NEWS & INSIGHTS

# CMS issues CY 2026 MPFS final rule

November 5, 2025
News & Insights

CMS recently issued the calendar year (CY) 2026 Medicare Physician Fee Schedule (MPFS) final rule to outline upcoming changes to physician reimbursement, telehealth requirements, quality programs, and more. The finalized policies are set to take effect on January 1, 2026.

As required by statute, the final rule includes two separate conversion factors (CF) for qualifying and non-qualifying alternative payment model (APM) participants. For CY 2026, the CF will be $33.57 for qualifying APM participants and $33.40 for non-qualifying APM participants, representing projected increases of 3.77% and 3.26% from the CY 2025 CF, respectively. CMS finalized its proposal to apply a -2.5% efficiency adjustment to the work relative value units for non-time-based services. In addition, the agency finalized significant updates to its practice expense methodology.

CMS is moving ahead with its efforts to streamline processes for adding services to the Medicare Telehealth Services List. The agency will remove the distinction between provisional and permanent services, and it will limit its review on whether the service can be furnished using an interactive, two-way audio-video telecommunications system.

Along with making this change, CMS finalized a policy to permanently remove telehealth frequency limitations for subsequent inpatient visits, subsequent nursing facility visits, and critical care consultations. In addition, the agency authorized rural health clinics and federally qualified health centers to continue billing for non-behavioral health services furnished via telecommunication technology through December 31, 2026.

To decrease Part B spending on skin substitutes, CMS finalized a policy to separately pay for these products as incident-to supplies in both non-facility and hospital outpatient settings. CMS will create three payment groups for skin substitutes based on their FDA regulatory categories. The agency intends to propose separate rates for each group in future rulemaking, but for CY 2026, it established an initial payment rate of $127.28 for all three categories.

CMS finalized its proposal to establish the Ambulatory Specialty Model. Set to launch in 2027 and run for five performance years, the new mandatory payment model will focus on specialty care in the outpatient setting for beneficiaries with heart failure and lower back pain.

The CY 2026 MPFS final rule also includes expanded payment policies for digital mental health treatment, new add-on codes for Advanced Primary Care Management services, and more. Revenue cycle professionals can view CMS' press release and fact sheet for more information. Click here to view CMS' fact sheet on key changes to the Medicare Shared Savings Program in CY 2026.

Related Topics:
Billing and reimbursement, Coding, Medicare news, OPPS

# OIG identifies gaps in Medicare’s bundled payment rates for OUD treatments

November 12, 2025
News & Insights

Medicare could have saved over $300 million if CMS’ bundled payment rates for opioid use disorder (OUD) treatment services had reflected the types and frequency of services actually provided to enrollees, according to a recent Office of Inspector General (OIG) audit report.

CMS established Part B coverage of OUD treatment services furnished by opioid treatment programs (OTP) in 2020 and defined its methodology for bundling payments. The bundle combines payments for a drug component and a non-drug component, which includes the following services:

- The dispensing and administration of OUD medications
- Substance use counseling
- Individual group therapy
- Toxicology testing

To bill for this bundled payment, OTPs must provide at least one OUD treatment service for the episode of care.

The OIG set out to analyze CMS’ bundled payments for OUD treatment services and determine whether services provided to enrollees complied with certain Medicare requirements. The audit covered nearly 2.7 million Part B paid claim lines representing over $560 million in bundled payments with dates of services from January 1, 2020, through September 20, 2022, for OUD treatment services billed with Healthcare Common Procedure Coding System (HCPCS) codes G2067, G2068, and G2074. These three codes represented more than 99% of the total Part B bundled payments during the audit period, according to the OIG.

The OIG reviewed a random sample of 100 claim lines associated with 79 different OTPs. For each sample item, it determined the type of drug, types of OUD treatment services, and frequency of services to calculate a revised payment rate for these services. The OIG also reviewed whether the supporting documentation included a treatment plan, as well as whether the plan listed the frequency of services.

For 89 sample items, the bundled payments were higher than the OIG-calculated amounts based on the OUD services provided by OTPs to enrollees. For 49 sample items, OTPs provided only medication and medication-dispensing services, but Medicare made the full bundled payment.

Overall, the bundled payments for the 100 sample items totaled $21,216, whereas the OIG calculated the total payments to be $9,901. The OIG estimated that Medicare could have saved $301.5 million (53% of total payments) during the audit period if CMS’ bundling methodology reflected the types and frequency of treatment services provided to enrollees.

Ten of the 100 sample items included OUD treatment services that did not comply with Medicare requirements. Three did not have an associated treatment plan covering the episode of care, and seven did not indicate the frequency at which an enrollee was to receive behavioral health services in the plan. The OIG estimated that CMS made 266,446 bundled payments during the audit period for episodes of care without an associated treatment plan or with a treatment plan that did not comply with Medicare requirements.

The OIG provided the following recommendations to CMS:

- Use the audit results and consider revising its methodology for determining the non-drug component of the weekly bundled payment rates
- Consider developing, within its statutory authority, additional HCPCS codes for the weekly bundles (e.g., codes reflecting services provided at lower frequencies)
- Work with other agencies to monitor whether or not OTPs have properly documented OUD treatment services in enrollees’ treatment plans

Review CMS’ web pages on OTPs and OUD screening and treatment for more information.

***Editor's note:*** *This article originally appeared in* Revenue Integrity Insider*, NAHRI's weekly e-newsletter.*

Related Topics:
Auditing and monitoring, Billing and reimbursement, Medicare news

# Apply to speak at the 2026 Revenue Integrity Symposium

November 19, 2025
News & Insights

Join us on the podium at the 2026 Revenue Integrity Symposium (RIS), to be held September 24-25, 2026, in Savannah, Georgia. The National Association of Healthcare Revenue Integrity (NAHRI) is now accepting proposals to speak at 2026 RIS. The deadline to apply is January 12, 2026.

RIS gathers innovative revenue cycle leaders together to learn, engage professionally and personally, and share best practices and knowledge that can be put to work immediately. We offer unmatched, focused educational opportunities across three tracks and an essential space to create deeper, more energizing connections.

**Suggested topics**

Whether you're an experienced speaker or are just starting out speaking at a conference, RIS is an excellent opportunity to share your insights with your peers.

We're seeking proposals on a variety of revenue integrity and revenue cycle topics, from analysis of regulations to case studies. Whether you're breaking down payer rules and regulations into clear, actionable steps or sharing lessons and successful projects from your facility, we want to hear from you.

We invite speakers to apply to present on all aspects of revenue integrity, revenue cycle, and Medicare compliance including, but not limited to, the following:

- Maintaining an up-to-date and compliant chargemaster and setting policies for charging for procedures and supplies
- Best practices for reducing payer denials and winning appeals
- Data-driven strategies for addressing revenue leaks and improving revenue cycle workflows
- Cross-functional programs, including stakeholders from across the revenue cycle and clinical leaders, to support revenue integrity and ensure accurate, complete reimbursement
- Current payer audit targets and strategies to protect revenue
- Strategies for complying with payer rules and regulations, such as patient status, price transparency, and more
- Improving a revenue integrity program using analytics, metrics, and key performance indicators
- Efficiently addressing NCCI edits and MUEs
- Methods for designing and implementing a revenue integrity program, developing workflows, setting goals, and staffing
- Understanding the impact of patient status and payer regulations
- Developing strategies for accurately documenting, coding, and billing patient encounters and stay

Keep in mind that RIS attendees represent a broad range of experience and backgrounds, so don't hesitate to submit proposals that are geared toward advanced or beginner audiences. However, when crafting your proposal, do take time into consideration: educational sessions are 60 minutes total but at least five to 10 minutes must be reserved at the end for Q&A, meaning speakers have 50-55 minutes of presentation time. You must be prepared to fill the entire time allotted to your session. You are welcome to apply with a co-speaker; however, we recommend a maximum of two speakers per session.

Individuals selected to speak at RIS will be notified in February 2026.

**How to apply**

Before applying, please ensure you are prepared with the following:

- Presentation information, including an outline/abstract or agenda, brief synopsis draft version or example of a previous presentation, learning objectives, title, and audience level with rationale
- A brief statement explaining why you are qualified to present on your topic and previous speaking experience

The deadline to submit your application is January 12, 2026. Please complete all fields. Leaving the form open for a lengthy period of time may cause it to time out, so it's advised to draft your submission in a separate document and paste it into the appropriate fields.

Speakers are welcome to submit more than one session but must fill out a separate form for each submission.

NAHRI will waive admission fees for all selected speakers, including up to one co-speaker per session. However, 2026 RIS speakers and co-speakers will be responsible for the cost of their own travel, accommodations, and meals.

The NAHRI Networking and Events Committee will begin reviewing applications in January 2026, so apply here today!

Related Topics:
Billing and reimbursement, Denials and appeals

# CMS releases 2026 OPPS final rule

November 26, 2025
News & Insights

CMS moved ahead with significant expansions to its site-neutral payment policies, including reductions to payments for certain services at expected off-campus provider-based departments (PBD), additional price transparency requirements, changes to its methodology for setting MS-DRG rates, and more, according to the 2026 Outpatient Prospective Payment System (OPPS) final rule.

CMS finalized a 2.6% increase to OPPS payments for 2026. The agency also finalized its proposal to expand its site-neutral payment policy to include drug administration services furnished at excepted off-campus PBDs. For 2026, the agency will apply the Medicare Physician Fee Schedule (MPFS) rate to any drug administration Healthcare Common Procedure Coding System (HCPCS) reported at excepted off-campus PBDs.

In another move toward site neutrality, CMS will begin to phase out the inpatient-only list starting in 2026. The list will be phased out over three years. Procedures removed from the inpatient-only list will be exempt from medical review audits related to the 2-midnight policy. The exemption policy would be in effect until CMS determines that the procedure is more commonly performed in the outpatient setting among Medicare beneficiaries.

CMS finalized its proposal to unpackage skin substitute products when paid under the OPPS and establish Ambulatory Payment Classifications (APC) based on product characteristics. Similar to the 2026 MPFS final rule, the agency will align skin substitute categorization with the product's FDA regulatory status. For 2026, CMS will use a single payment rate based on the highest average for the three FDA categories of skin substitute products. Different payments may be created for the three categories in future rulemaking. These policy changes apply to both physician office settings and hospital outpatient departments.

CMS is moving ahead with its proposal to median payer-specific negotiated charges, as reported on the Medicare cost report, to calculate MS-DRG relative weights beginning in fiscal year 2029.

CMS made some modifications to its proposals for hospital price transparency policies, but generally finalized them. Starting January 1, 2026, hospitals must disclose the tenth, median, and ninetieth percentile allowed amounts in their machine-readable files when payer-specific negotiated charges are based on percentages or algorithms. Hospitals would also be required to include the count of allowed amounts used to determine the percentiles. CMS also made changes to attestation requirements and additional technical requirements.

The final rule details numerous other changes that will have meaningful impacts on hospital operations. Along with publishing a fact sheet and press release on the final rule, CMS released a separate fact sheet on hospital price transparency policy changes.

***Editor's note:*** *A version of this article originally appeared in* Revenue Integrity Insider*, NAHRI's weekly e-newsletter.*

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