some of the distortions that have occurred in the PFS historically.

Practice Expense

Site of Service Payment Differential

For CY 2026, we are finalizing our proposal to reduce the portion of the facility Practice Expense Relative Value Units (PE RVUs) allocated based on work RVUs to half the amount allocated to non-facility PE RVUs. This change to the indirect cost allocation methodology is intended to better recognize the relative resources involved in furnishing services paid under the PFS in facility and non-facility settings, and we believe the implementation of this update will correct potential distortions in the allocation of indirect PE under our current methodology.

Use of OPPS Data for PFS Rate Setting

We are finalizing our proposal to utilize data from auditable, routinely updated hospital data (i.e., the Medicare Hospital Outpatient Prospective Payment System (OPPS)) to set relative rates and inform our costs assumptions for some technical services paid under PFS. For CY 2026, we are finalizing our proposal to use this data in setting rates for radiation treatment services, and for some remote monitoring services. This approach promotes price transparency across settings, offers more predictable rate-setting outcomes, and limits the influence of limited survey data.

Skin Substitutes

For CY 2026, we are finalizing to pay for skin substitute products as incident-to supplies when they are used as part of a covered application procedure paid under the PFS in the non-facility setting or under the OPPS in the hospital outpatient department setting. CMS is also finalizing to align skin substitute categorization consistent with their FDA regulatory status, such as 361 Human Cells, Tissues, and Cellular and Tissue-Based Products (HCT/P) and the device types: Pre-Market Approvals (PMAs) and 510(k)s. CMS continues to believe that grouping and paying for skin substitute products based on relevant product characteristics, consistent with their FDA regulatory status, recognizes the clinical and resource differences in product types and would incentivize competition to create more innovative products, while also resulting in significant savings to the Medicare Trust Fund. We note that for CY 2026, CMS is finalizing the use of a single payment rate reflecting the highest average for these three categories of skin substitute products to ensure we are not underestimating the resources involved with furnishing these services. In future years, we intend to propose payment rates that differentiate among the three FDA regulatory categories. CMS is finalizing these policy changes in both the hospital outpatient department and physician office settings to remain consistent across different settings of care. The finalized payment policy for skin substitutes in the hospital outpatient setting is provided in the CY 2026 OPPS/ Ambulatory Surgical Center (ASC) proposed rule.

III. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
14315.1	Contractors shall be aware of the policies published in the MPFS Final Rule (Regulation number CMS-1832-F Medicare and Medicaid Programs; CY 2025 Payment Policies under the PFS and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program;), which are summarized with this change request and apply those policies as appropriate.	X	X	X						
14315.2	Contractors shall continue to pay for the Medicare telehealth originating site facility fee as 80 percent of the lesser of the actual charge or $31.85, as described by HCPCS code Q3014 "Telehealth facility fee," effective for dates of service on and after January 1, 2026.	X	X	X						
14315.3	Contractors shall use the list of telehealth services found on the CMS website at http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.	X	X							
14315.4	Contractors shall use the list of codes that are subject to the CT modifier reduction found on the CMS website at https://www.cms.gov/medicare/payment/fee-schedules/physician-fee-schedule/computed-tomography-modifier-reduction-list.		X							
14315.5	Contractors shall use the prolonged preventive services G0513 and G0514 as an add-on to the covered preventive services located on the CMS website at https://www.cms.gov/medicare/paym		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	ent/fee-schedules/physician/preventive-services.									

IV. PROVIDER EDUCATION

Medicare Learning Network® (MLN): CMS will develop and release national provider education content and market it through the MLN Connects® newsletter shortly after we issue the CR. MACs shall link to relevant information on your website and follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 for distributing the newsletter to providers. When you follow this manual section, you don't need to separately track and report MLN content releases. You may supplement with your local educational content after we release the newsletter.

Impacted Contractors: A/B MAC Part A, A/B MAC Part B, A/B MAC Part HHH

V. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

VI. CONTACTS

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VII. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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