

CMS Proposed Rule:

2026 Medicare Physician Fee Schedule

ASAM Summary of Major Provisions

On July 14, 2025 the Centers for Medicare and Medicaid Services (CMS) issued a [Proposed Rule](#) which revises calendar year (CY) 2026 payment policies under the Medicare Physician Fee Schedule (PFS) and makes other policy changes.

CMS has also published a fact sheet on the 2026 Medicare PFS proposed rule, available [here](#).

A summary of the major proposed changes that impact addiction medicine are listed below.

Conversion Factor

The Medicare conversion factor (CF) is a number multiplied by relative value units (RVUs) to derive physician payment. Beginning in 2026 as required by statute, there will be two separate CFs: one for qualifying alternative payment model (APM) participants and one for non-qualifying practitioners. CMS proposes a CY 2026 Medicare CF of \$33.59 for qualifying APM participants, and a CY 2026 CF of \$33.42 for non-qualifying practitioners, an approximate 4% increase from the current CF for both. The nearly 4% increase outpaces the expected rise in practice cost inflation for 2026, which is estimated to be nearly 3%.

43% of codes billed by self-identified Addiction Specialist Physicians (ASPs) billing Medicare in 2024 will be subject to the efficiency adjustment. However, no efficiency adjustments are proposed for the top codes billed by ASPs in 2024, which collectively comprise about 71% of services billed to Medicare by ASPs in 2024. Those codes are:

1. 99214 (OFFICE/OUTPATIENT ESTABLISHED MOD MDM 30 MIN)
2. 99213 (OFFICE/OUTPATIENT ESTABLISHED LOW MDM 20 MIN)
3. G2211 (VISIT COMPLEXITY INHERENT TO E/M)
4. 99232 (SBSQ HOSPITAL IP/OBS CARE MOD MDM 35 MINUTES)
5. 99233 (SBSQ HOSPITAL IP/OBS CARE HIGH MDM 50 MINUTES)

The chart below shows the proposed national payment rates for non-qualifying APMs for these services in 2026:

HCPSC Codes	2025 National Non-facility Rate	2025 National Facility Rate	Proposed 2026 Non-facility Rate	Proposed 2026 Facility Rate	Non-Facility Changes (%)	Facility Changes (%)
99214	\$125.18	\$93.80	\$135.35	\$84.22	8.12%	-10.2%
99213	\$88.95	\$63.72	\$94.91	\$56.81	6.7%	-10.8%
G2211	\$15.53	\$15.53	\$17.38	\$14.37	11.9%	-7.5%
99232	-	\$76.34	-	\$70.52	-	-7.6%
99233	-	\$113.86	-	\$107.28	-	-5.8%
				AVG	8.9%	-8.3%

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Toplines on payment:

- Top 3 services billed by ASPs in non-facility settings are proposed to increase by an average of 9%
- Top 5 services billed by ASPs in facility settings set to see an 8% cut

Telehealth Services

In-person Requirement for Mental Health Visits

Beginning October 1, 2025, absent Congressional action, an in-person visit within 6 months before the initiating telehealth-based mental health visit will be required, in addition to subsequent in-person visits every 12 months thereafter, unless the patient and clinician agree that the risks and burdens of an in-person visit outweigh the benefits. **This requirement does not apply to visits for SUD treatment, or co-occurring mental health/SUD treatment services.**

Changes to the list of telehealth services

Federal regulations allow CMS to update its policy for adding services allowable via telehealth. The agency updated its policy twice (2021 and 2024) since the COVID-19 pandemic and is proposing once again to modify its approach. This time, CMS proposes to simplify the current approach which assigns a status of “provisional” or “permanent” to codes, and instead consider all codes currently on the list as “permanent” to retain that status. CMS will consider whether to transition codes currently listed as provisional to permanent after further analysis.

CMS is proposing to delete G0136 (*Administration of a standardized, evidence-based social determinants of health risk assessment tool, 5 to 15 minutes*) as a Medicare-covered service, and therefore remove it from the list of covered telehealth services for 2026. Coverage remains for CY 2025. CMS is also proposing to permanently remove frequency limitations on furnishing the following services through telehealth, commonly billed by Addiction Specialist Physicians:

- 99232 (Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, 35 min)
- 99233 (Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, 50 min)

Audio-only Status Under the Definition of Telehealth

CMS finalized for CY 2025 that audio-only technology can be used to furnish **any** service on the Medicare telehealth list. The agency is not proposing any changes to that regulation for 2026, so services on the telehealth list may continue to be provide via two-way real-time audio-only technologies. Note that the list **does not** include services furnished in opioid treatment programs (OTPs) as these services described by those codes do not meet Medicare’s definition of a telehealth service.

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The full list of proposed services on the telehealth list can be found [here](#). It includes services such as evaluation and management services, psychotherapy, tobacco misuse counselling, office-based substance use disorder (SUD) treatment, chronic pain care, and more.

Direct Supervision

Behavioral Health Services

Beginning in 2023, Medicare began to allow clinicians to provide “general” supervision for behavioral health services furnished under their direction. In essence, this means that the supervising clinician who is eligible to bill Medicare directly for their services, has overall control and direction over the service, but does not need to be physically present during the performance of the service. CMS is not proposing any changes to that policy for 2026.

Non-behavioral Health Services

Currently, CMS allows certain services, including most incident-to services to be performed under direct supervision, meaning that the supervising physician or other supervising practitioner must be present in the office suite and “immediately available” to furnish assistance and direction throughout the performance of the procedure. Through December 31, 2024, the presence of the physician (or other practitioner) includes virtual presence through audio/video real-time communications technology (excluding audio-only). CMS is proposing to continue this status quo through 2025.

Beginning in 2026, CMS is proposing to redefine direct supervision for certain services to note that the presence of the physician (or other practitioner) includes virtual presence through audio/video real-time communications technology (excluding audio-only). The services that would be included under this definition include services furnished incident to a physician’s service when they are provided by auxiliary personnel employed by the physician and working under his or her direct supervision and for which the underlying HCPCS code has been assigned a PC/TC indicator of ‘5’ (meaning that it’s an incident-to service); and office and other outpatient visits for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional, such as CPT code 99211.

Services that do not fall in this category after 2025 would require direct supervision without the ability to provide this supervision via audio/video real-time communications technology.

Teaching Physician Services

CMS will formally sunset by the end of 2025, the current ability that allows teaching physicians have a virtual presence for purposes of billing for services furnished involving residents in all teaching settings when the service is furnished virtually (excluding audio-only). Beginning in 2026, teaching physicians must maintain physical presence during critical portions of resident-furnished services, with an exception for certain rural areas.

Advancing Access to Behavioral Health Services

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In last year's rulemaking, CMS established new payment and coding for the following services:

- Safety planning interventions;
- Post-discharge telephonic contacts intervention;
- Community Health Integration;
- Principal Illness Navigation;
- Advanced Primary Care Management (APCM);
- Digital Mental Health Treatment (DMHT); and
- Interprofessional Consultation Billed by Practitioners Authorized by Statute to Treat Behavioral Health Conditions.

CMS is proposing the following changes to those services:

The agency began making payment for behavioral health integration (BHI) services provided by a primary care team and psychiatric consultant in 2017. CMS also created new services for behavioral health care management. In the 2025 final rule, CMS established new codes describing APCM, a suite of extensive services provided by the primary care team.

For 2026, CMS is proposing to establish 3 new add-on codes to describe BHI services provided complimentary to APCM services to remove the time limitation on existing psychiatric collaborative care management services:

- *GPCM1: (Initial psychiatric collaborative care management, in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional)*
- *GPCM2: (Subsequent psychiatric collaborative care management, in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional)*
- *GPCM3: (Care management services for behavioral health conditions, directed by a physician or other qualified health care professional, per calendar month)*

The valuations for these codes if finalized would directly mirror analogous CPT codes.

CMS is seeking comments on:

- How should the agency account for cost sharing if APCM includes both preventive services and other Part B services?
- Whether CMS should consider including the Annual Wellness Visit, depression screening, or other preventative services in the APCM bundle, and if so, which services and why?
- Should CMS consider other changes to APCM or additional coding to further recognize the work of advanced primary care practices in preventing and managing chronic disease?

Motivational Interviewing

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CMS is seeking comments and feedback on a variety of questions related to motivational interviewing and whether the agency should adopt coding and payment for the service.

Principal Illness Navigation (PIN) and Community Health Integration Services (CHI)

CMS clarifies that marriage and family therapists, mental health counselors, and licensed clinical social workers may bill Medicare directly for PIN and CHI services. The proposal also clarifies that if these professionals are performing as auxiliary personnel under the general supervision of a billing practitioner, in the absence of state-level requirements to perform these functions, they meet the training and certification requirements.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

General Care Management

Beginning in 2025, rather than pay a weighted average of the compilation of individual CPT and HCPCS codes that bundled by HCPCS code G0511 (care management), Medicare now pays RHCs and FQHCs for billing the individual codes that make up G0511. CMS is now proposing to align care management services paid under the MPFS with care coordination services paid to FQHCs/RHCs.

CMS is proposing to extend that policy further to requiring FQHCs/RHCs to bill for psychiatric collaborative care management as standalone services.

Direct Supervision

CMS is proposing to permanently allow FQHCs and RHCs to provide direct supervision via virtual presence (audio/video real-time communications technology, excluding audio-only) for services that require direct supervision.

Telehealth

The requirement for individuals visiting FQHCs/RHCs for mental health reasons to have an in-person visit at least 6 months prior to a telehealth visit will begin January 2026. An exception remains for patients located in an eligible facility in a rural area or health professional shortage area. Telehealth visits for non-mental health reasons will continue to be covered until December 2026.

Medicare Coverage Guidance for Behavioral Health Services

For additional Medicare coverage guidance and other billing resources, click [here](#) for ASAM's list of resources.

If you have any comments, questions, or concerns about these proposals, please contact Corey Barton, Director of Practice Management and Regulatory Affairs at cbarton@asam.org.