ENDOCRINE SOCIETY
Hormone Science to Health

Medicare Physician Fee Schedule CY 2027 Final Rule Highlights

On November 4, the Centers for Medicare & Medicaid Services (CMS) released the CY 2027 Medicare Physician Fee Schedule (MPFS) final rule and fact sheet. CMS finalized conversion factors of $32.95 for qualifying alternative payment model (APM) participants and $32.63 for non-qualifying APM participants, representing decreases of 1.83% and 2.31%, respectively, from the CY 2026 conversion factors. The decrease reflects the expiration of the statutory increase to the conversion factor of 2.5% for 2026, and adoption of final policies that affect overall payment rates.

Impact on the Specialty of Endocrinology

CMS estimates the final policies in the rule will have a net impact of +1% in total Medicare payment for the specialty of endocrinology. Positive changes in overall Medicare payment for endocrinology services are due to revisions to G2211 used to represent the added complexity associated with longitudinal care, and other policies that favor cognitive over procedural care. Note that impact of final policies on group practices and individual physicians varies based on practice type, payer type, mix of patients and the types of services provided to those patients.

Changes to Additional Payment for Complex Patient Care – HCPCS Code G2211

CMS finalized policy to eliminate G2211, the add-on code used to indicate complex longitudinal patient care and replace it with a modifier. Under the final policy, modifier B1, when appended to an appropriate E/M code, will increase payment by 16% of the value of the base E/M CPT code instead of a flat payment rate of approximately $17.00 for the now deleted G2211 add-on code. While this policy does provide higher payment rates for complex patient care, the associated work RVUs of G2211 are no longer available and will not count towards RVU targets for those who have them. As noted above, the positive impact to the specialty of endocrinology is due to this policy given that payment for the new modifier will be higher than the flat rate for the G2211 code.

Evaluation and Management Services Using Modifier -25

CMS revised its proposal to reduce payment for an office/outpatient (O/O) E/M visit reported with modifier -25 when the physician also performs a procedure on the same day. Effective January 1, 2027, CMS will limit the policy to procedures with a 0-day global period, rather than the proposed 0-, 10-, and 90-day global periods. When a physician furnishes an E/M visit and one or more procedures on the same day, Medicare will pay 100% of the higher-valued service and 80% of the lower-valued service(s). CMS initially proposed a 50% reduction for the lower-valued service(s). The policy applies only to O/O E/M services (CPT codes 99202–99204, 99025, and 99211–99215) furnished on the same day as a 0-day global procedure. CMS will not apply the payment reduction policy to other E/M services, including inpatient, emergency department, or critical care visits.

Remote Monitoring Services: CMS Delays Third-Party Contracting Policy

CMS finalized three policy changes for remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM) services, with one policy delayed until 2029. The changes aim to strengthen clinical oversight and address program integrity concerns identified by the HHS Office of Inspector General. The following policies were finalized in the 2027 rule.

- Initiating Visit: Practitioners must conduct a separate, reportable initiating visit before starting RPM or RTM services. The visit may occur in person or via telehealth and must include a discussion of the services and patient consent. The visit does not need to focus solely on remote monitoring.
- Established Patients: CMS finalized a requirement that RTM services, like RPM, may only be furnished to established patients with whom the practitioner has an existing clinical relationship.
- Supervision Requirements: CMS delayed until January 1, 2029, its requirement that clinical staff furnishing RPM and RTM services must be directly employed by the billing practitioner or

practice. Per CMS, this delay will give providers time to either train in-house staff or hire additional staff to perform RPM and RTM services instead of contracting those services to outside entities/third party contractors. Once effective, practitioners cannot bill Medicare for RPM and RTM services performed by staff employed by third party companies.

Payment for Fine Needle Aspiration (FNA) (10005, 10006) Will Increase in 2027

Beginning on January 1, 2027, payment for FNA services described CPT codes 10005 (*Fine needle aspiration biopsy, including ultrasound guidance; first lesion*) and 10006 (*Fine needle aspiration biopsy, including ultrasound guidance; each additional lesion* will increase approximately 20%. CMS finalized creating a new practice expense equipment item, ER130 (*Fine Needle Aspiration portable ultrasound*), with an input price of $83,750. CMS also finalized work relative value units (RVUs) 1.35 for CPT code 10005 and 1.00 for 10006.