2027 Proposed Medicare Physician Fee Schedule Rule Summary for Addiction Medicine

On July 16, 2026, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that would 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. Comments are due September 14, 2026.

A summary of the proposals that may affect addiction medicine practices 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. CMS estimates the CY 2027 qualifying APM CF at $33.1693 and the non-qualifying APM CF at $32.8409. Compared to the CY 2026 CFs, that is a 1.19% CF reduction for qualifying APM participants and 1.68% for non-qualifying clinicians.

Table 1: Proposed 2027 payment 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	$132.68	−4.7%	$134.00	−4.2%
2	99213	Established-patient office/outpatient visit, low MDM	$93.27	−4.6%	$94.20	−4.1%
3	G2087	Subsequent-month office-based OUD treatment bundle	$443.02	−2.2%	$447.45	−1.7%
4	99215	Established-patient office/outpatient visit, high MDM	$184.57	−6.5%	$186.41	−6.0%
5	90833	Psychotherapy with E/M, 30 minutes	$87.36	+4.9%	$88.23	+5.4%
6	G0439	Subsequent annual wellness visit	$133.33	−5.6%	$134.67	−5.2%

Rank	Code	Service	2027 non-QP rate	Change from 2026	2027 QP rate	Change from 2026
7	99232	Subsequent hospital inpatient/observation care, moderate MDM	$68.97	-2.1%	$69.66	-1.7%
8	99489	Additional 30 minutes of complex chronic care management	$76.52	−4.8%	$77.28	−4.3%
9	99309	Subsequent nursing-facility care, moderate MDM	$110.67	−5.6%	$111.78	−5.1%
10	99490	First 20 minutes of chronic care management	$64.04	−5.6%	$64.68	−5.1%

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 says 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. In the 2027 PFS, CMS proposes to 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 proposes to modify the primary care exception for services furnished by residents. CMS is proposing to remove language limiting the exception to lower and mid-level office/outpatient E/M visits. If finalized, CMS could 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 what those payment rates could look like if finalized.

Table 2: Proposed 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	$94.58	+10.2%	$95.53	+10.7%
90833	Psychotherapy + E/M, 30 min	$87.36	+7.2%	$88.23	+7.7%
90834	Psychotherapy, 45 min	$125.45	+10.1%	$126.71	+10.7%
90836	Psychotherapy + E/M, 45 min	$110.67	+7.2%	$111.78	+7.8%
90837	Psychotherapy, 60 min	$184.89	+10.7%	$186.74	+11.3%
90838	Psychotherapy + E/M, 60 min	$146.14	+7.0%	$147.60	+7.5%
90839	Crisis psychotherapy, first 60 min	$176.68	+10.2%	$178.45	+10.8%
90840	Crisis psychotherapy, each additional 30 min	$84.07	+9.0%	$84.91	+9.5%
90846	Family psychotherapy without patient, 50 min	$121.18	+14.5%	$122.39	+15.0%
90847	Family psychotherapy with patient, 50 min	$126.11	+15.1%	$127.37	+15.7%
90853	Group psychotherapy	$33.83	+11.3%	$34.16	+11.8%

Tobacco Cessation & SBIRT Services

CMS proposes to apply the full 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 proposed increases would better recognize the clinical intensity and work associated with evidence-based interventions for unhealthy alcohol and substance use.

The table below outlines what those payment rates could look like if finalized.

Table 3: Proposed 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	**$17.08**	**+11.2%**	**$17.25**	**+11.7%**
99407	Tobacco cessation counseling, >10 min	**$32.51**	**+11.9%**	**$32.84**	**+12.4%**
G2011	SBIRT, 5–14 min	**$19.38**	**+11.6%**	**$19.57**	**+12.1%**
G0396	SBIRT, 15–30 min	**$41.38**	**+11.6%**	**$41.79**	**+12.2%**
G0397	SBIRT, >30 min	**$78.49**	**+16.3%**	**$79.27**	**+16.9%**

Psychiatric Collaborative Care

CMS proposes 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 what those payment rates could look like if finalized.

Table 4: Proposed 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	$225.29	+40.5%	$227.54	+41.2%
99493	Subsequent psychiatric collaborative care management, first 60 minutes	$169.13	+16.7%	$170.82	+17.3%

Code	Service	2027 non-QP rate	Change from 2026	2027 QP rate	Change from 2026
99494	Additional 30 minutes of psychiatric collaborative care management	$80.46	+30.8%	$81.26	+31.6%
G2214	Initial or subsequent psychiatric collaborative care management, first 30 minutes	$84.07	+38.3%	$84.91	+39.0%
G0568	Initial psychiatric collaborative care management, one calendar month	$221.35	+36.9%	$223.56	+37.6%
G0569	Subsequent psychiatric collaborative care management, subsequent month	$170.77	+17.0%	$172.48	+17.6%

Visit Complexity Inherent to E/M Services

CMS proposes discontinuing HCPCS add-on code G2211 and replacing it with a claim modifier, MOD1. The final modifier would use a two-character HCPCS modifier code.

MOD1 would be reported under the same circumstances as G2211: when an 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. CMS proposes to match the current G2211 descriptor with technical revisions.

CMS contends that a modifier would more accurately identify the qualifying E/M service, simplify claim processing, and permit the additional resources to be incorporated into the payment for the primary E/M service. Addiction medicine clinicians who routinely use G2211 for longitudinal SUD care should monitor how CMS translates the current payment and reporting rules to MOD1 in the final rule and implementation guidance.

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 proposed rule, the agency does invite additional feedback on whether they should consider updates to the rates and whether additional coding is needed to describe ASAM Level 1.7, medically managed outpatient treatment.

Consultative Services

As part of a broader request for information on redesigning primary care payment, CMS asks whether office/outpatient E/M visits should eventually be divided into distinct categories such as longitudinal care, acute care, and consultative care. CMS notes 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 seeks 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. This is a request for information and not a proposal for a new code in CY 2027.

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.