CAPITOL STREET

July 15, 2026

MedTech Pay & Policy in Proposed '27 Physician Rule

CF Cuts Result in Lower Pay for Most Procedure Codes

Relevant Companies

Our Take & Next Up

The CY 2027 Physician Fee Schedule (PFS) proposed rule (here) contains statutorily mandated cuts (-1.2% to -1.7%) to the Conversion Factor (CF), resulting in reimbursement cuts to most procedure codes. Medicare's PFS CF is set to decline -1.2% to -1.7% by statute, though Congress could mitigate the cut in a year-end spending package, as it has in prior years. The rule also includes a proposal to limit remote physiologic monitoring/remote therapy monitoring services (DRIO, OMDA, PRVA) and a request for information (RFI) on duplicate imaging/lab tests (DGX, GEHC, LH, PHG, SIEGY). See co-specific commentary below: CVRX, GKOS, INSP, and NYXH. The final PFS rule is expected in late October/early November and new policies are effective Jan. 1, 2027.

Key Points

The expiration of a temporary 2.5% payment increase to Medicare physician payments from CY 2026 results in an overall pay cut for most procedure codes in CY 2027. CMS proposes a Conversion Factor (CF) reduction of -1.2% (for qualifying alternative payment models) and -1.7% (for non-qualifying APMs). This reflects a partial offset of the expiring 2.5% payment bump via statutory updates (+0.75% qualifying, +0.25% non-qualifying) and a budget neutrality adjustment (+0.53%). The CF is the main input in the reimbursement calculation for all PFS codes.

The CF cut could be moderated by Congress in a year-end spending bill, with Congress eyeing more comprehensive physician pay reform in 2027, but we view this as a patch at best. A bipartisan *MACRA* bill from Reps. Schrier (D-WA) and Joyce (R-PA) would tie the CF to the Medicare Economic Index (MEI) and streamline the Merit-based Incentive Payment System (MIPS) and could be a potential lame duck vehicle to watch alongside the rule (our take here).

The '27 PFS rule contains a broad range of pay raises and cuts to various subspecialties and generally favors Behavioral Health & some Primary Care (as well as Rad Onc, Vasc Surgery) over Specialty Care (Dermatology, Orthopedic Surgery). Primary care increases are seen in Geriatrics (+4%), General Practice (+2%), and Nurse Practitioners (+2%). Most other categories hover around the -1% to +1% range, with some categories seeing no percent change at all.

- Some of the largest Specialty increases are seen in Clinical Social Work (+12%), Clinical Psychology (+11%), Vascular Surgery (+3%), Radiation Oncology (+3%), and Interventional Radiology (+3%), and
- Some of the largest Specialty decreases are seen in Dermatology (-9%), Otolaryngology (-9%), Orthopedic Surgery (-7%), Colon/Rectal Surgery (-4%), Plastic Surgery (-4%), and Urology (-2%).

CMS is also seeking comments on how it might reconsider primary care service valuation to "better support [its] objectives of shifting the U.S. healthcare system toward a focus on preventive rather than reactive medicine." CMS wants to expand on previous work to improve primary care valuation in the PFS, as well as CMS Innovation Center Models and is seeking comments on three main topics: 1) reconsidering relative primary care payment in the PFS; 2) understanding the payment implication of including technology in primary care; 3) establishing prospective primary care payment in the Medicare Shared Savings Program and potentially in the Original Medicare program broadly.

PRACTICE EXPENSE CHANGES

CMS is proposing to continue replacing its outdated 2007-based practice expense (PE) formula with a more current methodology designed to better reflect current costs and reduce large year-to-year payment swings. For CY 2027, CMS proposes to lower the PE portion of payment for visits provided during a Medicare Part A skilled nursing facility stay to match its site-of-service payment policy. Recall, CMS in CY 2026 changed its PE methodology using hospital outpatient data to set more precise pay, versus survey data from the American Medical Association (AMA), which we saw as a "poke" at the often-criticized Relative Value Update Committee (RUC) - our prior take here.

DEVICE-SPECIFIC PROPOSALS: CVRX, GKOS, INSP, NYXH

The physician reimbursement code associated with INSP's Inspire V and NYXH's Genio (64568) is down almost -9%. According to INSP, Medicare contractors direct physicians to bill using CPT 64582 for Inspire V, which is down from $723 to $706, or -2.4%. According to the company; however, commercial insurers use CPT 64568, which is down from $660 to $603, or -8.6%. The difference in payment between 64582 and 64568 in the proposed CY 2027 PFS rule is about $100 (the delta was previously about $70 in CY 2026).

Recall, new "C codes" for INSP's Inspire V (C8007) and NYXH's Genio (C8011) were up +12% for CY 2027 in the outpatient hospital (OPPS) setting and +17% in the ambulatory surgery center (ASC) setting compared to the CY 2026 payment for CPT code 64582 (our take here). The proposed CY 2027 reimbursement for C8007 and C8011 was up to $35,414 in the OPPS setting (compared to the prior rate of $31,526) and $31,722 in the ASC setting (compared to the prior rate of $27,161). Recall, CMS in February announced the creation of C codes (effective Jan. 1, 2026) to be used with Hypoglossal Nerve Neurostimulator (HGNS) procedures with the facility payment equal to the Inspire IV CPT code 64582.

INSP may still be seeking a dedicated CPT code for INSP's single-lead system. However, the process for getting a new CPT code is lengthy and INSP's request for a new code was recently rejected by the AMA CPT Panel in May 2026 (here). There is one more opportunity for a new code for Jan. 1, 2028 at the CPT Editorial Panel meeting on Sept. 17-19, 2026 (Minneapolis, MN).

CVRX's Barostim reimbursement code (64654) is down -1%. The physician reimbursement for Barostim (64564) is down from $562 in CY 2026 to $557 in CY 2027 (proposed). Recall, the proposed CY 2027 OPPS

reimbursement for Barostim (64654) remained in the same APC (1580), providing stability with a reimbursement rate of $45,000 (our take here).

GKOS iStent reimbursement code (66991) is down -3%. While the physician payment for iDose (0660T, 0661T) is carrier priced, the reimbursement for iStent (66991) is down from $585 in CY 2026 to $565 in CY 2027 (proposed). Recall, the proposed CY 2027 OPPS reimbursement for iDose (0660T, 0661T) remained in the same APC (5492) with a payment rate of $4,827, up from $4,223 in last year's rule. The OPPS rate for iStent (66991) also remained in APC 5493 and was up from $5,437 in CY 2026 to $6,143 in CY 2027 (proposed) - our take here.

REMOTE MONITORING: DRIO, OMDA, PRVA

CMS is proposing to limit remote physiologic monitoring (RPM) and remote therapy monitoring (RTM) services to established patients, which would reduce utilization. If finalized, CMS would require starting Jan. 1 an initial in-person or billable visit before monitoring begins and paying for these services only when provided by a practice's own clinical staff, not outside contractors. CMS also proposes lowering payment rates to reflect lower device costs and is considering replacing current CPT codes with four new Medicare G-codes to address oversight concerns raised by the HHS Office of Inspector General (OIG).

RFI ON DUPLICATE IMAGING, LAB TESTS: DGX, GEHC, LH, PHG, SIEGY

CMS is issuing a request for information (RFI) to inform potential actions aimed at addressing interoperability and duplicate testing. CMS notes that imaging data and lab test results are often siloed within the acquiring systems' electronic health record and inaccessible outside of those systems. The agency also notes that it's exploring the following mechanisms for addressing duplicative payments.

- Clarifications to billing instructions to labs and imaging centers on parameters of duplicate lab or imaging tests;
- Local Medicare Administrative Contractor (MAC) edits resulting in non-payment or pay reductions for duplicate lab or imaging tests;
- Use of payment integrity levers to recoup payments from providers and suppliers who performed duplicate lab or imaging tests; and
- Application of frequency limits to certain tests where clinically appropriate

Medicare's CRUSH RFI from February also seeks to prevent waste, fraud, and abuse in diagnostic lab testing with rulemaking expected in October. CMS may release a proposed rule related to the CRUSH RFI in October 2026, according to the White House Office of Management and Budget's (OMB) unified agenda released in early July (here). The OIG is also investigating genetic test fraud, which we believe will lead to more regional oversight (our take here).

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