

WHITE PAPER

The CY2027 Medicare Fee Schedule

What the proposed 2027 rule does to your conversion factor, modifier 25 visits, G2211 and your specialty, with a checklist to work through before January 1.

ABOUT THIS PAPER

This paper covers the CY2027 Physician Fee Schedule proposed rule (CMS 1848 P), released July 14, 2026. Comments closed September 14, 2026. CMS expects to publish the final rule around November 1, 2026, and the final numbers can differ. We will update this paper when the final rule is out.

The conversion factor falls again in 2027, same day visits with a procedure lose half their value, and G2211 changes shape. This paper walks through each change in plain terms, shows which specialties gain and which lose, and ends with the checklist we are running for our own clients before January 1.

The short version

- The conversion factor drops. The proposed non QP conversion factor is \$32.8409, down 1.68% from \$33.4009. For qualifying APM participants it is \$33.1693, down 1.19%.
- Modifier 25 visits on procedure days get cut. When an E/M visit and a 0, 10 or 90 day global procedure happen on the same day, only the highest valued service would be paid at 100%. Every other service would be paid at 50%.
- G2211 becomes a modifier. The flat add on code would be replaced by a modifier worth 16% of the base office or home E/M visit, or 32% for clinicians in MSSP and LEAD ACOs.
- Winners and losers are clear. Clinical social workers (+12%) and clinical psychologists (+11%) gain the most. Dermatology and otolaryngology (both about 9% down) and orthopedic surgery (about 7% down) lose the most.
- Telehealth flexibilities are safe through 2027. The Consolidated Appropriations Act, 2026 extended them through December 31, 2027, so nothing in this rule takes telehealth away next year.

1. Why the conversion factor falls again

For 2026, Congress added a one year 2.5% increase to physician payment. That increase expires on December 31, 2026. The statutory updates written into MACRA for 2027 are small: 0.75% for qualifying APM participants and 0.25% for everyone else. CMS also applies a positive 0.53% budget neutrality adjustment tied to changes in work RVUs. Together those do not make up for the 2.5% that disappears, so the proposed conversion factor falls.

	CY2026	CY2027 proposed	Change
Conversion factor, non QP	\$33.4009	\$32.8409	down 1.68%
Conversion factor, QP	\$33.5675	\$33.1693	down 1.19%
Anesthesia CF, non QP	n/a	\$20.2143	down 1.38%
Anesthesia CF, QP	n/a	\$20.4165	down 0.89%
Telehealth originating site fee (Q3014)	\$31.85	\$32.65	up

Why this matters beyond Medicare

Many commercial contracts pay a percentage of the Medicare fee schedule. If your contract references the current year schedule, your commercial rates fall on January 1 along with Medicare, even though nobody renegotiated anything. If it references a fixed year, they do not. Check which one you signed.

2. The efficiency adjustment stays, with no new cut

In 2026 CMS reduced the work time assumed for non time based services by 2.5%, on the theory that practitioners get faster at procedures they do often. The proposed rule keeps that reduction in place and says it will be recalculated every three years, so the next change would come in 2029. Time based services are exempt, which protects office and outpatient E/M visits, behavioral health and care management codes.

3. Same day E/M with a procedure: the 50% rule

This is the change most practices will feel first. Today, when a separately identifiable E/M visit is billed with modifier 25 on the same day as a minor or major procedure, both are paid in full. Under the proposal, when the same practitioner or group furnishes an E/M visit and a service with a 0, 10 or 90 day global period on the same day, the highest valued service is paid at 100% and every other service at 50%.

Dermatology, otolaryngology and podiatry are hit hardest because so much of their work combines a visit and a minor procedure. Pain management, orthopedics and urgent care will feel it on injection and laceration days.

What to check now

Pull the last six months of claims with modifier 25. Count how many visits paired an E/M with a 0 or 10 day global procedure, and what the lower valued service paid. That number, halved, is roughly what the rule would take out of your 2027 revenue if nothing else changes.

4. G2211 turns into a modifier

G2211 was created in 2024 to pay for the ongoing, longitudinal relationship in primary care and other continuing care. Today it is a flat add on code. The proposal replaces it with a modifier that adds 16% to the base office or home E/M payment, and a second modifier worth 32% for clinicians participating in MSSP or LEAD ACOs. Both are voluntary and keep the current rules about when the add on can be used.

For a practice that bills higher level visits, a percentage add on is worth more than the old flat amount. For practices that under code visits, it is worth less. Either way, your EHR charge build and your billing rules need to change before January so the modifier is actually captured.

5. Practice expense is being rebuilt

Practice expense is the part of each payment meant to cover staff, space and equipment. CMS proposes to allocate indirect practice expense using both work RVUs and clinical labor, instead of the current method that takes the greater of the two. It also proposes removing the specialty specific indirect cost indices over two years, and a stabilizer that would cap most annual practice expense changes at 5% up or down.

The 2026 shift between facility and non facility payment stays in place. The AMA estimated that change cut facility payment by about 7% and raised non facility payment by about 4%. Practices that work mostly in their own offices benefit; practices that work mostly in hospitals and ASCs do not.

6. Who gains and who loses

CMS publishes an estimated combined impact for each specialty. These are the figures reported so far for the specialties we bill most often. Specialties not listed were not confirmed in the sources we could verify.

Specialty	Estimated combined impact
Clinical social worker	+12%
Clinical psychologist	+11%
Family practice	+1%
Cardiology	about +1%
Interventional pain management	about 2% down
Orthopedic surgery	about 7% down
Dermatology	about 9% down
Otolaryngology	about 9% down

Two things drive the gains for behavioral health. Smoking cessation (99406, 99407) and SBIRT (G2011, G0396, G0397) join the timed behavioral health transition, worth about 19.1% more. Collaborative care work values rise sharply: 99492 from 1.88 to 2.75 work RVUs, 99493 from 2.05 to 2.26, 99494 from 0.82 to 1.13, and G2214 from 0.77 to 1.13.

7. Telehealth, remote monitoring and supervision

- Telehealth. The Medicare flexibilities (home as the originating site, no geographic limit, audio only, the waived in person requirement for tele mental health) run through December 31, 2027 under the Consolidated Appropriations Act, 2026. The proposed rule adds five G codes to the telehealth list.
- Remote monitoring. CMS proposes to limit RPM and RTM to established patients, to require a separately billable initiating visit that documents consent, and to require that the clinical staff doing the monitoring are employed by the practice, not contracted. Four new G codes would consolidate 17 existing codes, with lower values.
- Teaching settings. Either the teaching physician or the resident may be the one physically present with the patient, and the primary care exception expands to all E/M levels.
- Physical therapy. The KX modifier threshold rises from \$2,480 to \$2,540.

8. MIPS in 2027

The performance threshold stays at 75 points through the 2028 performance year. Data completeness rises from 75% to 80%, which catches practices that report on a sample. Three new MVPs are proposed

(diabetic disease, hypertension and hospitalist), and CMS plans to end traditional MIPS after the 2029 performance year, when MVPs become the only path.

The checklist to finish before January 1

- ✓ List every commercial contract priced as a percentage of Medicare and note whether it uses the current year schedule or a fixed year.
- ✓ Model your 2027 Medicare revenue at the proposed \$32.84 conversion factor using your own top 20 codes.
- ✓ Pull six months of modifier 25 claims and size the impact of the 50% same day rule.
- ✓ Ask your EHR vendor how the G2211 modifier will be built, and check your ACO status for the 32% version.
- ✓ If you run RPM or RTM, confirm every enrolled patient is established and that monitoring staff are employees.
- ✓ Check MIPS data completeness against the new 80% threshold.
- ✓ Read the final rule when it is released in early November and update your model.

Where WeBill Health fits

Fee schedule changes land on your claims before they land in your reports. WeBill Health maintains internal payer rule libraries organized by specialty and by carrier, built and updated by people who work claims in your specialty every day, and every claim receives human pre submission review against them before it goes out. When the final rule is published, a person updates the library and a person applies it to your claims. You see the effect in your weekly velocity report, with a dedicated US based billing manager to walk you through it.

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