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In this issue

Telehealth

Address answers, new codes, permanent expansions in telehealth update

While the fate of popular telehealth waivers created during the COVID-19 public health emergency remains in limbo — due to the recent shutdown-ending legislation that only extended the waivers through Jan. 30, 2026 — Medicare's original telehealth remains intact, and the agency included five expansions and clarifications in the final 2026 Medicare physician fee schedule.

Home address enrollment solution

In the proposed 2026 Medicare physician fee schedule, CMS was silent on the issue of providers who perform telehealth services from home but were allowed to bill under their office address, rather than update their enrollment to include their home address. Because that information is publicly available, it was a major concern to providers who occasionally work from home.

In the final rule, CMS pointed to the following FAQ for the Physician Compare Initiative that gives two options for keeping their private contact information private:

Question: *"I provide non-patient-facing or telehealth-based medical care from my home and need to enroll my home as a practice location. How do I prevent my home address and personal phone number from being published on my profile?"*

Answer: "Doctors and clinicians can either mark the address as a 'Home office for administrative/telehealth use only' location in the Provider Enrollment, Chain, and Ownership System (PECOS), which will suppress street address details,

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or email the Quality Payment Program (QPP) Service Center to suppress the street address and/or phone number."

CMS adds 5 new codes, plus revised G0136

CMS finalized its plans to add five new codes to the list of services that can be performed via telehealth next year. The update will allow providers to perform the following services via telehealth for eligible patients:

- Multiple family group counseling **(90849)**.
- Diagnostic analysis of auditory osseointegrated sound processors (**92622** and **92623**).
- Group behavioral counseling for obesity (**G0473**).
- The infectious disease add-on code that can be reported with observation and inpatient E/M services (**G0545**).

CMS also reintroduced code **G0136** to the list of covered telehealth services. CMS had planned to remove the code from the telehealth list because it intended to delete the code. Instead, CMS changed the code's descriptor to describe assessments of patient diet and activity levels (*PBN 11/17/25*). It will remain on the telehealth list.

Farewell to frequency limits

CMS will permanently end frequency limits for nine services reported by telehealth:

- Three subsequent hospital codes **(99231-99233)**.
- Four subsequent nursing facility codes (**99307-99310**):
- Two critical care consult codes (**G0508-G0509**).

The agency has consistently received overwhelming support for lifting frequency limits and found no evidence that it causes excessive or improper reporting, according to the final 2026 Medicare physician fee schedule.

The agency signaled that it is willing to trust the treating provider's clinical judgement. "We believe that physicians and other practitioners, who have the greatest familiarity and insight into the needs of individual beneficiaries, can use their complex professional judgment to determine whether they can safely furnish a service via telehealth, given the entirety of the circumstances, including the clinical profile and needs of the beneficiary, to determine the appropriate service modality."

However, the agency also stated it will keep an eye on the expansion and issue additional safeguards, if necessary.

Teaching expansion gets a passing grade

CMS reversed course on its plan to end the virtual presence waiver for teaching physicians and made the expansion permanent. "After consideration of public comments, we are finalizing to permanently allow teaching physicians to have a virtual presence in all teaching settings, only in clinical instances when the service is (a 3-way telehealth visit, with the teaching physician, resident, and patient in

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different locations).” All other teaching physician billing will stay in place, CMS stated in the final rule.

Remote monitoring reminder

CMS also responded to some confusion about what is — and is not — a telehealth service, observes Betsy Nicoletti, CPC, founder, CodingIntel. The agency had to remind some commenters that remote physiologic monitoring (RPM), remote therapeutic monitoring (RTM) and digital mental health treatment (DMHT) services are not telehealth services as defined by the agency and therefore aren’t subject to telehealth restrictions or eligible for addition to the list of telehealth services.

“We would like to clarify that these services, which are inherently non-face-to-face, do not meet the definitions of section 1834(m) of the Act, fall outside the scope of the definition of Medicare telehealth service and … are not subject to section 1834(m) of the Act,” CMS wrote in the final rule. It also stated that practices should not report these services with a telehealth place of service code, in response to a related question. — *Julia Kyles, CPC* (julia.kyles@decisionhealth.com) ■

RESOURCE

- Physician compare initiative FAQs: www.cms.gov/medicare/quality/physician-compare-initiative/frequently-asked-questions

Billing

CMS slaps uniform payment rate on skin substitutes, applies incident-to rules

Get ready for a reduction in reimbursement for so-called skin substitutes, the externally applied grafts used to treat non-healing diabetic foot ulcers and venous leg ulcers.

CMS has finalized a plan to pay a uniform amount for the grafts under Medicare’s incident-to policy. Medicare will reimburse at a rate of $127.26 per square centimeter for each of 19 HCPCS supply codes (*see list, below*). Practices will be able to bill for those codes in conjunction with CPT graft application codes **15271** to **15278**.

The new policy is intended to “limit some of the current profiteering practices occurring in this industry,” CMS states in the final 2026 Medicare physician fee schedule.

The agency enacted the new policy after seeing its payments for the devices mushroom from $252 million in 2019 to more than $10 billion last year — a 40-fold increase. During that same period, the number of services billed with the codes only doubled, the agency said. CMS anticipates that the new policy will reduce its skin substitute payments by 90%, according to an agency press release.

The new payment limit applies to skin substitutes defined as “products that are human cells, tissues and cellular and tissue-based products (HCT/Ps)” under section 361 of the Public Health Services Act. It applies in addition to devices that require FDA 510(k) clearance and those that are subject to FDA premarket approval applications, CMS states in the final 2026 Medicare physician fee schedule.

Exempted from the policy are those products approved as drugs or biologicals under section 351(i) of the Public Health Services Act, which the statute defines as “a virus, therapeutic serum, toxin, antitoxin, vaccine, blood, blood component or derivative, allergenic product, protein, or analogous product … applicable to the prevention, treatment or cure of a disease or condition of human beings.” (42 U.S. Code 262[i])

In addition to Medicare’s finalized incident-to policy, providers can expect new medical necessity limits on skin substitute products, based on a unified local coverage determination (LCD), Skin Substitute Grafts/Cellular and Tissue-Based Products for the Treatment of Diabetic Foot Ulcers and Venous Leg Ulcers, which will also take effect Jan. 1.

That LCD, which is supplemental to Medicare’s national coverage policy, sets covered indications and requirements for standard of care treatment as well as coverage requirements for the products themselves. — *Laura Evans, CPC* (laura.evans@decisionhealth.com ■

RESOURCES

- Final 2026 Medicare physician fee schedule: www.federalregister.gov/d/2025-19787/p-1709
- Medicare uniform (future) local coverage determination: www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=39756&ver=7&keyword=Skin%20Substitute%20Grafts&keywordType=starts&areaId=all&docType=NCA,CAL,NCD,MEDCAC,TA,MCD,6,3,5,1,F,P&contractOption=all&sortBy=relevance&bc=1

Skin substitute HCPCS codes that are subject to Medicare's 2026 uniform payment policy

The following codes will be reimbursed next year at a uniform rate of $127.26/sq cm.

HCPCS code	Descriptor
A2001	Innovamatrix ac, per sq cm
A2002	Mirragen adv wnd mat per sq
A2005	Microlyte matrix, per sq cm
A2006	Novosorb synpath per sq cm
A2007	Restrata, per sq cm
A2008	Theragenesis, per sq cm
A2009	Symphony, per sq cm
A2010	Apis, per square centimeter
A2011	Supra sdrm, per sq cm
A2012	Suprathel, per sq cm
A2013	Innovamatrix fs, per sq cm
A2015	Phoenix wnd mtrx, per sq cm
A2016	Permeaderm b, per sq cm
A2018	Permeaderm c, per sq cm
A2019	Kerecis marigen shld sq cm
A2021	Neomatrix per sq cm
A2022	Innovabrn/innovamatx xl sqcm
A2024	Resolve or xenopatch sq cm
A2027	Matriderm per sq cm

Medicare Shared Savings Program

Shared Savings pushes risk, but experts debate the impact

Most of the significant changes to the Medicare Shared Savings Program (MSSP) have been confirmed in the final 2026 Medicare physician fee schedule, with a major emphasis on making it easier for new and slow-to-advance entrants to take on risk. However, experts aren't sure it'll work.

CMS will reduce the length of time an ACO can participate in a one-sided model of the BASIC track from a maximum of seven performance years over two performance periods to five performance years with the first year starting in 2027.

After that, the neophyte ACO must sign up for Level E of the BASIC MSSP track for all performance years of the agreement period, or for the ENHANCED track. (Both tracks make the ACO eligible for Advanced APM status.)

Also, CMS will "increase flexibility" for these entrants regarding the minimum patient population of 5,000 assigned Medicare fee-for-service (FFS) beneficiaries required in MSSP benchmark years: Starting in 2027, the ACOs can have fewer than 5,000 in their first two performance years.

However, ACO entrants with fewer than 5,000 beneficiaries have to stay in the BASIC track during that time, and their shared savings and shared losses will be capped at a lesser amount. They'll also be excluded during that time from certain opportunities available to "low revenue ACOs participating in the BASIC track," such as advance investment payments and exemption from minimum savings requirement (MSR) requirements.

Experts see risk glass half full

Will this do the job of drawing new MSSP entrants to risk? Some experts are lukewarm.

Leigh Poland, vice president of the coding service line at AGS Health in Washington, D.C., thinks the changes will "probably" help some entrants, particularly smaller or rural ACOs who were previously excluded by their modest size. And she expects the shorter risk-free periods, not to mention the "higher shared savings rates for early risk-takers," might get some slow-moving ACOs to jump in.

Daniel B. Frier, Esq., co-founder of the Frier Levitt law firm and chair of its health care group, believes these change "should modestly accelerate migration to two-sided risk," though he feels "the caps and BASIC-only constraint for ACOs below 5,000 in any benchmark year may dampen the upside."

While he has no quarrel with the concepts, Darryl Drevna, senior director of regulatory affairs for the American Medical Group Association (AMGA) in Washington, D.C., feels that the constant tinkering to get members to take on risk makes MSSP feel riskier and less attractive.

"It's really hard for our members to continue to make investments in MSSP when they keep changing the methodology," Drevna says. "There's always going to be tweaks. But when your staff and technology costs go up, and there's only a modest update on the conversion factor, and the APM bonuses are expiring and they

(continued on p. 6)

Benchmark of the week

2026 top code payments a far cry from the lean years

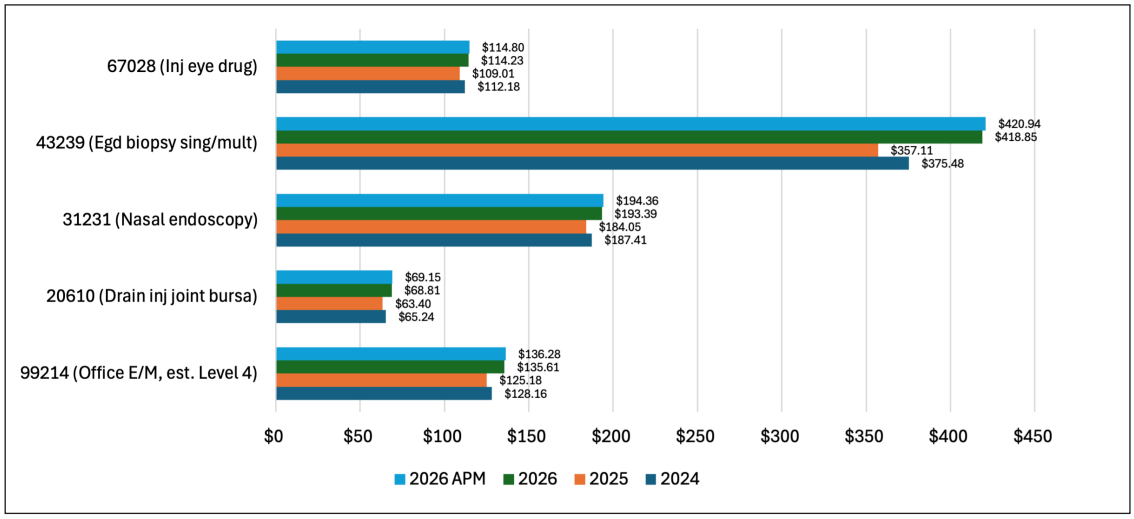
In the 2026 physician fee schedule final rule, the difference between the non-facility fees for non-APM participants and APM participants – a signal feature of the new rule, with two distinct conversion factors (CF) – may seem small at first glance (*PBN 11/10/25*). But it gets bigger as the number rise and compares favorably with recent years' fees.

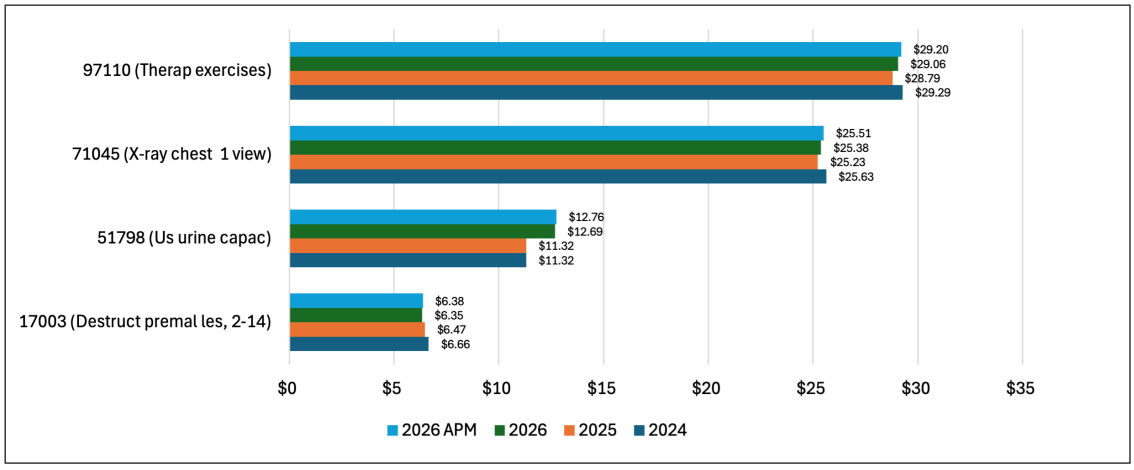
The analysis presented in the charts below showcases Medicare fees for CPT codes for procedures with the highest utilization for each chapter of the CPT manual (*PBN 11/18/24*). You can see in the chart, going back to the lean years of 2024 and 2025, that with the exceptions of **17003** (Destruction, premalignant lesions, 2 through 14) and **71045** (X-ray, chest, single view), these fees will be substantially higher now.

The dip in 2025 payments for these codes is clear on the chart. The original 3.4% cut to the CF in 2024 was mitigated with a 2.93% revision upward (*PBN blog 11/2/23*, *3/18/24*). The 2.8% cut in 2025, however, got no such adjustment (*PBN blog 12/18/24*, *PBN 3/24/25*). Yet total payment amounts on the nine codes were not much different between the two years – $941.37 in 2024 and $910.56 in 2025, a drop of 3.3%. The rise from 2025 to 2026, on the other hand, goes to $1,004.36, a 10.3% lift.

The difference between 2026 APM and non-APM payments, due to their divergent CFs, looks small when spelled out in numbers. But while the payment increases for some codes are infinitesimal, the more the payments pile up, the larger that difference looms. – *Roy Edroso (roy.edroso@decisionhealth.com) with additional reporting by Laura Evans, CPC, and Julia Kyles, CPC*

National, non-facility fee update for top E/M, procedure services, 2024, 2025, 2026 (non-APM, APM)





Source: Part B News *analysis of 2024-2026 Part B fee schedule payment rates*

(continued from p. 4)

need to be reauthorized — there's just a whole lot of uncertainty in what the overall system is going to look like even two weeks from now, let alone two or three years from now."

Drevna acknowledges the larger, more established ACOs will probably roll with the changes, but "if you're new to the program or if you're a smaller ACO, that beneficiary threshold requirement, for example, is going to create a barrier to entry."

The real motivators for new ACOs, in Frier's view, "remain the policies CMS locked in last year" — that is, the health equity benchmark (renamed "population adjustment" this year by the equity-averse new administration), and the prepaid shared savings for entrants looking for advanceable shared savings for reinvestment (*PBN 7/22/24*).

BHI, CoCM now attributable

Risk-shy ACOs may gain encouragement from a revised definition of primary care services used for purposes of beneficiary assignment: Starting in 2026, behavioral health integration (BHI) and psychiatric collaborative care management (CoCM) add-on services will be included in the definition of primary care services.

It may be confusing for some observers who assume recipients of BHI and CoCM are already getting assignment attribution for other primary care services. But David Halpert, chief of client team at Roji Health Intelligence in Chicago, points out the "plurality of primary care services" language in CMS attribution methodology "considers allowed charges when determining whether a patient should be attributed to one ACO or another. Since the behavioral health codes are add-ons — and can only be used with advanced primary care codes — they are counted as separate primary care services, with separate allowed charges, and can play a role in beneficiary attribution."

CMS also offers stakeholders a related request for information (RFI): "Should CMS consider new payments to Shared Savings Program ACOs for prospective monthly APCM payments to be delivered to primary care practices that satisfy the APCM billing requirements, with the payments reconciled under the ACO benchmark?"

Poland believes this will swell the assignment ranks of ACOs that have established behavioral health teams and currently see patients who primarily interact with them via those teams.

Frier likes the change. "It makes it easier for primary care practices using BHI/CoCM to reach and maintain assignment thresholds; recognizes more holistic care patterns that increasingly drive visit volume; and improves attribution fidelity for integrated practices, which in turn improves benchmark accuracy and confidence in financial results."

SDOH kept, equity cut

Also, in a change from the proposed rule, CMS won't pull the social determinants of health (SDOH) risk assessment code **G0136** from its definition of "primary care services" used for the purposes of assignment. The code's description, however, will be revised to focus on "physical activity and nutrition" (*PBN 11/17/25*).

The health equity adjustment to the ACO quality score, however, will be removed retroactive to 2025. This code adjusts an ACO's historical benchmark based on the share of beneficiaries who are low-income subsidy (LIS) and/or dual eligibles and can currently increase the MIPS quality score of an ACO by a maximum of 10 points.

CMS says this adjustment is duplicative of the Complex Organization Adjustment, which "upwardly adjusts an ACO's MIPS Quality performance category score when an ACO reports quality data via eCQMs [electronic clinical quality measures]," and of the eCQM/MIPS CQM reporting incentive, and these "have made it unnecessary to continue applying the health equity adjustment to an ACO's quality score."

Note other changes

Also, the Alternative Payment Model (APM) Performance Pathway (APP) Plus quality measure set for Shared Savings Program ACOs will lose the Screening for Social Drivers of Health, and its Consumer Assessment of Healthcare Providers and Systems (CAHPS) for Merit-based Incentive Payment System (MIPS) Survey will change from a mail-phone administration protocol to a web-mail-phone administration protocol in 2027.

Speaking of scoring, while Medicare CQMs seemed to be going away as a reporting method, now CMS is making them easier to use, e.g., with the "change in beneficiary eligibility for Medicare CQMs" to promote

"greater overlap with the ACO's assignable beneficiary population" (*PBN 11/18/24*).

"A lot of our members had used those successfully, and phasing them out had created some measurement gaps and challenges for ACOs," Drevna says. "This will make it a little bit easier for groups to continue to use their robust data collection and reporting that is already in place rather than forcing a quick transition. I think this is an instance where CMS heard from the provider community and adjusted accordingly."

CMS will allow ACOs to use Medicare CQMs if they have "at least one primary care service with a date of service during the applicable performance year" from the eligible provider, which the agency says "reduces ACOs' burden in the patient matching necessary to report Medicare CQMs because the list of beneficiaries eligible for Medicare CQMs will have greater overlap with the list of beneficiaries that are assignable to an ACO."

And the Shared Savings Program extreme and uncontrollable circumstances (EUC) policies will now be extended to any ACO that is affected by an EUC "due to a cyberattack, including ransomware/malware," in performance year 2025 and subsequent performance years. — *Roy Edroso* (*roy.edroso@decisionhealth.com*) ■

Medicare Diabetes Prevention Program

MDPP gets easier, but providers don't get a pay raise

CMS has kept most of the changes from the proposed rule that would make the Medicare Diabetes Prevention Program (MDPP) easier on suppliers and participants alike, though it remains to be seen whether that raises the program's low adoption rates despite persistent low payment rates.

In the final rule, CMS admits that "participation in MDPP has been low, with less than 1 percent of eligible beneficiaries participating in the program." About 10,000 out of an estimated 9.3 million eligible beneficiaries took part in the program over its first six years of eligibility.

The time would seem ripe for change, as the Centers for Disease Control and Prevention (CDC) altered its Diabetes Prevention Recognition Program (DPRP) — the basis of MDPP — in June, and Trump's director of the Center for Medicare and Medicaid Innovation (CMMI), Abe Sutton, has singled out the program for attention (*PBN 6/2/25*, *8/4/25*).

Key among the streamlining measures is the extension of the flexibilities allowed during the COVID-19 public health emergency (PHE) through 2029. This means "MDPP suppliers may provide virtual services as long as they are provided in a manner consistent with the CDC DPRP standards for distance learning," either in-person, through distance learning, or through a combination of the two.

CMS also will allow, on a "test" basis in the same period, asynchronous sessions, or sessions "delivered 100 percent through the internet via smartphone, tablet, or laptop in an asynchronous (non-live) classroom where participants are experiencing the content on their own time without a live (including non-artificial intelligence (non-AI)) Coach." They call this the program's "online" delivery mode.

Those doing online MDPP must show adherence via "documented completion of videos/presentations and other learning modules in the application; knowledge checks (multiple choice or short answer); participant contributions to group discussions on a community board; and participant responses to the Coach via email, text message, or in-app messaging." Also, suppliers can't mix a participant's online program with in-person and distance learning sessions.

CMS also will continue to allow beneficiaries to restart their MDPP program beyond the original once-per-lifetime cap if their services were interrupted by the PHE. Otherwise, it is still considered a once-per-lifetime benefit, though they hint this might change in the future.

The weigh-in requirement, as proposed, is shifted so that the beneficiary can either send an image of their body and their weight on a digital scale in one time-stamped photo, or send two images, one showing weight on the digital scale, and another showing "the beneficiary visible," both date-stamped. And patients can send this from sites other than their home. But while the proposed rule would have allowed a seven-day gap between a scheduled MDPP session and delivery of a documented weight tally, the final rule limits this to five days.

While CMS wants to get the MDPP numbers up and, to that end, is allowing suppliers who offer online sessions not to have live in-person sessions at all (and also chose not to cap the number of participants per supplier), the agency has not increased payments

substantially. While payment for **G9880** (5% Weight-Loss [WL] Achieved from baseline weight) has gone from $149 to $153, **G9881** (9% WL Achieved from baseline weight) rises only one dollar to $27 and **G9888** (Maintenance 5% WL from baseline weight in months 7-12) is flat at $8 per service.

And, as CMS acknowledges, the rate of $18 for **G9871**, the online version of **G9886** (Behavioral counseling for diabetes prevention, in-person, group, 60 minutes) and **G9887** (… ; distance learning, group, 60 minutes), "represents a 28 percent reduction that translates to 21 percent lower maximum program payments, compared to $26 for in-person and distance learning modalities."

In response to complaints about this after the proposed rule, CMS says that "this rate reflects the unique operational characteristics of Online delivery, including reduced overhead costs due to the elimination of physical location requirements during the Online delivery period, while maintaining the required live Coach interaction associated with each session." — *Roy Edroso* (roy.edroso@decisionhealth.com) ■

Physician fee schedule

2026 PFS round-up: CMS quiet on dental updates, work RVU changes

The final 2026 Medicare physician fee schedule, released Oct. 31, delivers major payment and policy updates that take effect in 2026. Take a closer look at some of the more under-the-radar regulatory changes coming in the new year.

No dental coverage changes. Medicare doesn't cover dentistry as such, but since 2024 it has covered certain dental procedures that are "inextricably linked" to covered conditions (*PBN 11/20/23*). CMS received a few submissions on the topic, though the agency did not specifically request coverage; for example, four submitters "expressed the concern that the absence of treatment of chronic dental infections could complicate covered medical treatment for the management of diabetes-associated retinopathy and nephropathy." Ultimately, CMS said it would "take the information and recommendations submitted into consideration for the future."

Work relative value units (RVU) remain the same. CMS stuck to the work relative value units it proposed for codes that will go into effect Jan. 1, 2026. The agency listed the new descriptors with placeholder codes in Table 19: CY 2026 work RVUs for new, revised and potentially misvalued codes in the proposed 2026 Medicare physician fee schedule. The final codes are in Table A-E12 of the final rule. To quickly match the placeholder codes to the reportable codes, see the file CY 2026 PFS Final Rule Placeholder codes to Final CPT codes, which was released with final rule.

New GPCIs, GAFs. The three-year deadline to reconfigure geographic practice cost indices (GPCI) has arrived, and some states, metropolitan areas, and non-metropolitan areas have their work, practice expense (PE) and/or malpractice (MP) GPCIs reduced, leading to lower geographic adjustment factors (GAF) showing the overall effect of these adjustments. Out of 110 states and metros/non-metros, 67 show a drop in GAF between 0.08% (e.g., San Francisco-Oakland-Hayward [Marin County], Calif.) and 1.61% (Southern Maine); 50 areas have a GAF floor lower than 1.0.

Most of the GAF leaders are either metro areas such are New York and Boston or non-metro areas in California, notwithstanding most of these have some of their GPCIs and even their GAFs adjusted down. The biggest gainer was Alaska which, by federal law, has its work GPCI fixed at 1.5; it clocked a 1.261 GAF despite drops in its PE (-1.48%) and MP (-6.93) GPCIs, and in its GAF (-0.71). Arkansas had the lowest GAF at 0.902; several commenters complained, but CMS responded that federal law "requires us to review, and if necessary, adjust the GPCIs at least every 3 years, therefore CMS does not have the authority to freeze the CY 2025 GPCIs."

Drugs and biologicals mixed on BFSFs. CMS did not finalize parts of its biggest proposals in this section of the final rule. In the proposed rule, it had addressed "bona fide service fees" (BFSF) paid by drug manufacturers "for a bona fide, itemized service actually performed on behalf of the manufacturer," and floated establishing a methodology to determine whether fair market value (FMV) has been paid for such services or whether they amount to price concessions for purposes of calculating average sales price (ASP) under Medicare Part B (*PBN 8/4/25*). — *Roy Edroso* (roy.edroso@decisionhealth.com) *and Julia Kyles, CPC* (julia.kyles@decisionhealth.com) ■

Editor's note: *Visit www.partbnews.com to discover additional updates about the final 2026 Medicare physician fee schedule, including changes for federally qualified health centers (FQHC) and rural health clinics (RHC).*