2027 Finalized Medicare Physician Fee Schedule Rule Summary for Addiction Medicine

On November 6, 2026, the Centers for Medicare & Medicaid Services (CMS) issued a final rule to revise calendar year (CY) 2027 payment policies under the Medicare Physician Fee Schedule (PFS) and make other changes to Medicare Part B payment and coverage policies.

A summary of the finalized policies that affect addiction medicine practice is provided below.

A fact sheet from CMS can be found here.

Conversion Factor

Beginning in 2026, Medicare uses two PFS conversion factors (CFs): one for qualifying Alternative Payment Model (APM) participants and one for those billing Medicare who are not qualifying APM participants. The CY 2027 qualifying APM CF is $32.95 and the non-qualifying APM CF is $32.63. Compared to the CY 2026 CFs, that is a 1.83% CF reduction for qualifying APM participants and 2.31% for non-qualifying clinicians.

Table 1: Finalized 2027 payment rates for top 10 services billed by clinicians treating addiction

Rank	Code	Service	2027 non-QP rate	Change from 2026	2027 QP rate	Change from 2026
1	99214	Established-patient office/outpatient visit, moderate MDM	**$131.17**	**-3.3%**	**$132.48**	**-2.8%**
2	99213	Established-patient office/outpatient visit, low MDM	**$92.01**	**-3.3%**	**$92.93**	**-2.9%**
3	G2087	Subsequent-month office-based OUD treatment bundle	**$440.81**	**-0.5%**	**$445.22**	**-0.0%**
4	99215	Established-patient office/outpatient visit, high MDM	**$183.37**	**-4.7%**	**$185.21**	**-4.2%**
5	90833	Psychotherapy with E/M, 30 minutes	**$87.77**	**7.7%**	**$88.65**	**+8.2%**
6	G0439	Subsequent annual wellness visit	**$131.49**	**-4.7%**	**$132.81**	**-4.2%**
7	99232	Subsequent hospital inpatient/observation care, moderate MDM	**$68.19**	**-3.2%**	**$68.88**	**-2.8%**

Rank	Code	Service	2027 non-QP rate	Change from 2026	2027 QP rate	Change from 2026
8	99489	Additional 30 minutes of complex chronic care management	**$76.35**	**-2.3%**	**$77.11**	**-1.8%**
9	99309	Subsequent nursing-facility care, moderate MDM	**$109.96**	**-4.0%**	**$111.06**	**-3.5%**
10	99490	First 20 minutes of chronic care management	**$63.63**	**-3.8%**	**$64.26**	**-3.3%**

Per the table above, ***almost all*** the top 10 services billed by clinicians treating addiction will see a payment ***decrease***, despite the increase in RVUs for some services.

Telehealth

The Consolidated Appropriations Act, 2026 extended key Medicare telehealth flexibilities through December 31, 2027. The statutory in-person visit requirements for mental health services furnished through telehealth are delayed until January 1, 2028, and Medicare may continue to cover audio-only telehealth services through the same date. These updates do not impact the special statutory exception for services furnished for the diagnosis, evaluation, or treatment of a substance use disorder which does not expire.

New Telehealth Claim Modifiers

Effective January 1, 2027, CMS is implementing two new modifiers (BB and BC) to identify telehealth services furnished by a telehealth platform owned by, contracted with, or paid by the billing practitioner, and telehealth services furnished incident to a physician's or practitioner's professional service. CMS notes that additional guidance on these modifiers is forthcoming.

Telehealth in FQHCs

Federal law extends the ability of Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) to serve as distant site telehealth providers through December 31, 2027. Non-behavioral health telehealth encounters continue to be paid using national average PFS payment amounts for comparable telehealth services. Mental health visits furnished through audio/video or qualifying audio-only technology continue to be paid under the RHC all-inclusive rate or FQHC prospective payment system rules.

Teaching Physicians Changes

Currently, Medicare policy allows a teaching physician to be virtually present during a Medicare telehealth service when the teaching physician, resident, and patient are each in different locations. For the 2027 payment year, CMS will expand its permanent virtual-presence policy to permit billing when either the resident or the teaching physician is physically present with the beneficiary and the other participates through real-time audio/video technology. This change would only apply to services on the Medicare Telehealth

Services List. The medical record would need to document whether and during which portion of the service the teaching physician was physically or virtually present, and the teaching physician would remain responsible for personal oversight and involvement in the portion of the case for which payment is sought.

CMS also finalized revisions to the primary care exception for services furnished by residents. CMS is removing language limiting the exception to lower and mid-level office/outpatient E/M visits. CMS can now specify additional E/M levels that residents may furnish in qualifying primary care centers under the direct supervision of the teaching physician, without the teaching physician's physical presence.

Psychotherapy

The CY 2027 payment year is the fourth and final year of the previously finalized phase-in of a 19.1% upward adjustment to the work RVUs for time-based psychotherapy services.

The table below outlines the finalized payment rates.

Table 2: Finalized national payment rates for psychotherapy services

Code	Service	2027 non-QP rate	Change from 2026	2027 QP rate	Change from 2026
90832	Psychotherapy, 30 min	$93.64	+9.1%	$94.58	+9.6%
90833	Psychotherapy + E/M, 30 min	$87.77	+7.7%	$88.65	+8.2%
90834	Psychotherapy, 45 min	$124.31	+9.1%	$125.56	+9.7%
90836	Psychotherapy + E/M, 45 min	$109.96	+6.5%	$111.06	+7.1%
90837	Psychotherapy, 60 min	$183.37	+9.8%	$185.21	+10.3%
90838	Psychotherapy + E/M, 60 min	$144.87	+6.0%	$146.32	+6.6%
90839	Crisis psychotherapy, first 60 min	$174.56	+8.9%	$176.31	+9.4%
90840	Crisis psychotherapy, each additional 30 min	$83.86	+8.7%	$84.69	+9.2%
90846	Family psychotherapy without patient, 50 min	$120.73	+14.0%	$121.93	+14.6%
90847	Family psychotherapy with patient, 50 min	$125.29	+14.4%	$126.55	+14.9%
90853	Group psychotherapy	$33.28	+9.5%	$33.61	+10.0%

Tobacco Cessation & SBIRT Services

CMS finalized a 19.1% psychotherapy-related work RVU adjustment to tobacco cessation and screening, brief intervention, and referral to treatment (SBIRT) services in CY 2027. CMS notes that these services have not been revalued for several years and that the increases would better recognize the clinical intensity and work associated with evidence-based interventions for unhealthy alcohol and substance use.

The table below outlines the new payment rates.

Table 3: Finalized national payment rates for tobacco cessation and SBIRT services

Code	Service	2027 non-QP rate	Change from 2026	2027 QP rate	Change from 2026
99406	Tobacco cessation counseling, 3–10 min	$16.64	+8.3%	$16.81	+8.8%
99407	Tobacco cessation counseling, >10 min	$32.30	+11.2%	$32.63	+11.7%
G2011	SBIRT, 5–14 min	$19.25	+10.8%	$19.44	+11.4%
G0396	SBIRT, 15–30 min	$41.44	+11.8%	$41.85	+12.3%
G0397	SBIRT, >30 min	$77.98	+15.6%	$78.76	+16.2%

Psychiatric Collaborative Care

CMS finalized a substantial revaluation of psychiatric Collaborative Care Model (CoCM) services to better account for the medical decision-making of the billing practitioner and psychiatric consultant and the work of the behavioral health care manager.

The table below outlines the new payment rates.

Table 4: Finalized national payment rates for psychiatric collaborative care services

Code	Service	2027 non-QP rate	Change from 2026	2027 QP rate	Change from 2026
99492	Initial psychiatric collaborative care management, first 70 minutes	$246.67	+53.9%	$249.14	+54.6%
99493	Subsequent psychiatric collaborative care management, first 60 minutes	$181.74	+25.4%	$183.56	+26.0%
99494	Additional 30 minutes of psychiatric collaborative care management	$86.79	+41.2%	$87.66	+41.9%

Code	Service	2027 non-QP rate	Change from 2026	2027 QP rate	Change from 2026
G2214	Initial or subsequent psychiatric collaborative care management, first 30 minutes	$90.38	+48.7%	$91.28	+49.4%
G0568	Initial psychiatric collaborative care management, one calendar month	$242.43	+50.0%	$244.85	+50.7%
G0569	Subsequent psychiatric collaborative care management, subsequent month	$183.05	+25.4%	$184.88	+26.0%

Visit Complexity Inherent to E/M Services

CMS has discontinued HCPCS add-on code G2211 and replaced it with two claim modifiers, B1 and B2, effective January 1, 2027.

Modifier B1 is reported under the same general circumstances as G2211: when an applicable office/outpatient or home/residence E/M service reflects the complexity inherent in care that serves as the continuing focal point for all of a patient's health care needs, or ongoing care for a single serious or complex condition. When appropriately reported, B1 increases payment for the underlying E/M service by 16%.

CMS stated that replacing the separately payable G2211 add-on code with a modifier more accurately identifies the qualifying E/M service, simplifies claim processing, and allows the additional resources associated with longitudinal care to be incorporated into payment for the underlying E/M service. **Addiction medicine clinicians who previously used G2211 for qualifying longitudinal SUD care should transition to the applicable modifier for services furnished beginning January 1, 2027.**

Modifier B2 provides a larger payment adjustment of 32% under specified circumstances involving certain accountable care arrangements.

Same-Day E/M Services and Procedures

CMS finalized a modified policy for separately identifiable office/outpatient E/M services furnished on the same day as certain procedures. Rather than the proposed 50% payment reduction for E/M services furnished with procedures having 0-, 10-, or 90-day global periods, CMS limited the policy to 0-day global procedures and will pay the lower-valued service at

80% of the otherwise applicable amount, while paying the higher-valued service at 100%. The final policy therefore substantially reduces the potential payment impact compared with the proposal. ASAM Comments on 2027 Proposed MPFS had urged CMS not to finalize the proposed 50% reduction, citing potential effects on integrated addiction, pain, primary, and psychiatric care.

Bundled Payments for SUD Treatment

CMS notes that interested parties have asked CMS to review the office-based SUD treatment bundles (G2086, G2087, and G2088) to address potential payment disparities between these office-based bundles and payments under the Medicare opioid treatment program benefit. Prior to the issuance of the proposed rule, ASAM highlighted similar concerns to CMS.

While CMS does not propose a specific payment or coding change to the bundles for the CY 2027 final rule, the agency notes that they will review the information received and consider updates to the rates and whether additional coding is needed to describe ASAM Level 1.7, medically managed outpatient treatment during future rulemaking cycles.

Consultative Services

As part of a broader request for information on redesigning primary care payment, CMS sought information on whether office/outpatient E/M visits should eventually be divided into distinct categories such as longitudinal care, acute care, and consultative care. CMS noted that consultative services generally address a specific clinical question and may involve substantial review and communication work that is not always reflected in the current E/M code set.

CMS sought input on how consultative visits should be defined, whether existing CPT consultation codes or other coding approaches should inform Medicare policy, what services and specialties should qualify, and how work RVUs, time, practice expense, and specialty utilization should be valued. CMS did not finalize any new policies in this domain and noted that changes in response to information received will be contemplated by CMS during future rulemaking cycles.

Behavioral Health and Care Management

The rule continues the payment framework under which RHCs and FQHCs may bill many care management and behavioral health integration services using the individual PFS codes rather than the former single G0511 bundle. Addiction medicine programs operating in or partnering with FQHCs should verify the applicable encounter, care management, telehealth, and cost-sharing rules for each service.