ATA and ATA Action CY2026 Medicare Physician Fee Schedule (PFS) Proposed Rule vs. Final Rule Comparison Chart
November 18, 2025

The Medicare Physician Fee Schedule (PFS) is an annual top priority for ATA and ATA Action. The PFS sets coverage and reimbursement rates for all Medicare services, including virtual care, for the coming year. Many private payors, Medicaid contractors, and other stakeholders across the country rely on the Medicare PFS to help shape their benefit plans.

This chart compares the proposed rule and the final rule and incorporates the ATA's comments.

Policy	Proposal	ATA/ATA Action Comments	Final Rule
Box 32: Provider Address Location	Didn't address the current flexibility allowing providers that render telehealth services to list their affiliated practice address rather than their home address on Medicare enrollment and billing forms. This is set to expire on December 31, 2025.	ATA urged CMS to extend the flexibility after December 31, 2025 and work towards a permanent solution.	CMS linked to an FAQ outlining how providers can suppress their address on Medicare forms and clarified that clarify in the future any updates to this policy will be issued via subregulatory guidance.
Medicare Telehealth Codes List	Revise the 5-step review process for reviewing requests to the Medicare Telehealth Services List. Remove step 4 (Consider whether the service elements of the requested service map to the service elements of services on the list that has a permanent status described in previous final rulemaking) and step 5 (Consider whether there is evidence of clinical benefit analogous to the clinical benefit of the in-person	ATA supported these proposals and urged to finalize.	Finalized as proposed

	service when the patient, who is located at a telehealth originating site, receives a service furnished by a physician or practitioner located at a distant site using an interactive telecommunications system) from our review criteria and retain steps 1 through 3. Under this update, all services on the Medicare Telehealth Services List would be considered included on a permanent basis. Proposed to add codes to Medicare Telehealth Services list: • CPT code 90849 (*Multiple-Family Group Psychotherapy*) • CPT code G0473 (*Face-to-face behavioral counseling for obesity, group (2 to 10), 30 minutes*) • CPT code G0545 (*Visit complexity inherent to hospital inpatient or observation care associated with a confirmed or*	ATA supported the addition of these codes.	Finalized as proposed.

	suspected infectious disease) • CPT codes 92622 (*Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; first 60 minutes*) and 92623 (*Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; each additional 15 minutes* Proposed not to add: • CPT codes 90935 (*Hemodialysis procedure with single evaluation by a physician or other qualified health care professional*), 90937 (*Hemodialysis*), 90945 (*Dialysis procedure other than hemodialysis*, and 90947 (*Dialysis*	ATA didn't comment.	Finalized as proposed.

	procedure other than hemodialysis • Home INR Monitoring (HCPCS code G0248) • telemedicine E/M services (CPT codes 98000 through 98015) Proposed to delete from list: • HCPCS code G0136	ATA didn't comment.	CMS decided not delete this code from the list.
Telehealth Frequency Limitations	Permanently remove frequency limitations on furnishing these services via telehealth for the following codes relating to Subsequent Inpatient Visits, Subsequent Nursing Facility Visits, and Critical Care Consultation Services.	ATA supported this proposal.	Finalized as proposed.
Virtual Direct Supervision	Permanently adopt 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 described at § 410.26, except for services that have a global surgery indicator of 010 or 090.	ATA supported this proposal.	Finalized as proposed.

Virtual Direct Supervision	Proposed not to extend CMS current policy to allow teaching physicians to have a virtual presence for purposes of billing for services furnished involving residents in all teaching settings through December 31, 2025. Proposed for services provided within MSAs, physicians must maintain physical presence during critical portions of all resident-furnished services to qualify for Medicare payment, not just in-person services, ensuring consistent oversight standards.	ATA urged CMS to extend the current flexibility that continues to allow virtual supervision within all training locations including MSAs.	Finalized 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 different locations). This will continue to permit teaching physicians to have a virtual presence during the key portion of the Medicare telehealth service for which payment is sought, through audio/video real-time communications technology, for all residency training locations.
Medicare Diabetes Prevention Program (MDPP)	Proposed to: • extend flexibilities allowed during the PHE for COVID-19 through December 31, 2029 • to test the inclusion of an asynchronous delivery modality through December 31, 2029. • allow MDPP suppliers to deliver the Set of MDPP services Online through December 31,	ATA supported these proposals.	Finalized as proposed. Note: Finalized that MDPP suppliers may not mix delivery modalities by billing for a combination of Online, In-Person, and Distance learning sessions during the Online delivery period.

	2029, clarify that MDPP suppliers are not required to maintain in-person delivery capability through December 31, 2029 These changes are expected to expand beneficiary access to MDPP, reduce barriers to participation, improve MDPP session attendance and retention, and promote safety.		
Remote Monitoring	Proposed to adopt CPT codes describing 2 to 15 days of monitoring (both RTM & RPM) and the first 10 minutes of treatment management services.	ATA supported this proposal.	Finalized as proposed.
	Proposed valuations (for the above codes) that were lower than the RUC recommendations.	ATA urged CMS to reimburse for these codes at a fair rate understanding that rates for remote monitoring services have been decreasing over the years.	Finalized as proposed.
	No mention of place of service clarification for RM services.	ATA asked the Agency for guidance explaining when the POS 10 code should be utilized rather than POS 11 code, and whether one code is always applicable to remote monitoring services versus the other.	CMS clarified that for RPM, RTM, and DMHT services POS is not applicable. POS is only for telehealth services subject to section 1834m.

Digital Mental Health Treatment Codes (DMHT)	Expand existing DMHT device code to include an additional classification for ADHD devices.	ATA supported but suggested that the codes be further expanded to other PDTs that treat mental health conditions, and that some mechanism be created to allow for distinguishing between the condition treated by the device. For example, a new code for each FDA classification and a modifier for use with classifications that treat more than one condition.	Finalized as proposed.
	CMS will continue with contractor pricing of DMHTs	ATA detailed issues with MACs and requested guidance be provided by agency to MACs.	In response to the request for MAC guidance, CMS will work with the MACs to improve the understanding of the billing rules for HCPCS code G0552. CMS still does not believe it has enough information to appropriately establish a national price for DMHT devices and therefore will continue with contractor pricing as proposed.
	CMS clarified that the ordering/prescribing practitioner need not be the diagnosing practitioner.	ATA was grateful CMS made this clarification.	Finalized as proposed.
In Home Testing	Proposed rule didn't address in-home testing.	ATA urged CMS to consider coverage and payment policies that enable a patient or their care-giver to collect specimens and perform diagnostic tests in their home. Further, we suggested that CMS appropriately reimburse for the time spent and cost incurred by health care providers in connection with a patient's in-home specimen collection and testing.	Not addressed in final rule.

Advanced Primary Care Management Codes	Proposed to create three new G-codes to be billed as add-on services when the APCM base code (HCPCS codes G0556, G0557, and G0558) is reported by the same practitioner in the same month.	ATA supported but asks that it not be limited to primary care.	Finalized as proposed. ATA's comment was not addressed.
Requests for Information	Seeking comments on additional coverage of digital tools, including SaaS.	ATA supported expansion of digital health coverage under existing benefits and urged focus on FDA regulated devices and evaluation of technology use and regulatory burden rather than one size fits all approaches. We also suggested a task force to further evaluate complex technologies and payment policies.	No response to SaaS comments and limited response overall. Notably, CMS said the following regarding expansion of the DMHT codes: "Since the resource costs reflected in the practice expense should be lower for services involving digital tools that do not require FDA clearance, approval, or authorization or meet the condition of payment that the billing practitioner bears the cost of supplying the DMHT device for HCPCS code G0552, we anticipated that the corresponding valuation for any additional coding would be appropriately lower than G0552."

Requests for Information	Seeking comments on medically tailored meals.	ATA encouraged CMS to create HCPCS codes (akin to those S and B codes used for medical foods) for MTMs and MTGs and allow flexibility for providers (e.g., PCPs, Registered Dietitians, and other specialty care providers) to be eligible to bill for the services separately. We also supported CBO referral and involvement and answered the RFI questions.	CMS didn't respond specifically to any of the RFI comments. But, below are other mentions related to medically tailored meals and nutrition in the PFS: "MDPP suppliers have the flexibility to provide Beneficiary Engagement Incentives (BEIs) to support program goals. Since medically tailored meals are considered a BEI, we are not revising the MDPP payment methodology to separately account for medically tailored meals at this time." Additionally, CMS revised the code descriptor to the following text: *G0136—[Administration of a standardized, evidence-based assessment of physical activity and nutrition, 5-15 minutes, not more often than every 6 months].*