CY 2027 Medicare Physician Fee Schedule Final Rule

How CMS Responded to ATA Action's Comments

Prepared for ATA and ATA Action members, November 2026

Overview

CMS published the CY 2027 Medicare Physician Fee Schedule final rule (CMS-1848-F) in the Federal Register on November 9, 2026. Most policies take effect January 1, 2027. This document walks through each major issue ATA Action raised in our August 31, 2026 comment letter and press release, along with the Virtual Foodcare Coalition's September 14, 2026 letter on lactation care services, summarizes what we asked for, and explains what CMS did in the final rule.

Three results stand out:

- CMS delayed the remote monitoring direct employment requirement by two years, to January 1, 2029, and committed to issue guidance on acceptable staffing arrangements before then. CMS did not withdraw the policy.
- CMS dropped its proposal to remove clinical staff costs from the RPM and RTM treatment management codes, and it did not finalize the consolidated remote monitoring G-codes. CMS did finalize the cuts to device supply and set-up payment, phased in over multiple years.
- CMS finalized the virtual care proposals we supported, including the telehealth list additions, the teaching physician flexibility, health coaching payment, and the new AI improvement activity. CMS did not act on several of our requests that fell outside its proposals, including digital mental health treatment pricing, MDPP Online payment, and home address privacy.

The final rule does not identify commenters by name. Where this document describes a CMS response, it refers to the agency's response to the group of commenters that raised the issue. Federal Register page citations appear at the end of each section.

Summary of Outcomes

Issue	What we asked for	Outcome in the final rule
RPM/RTM direct employment requirement	Do not finalize; use targeted safeguards instead	Finalized, but delayed two years to January 1, 2029. Guidance on acceptable staffing arrangements to come.
RPM/RTM payment cuts	Defer all valuation changes until the RUC review	Mixed. Device supply and set-up cuts finalized and phased in. Treatment management cut dropped.
Established patient and initiating visit	Do not finalize as drafted; count discharge and telehealth encounters	Finalized as proposed, with helpful clarifications and grandfathering of current patients.
Consolidated RPM/RTM G-codes	Do not finalize	Not finalized. CMS may return to it in future rulemaking.

Issue	What we asked for	Outcome in the final rule
Care management and other RFIs	Use the record before restricting RPM; give more time to respond	No policy change. CMS will consider comments in future rulemaking. No added response window.
Telehealth list, teaching physicians, critical care	Finalize	Finalized, with additional codes added to the telehealth list.
MIPS AI improvement activity	Finalize; name digital therapeutics as an example	Finalized as proposed. Digital therapeutics not added.
Medicare Diabetes Prevention Program	Pay Online sessions at parity; extend past 2029	Not addressed.
Telehealth modifiers (BB and BC)	Limit to virtual-only providers; define "virtual platform"	Modifiers required January 1, 2027. No limits or definitions in the rule. Guidance posted on the CMS website.
Home address privacy (Box 32)	Create an alternative to reporting a home address	Not addressed.
Software as a Medical Service	Clarify scope; guide the MACs on contractor pricing	Term finalized. Scope questions deferred. CMS dropped contractor pricing in favor of national rates.
Digital mental health treatment	Fix MAC pricing; commit to national rates; expand codes	G0552 remains contractor priced. No expansion. One supply price updated.
Other digital therapeutics and in-home testing	Expand coverage and payment	Not addressed.
Lactation care services (Virtual Foodcare Coalition)	Add the new codes to the telehealth list; value the lactation consultant category at actual cost	Codes finalized with a higher labor rate. CMS declined to add them to the telehealth list.
Virtual foodcare	Confirm virtual delivery of coaching and nutrition services; code medically tailored meals	Health coaching finalized with higher payment and general supervision. Medically tailored meals ruled out of scope.

Remote Patient Monitoring and Remote Therapeutic Monitoring

Remote monitoring was the centerpiece of our letter and press release. We asked CMS to withdraw or substantially modify four proposals and to give the industry time to adjust to any changes.

Direct employment requirement

What we said. CMS proposed to pay for RPM and RTM only when the clinical staff furnishing the service are direct employees of the billing practitioner or practice, effective January 1, 2027. We urged CMS not to finalize the requirement. We explained that the OIG reports did not recommend it, that it would reverse CMS's 2020 decision to allow general supervision, and that it would disqualify clinically integrated arrangements at academic medical centers, health systems with multiple tax identification numbers, and centralized virtual care centers. We proposed nine guardrails as an alternative and asked for a phase-in period well beyond January 1, 2027.

What CMS finalized. CMS finalized the requirement with a two-year delay. Beginning January 1, 2029, practitioners cannot bill RPM or RTM codes unless a direct employee of the practitioner or the practice performs the clinical staff work. Contracting with third-party companies for clinical staff remains allowed through December 31, 2028.

CMS made three points that matter for members:

- CMS agreed that it needs more time to "specify additional clinical staff arrangements that may be appropriate for remote monitoring services" and will publish sub-regulatory guidance before 2029. That guidance is the opening to protect health system, academic, and other clinically integrated models.
- CMS confirmed that practices may obtain devices, software, connectivity, data hosting, cybersecurity, implementation support, and technical assistance from outside companies. The requirement reaches only third-party clinical staff time.
- CMS did not change the general supervision designation or the "incident to" regulation at 42 CFR 410.26. Until 2029, CMS expects billing practitioners to maintain real oversight and clinical integration with any third party, and says practitioners should not bill where that oversight is missing.

CMS did not adopt our alternative guardrails. It said it may consider other program integrity ideas in future rulemaking. In response to concerns about rural access, small practices, workforce shortages, and cost, CMS repeated that direct employment "is the best way to ensure care is integrated." CMS also rejected the argument that the OIG reports limit what it can do, stating that it has observed troubling trends that go beyond the OIG findings.

Bottom line. A partial win. The delay is longer than the one-year delay many commenters requested, and the promised guidance creates a path to preserve integrated arrangements. The underlying policy remains on the books, and ATA Action will press CMS and Congress to narrow or reverse it before 2029. (91 Fed. Reg. 71084-71086)

Payment reductions

What we said. CMS proposed to cut practice expense payment for RPM and RTM set-up and device supply codes by crosswalking them to lower-valued services, and to eliminate practice expense inputs for the treatment management codes on the theory that clinical staff are not typically involved. We called the cuts premature and unsupported by cost data, noted the conflict between removing clinical staff costs and requiring practices to employ that staff, and asked CMS to wait for the RUC review scheduled for January 2027.

What CMS finalized. CMS split its decision:

- Treatment management codes (99457, 99458, 99470, 98979, 98980, 98981). CMS did not finalize the proposal. It agreed with commenters that clinical staff often furnish these services and kept the direct practice expense inputs.
- Set-up and device supply codes (99453, 99454, 99445, 98975, 98976, 98977, 98984, 98985). CMS finalized the crosswalks as proposed. Because the statute limits one-year reductions for existing codes, CMS will phase in many of these cuts over multiple years, with a maximum reduction of 19 percent in the first year.
- Cognitive behavioral therapy device supply codes (98978, 98986). CMS will price these codes nationally for the first time in 2027. In response to comments, CMS raised the proposed values by

crosswalking both codes to 98977 so that all RTM device supply codes carry the same practice expense value. The phase-in protection does not apply to these two codes.

CMS acknowledged that the RUC will review practice expense for all 19 RPM and RTM codes in January 2027 and said it looks forward to those recommendations and to additional cost data from stakeholders for future rulemaking. CMS did not respond to our recommendation to align remote monitoring payment with chronic care management.

Bottom line. Mixed. CMS accepted our argument on clinical staff time, which protects the treatment management codes. The device supply and set-up cuts begin in 2027, but the phase-in and the RUC review give members a window to submit invoice and cost data before the full reductions take effect. (91 Fed. Reg. 71087-71089)

Established patient and initiating visit requirements

What we said. CMS proposed to extend the established patient requirement to RTM and to require a separately reportable, face-to-face initiating visit with the billing practitioner before RPM or RTM begins. We urged CMS not to finalize the proposals as drafted. At a minimum, we asked CMS to count hospital and emergency department discharge encounters, confirm that telehealth visits qualify, and explain how the requirement works with global surgery rules.

What CMS finalized. CMS finalized both requirements as proposed and declined to create exemptions. It added several clarifications that respond to our concerns:

- The initiating visit may be in person or by telehealth. After December 31, 2027, the telehealth option depends on Congress extending the Medicare telehealth flexibilities.
- A beneficiary becomes an established patient once the initiating visit requirement is met.
- The visit does not need to be solely about remote monitoring, and it does not need to be separately billable in every scenario. The practitioner must discuss RPM or RTM with the patient at the visit.
- Physicians in the same group practice and specialty count as a single practitioner for purposes of the visit.
- CMS set no time limit between the initiating visit and the start of monitoring.
- Beneficiaries already receiving remote monitoring before January 1, 2027 do not need an initiating visit to continue.
- A new visit is not required for a device change, a clinical change, or a change of billing practitioner within the same practice.
- CMS added no new documentation requirements.

CMS did not confirm that a discharge encounter with a hospitalist or other practitioner outside the billing practice satisfies the requirement. On global surgery, CMS referred readers to its CY 2024 final rule discussion rather than providing new guidance.

Bottom line. Finalized over our objection, but the telehealth option, the grandfathering of current patients, and the flexibility on what counts as a visit reduce the operational burden. Programs that enroll patients at hospital discharge still need a qualifying visit with the billing practitioner's group and should review their workflows before January 1, 2027. (91 Fed. Reg. 71082-71084)

Consolidated remote monitoring codes

What we said. CMS described four Medicare-specific G-codes that would replace 17 RPM and RTM codes with bundled set-up and monthly codes. We opposed consolidation because it would make months unbillable when any element is legitimately absent, require one entity to furnish every component, and fragment coding across payers.

What CMS finalized. CMS did not finalize the G-codes. The final rule characterizes the discussion as a comment solicitation and states that CMS will take the comments into consideration for possible future rulemaking. The existing CPT code set remains in place for 2027.

Bottom line. A win for now. CMS continues to cite the OIG finding that 43 percent of enrollees did not receive all three components of remote monitoring, so members should expect the idea to return. (91 Fed. Reg. 71089-71090)

Program integrity approach and OIG data

What we said. We supported CMS's program integrity goals but asked CMS and OIG to analyze the data more closely before acting, including the effect of the pandemic, medically necessary use of multiple devices, and billing rules that prevent reporting every code.

What CMS finalized. CMS acknowledged that many remote monitoring programs deliver reasonable and necessary care and that the pandemic drove some of the growth in utilization. It did not commit to further analysis. CMS said utilization has continued to grow since the public health emergency ended and that the same concerns apply to RTM even though the OIG reports focused on RPM. CMS also stated that its requirements do not conflict with the Rural Health Transformation Program or the ACCESS model. The final rule does not discuss the RPM Access Act.

Bottom line. CMS heard the access concerns but did not change its view of the program integrity risk. (91 Fed. Reg. 71080-71082)

Care Management and Other Requests for Information

Care management, primary care, AI, and CPT requests for information

What we said. We warned that the care management RFI asked the same questions about direct employment and initiating visits that CMS had already answered for remote monitoring, and we urged CMS to let the RFI record inform remote monitoring policy. We also asked for more time to respond to the RFIs through an extended window, a supplemental RFI, or listening sessions.

What CMS finalized. CMS summarized the comments and stated that it will consider them for future rulemaking. It made no policy changes to care management services. The agency's summary notes that commenters largely opposed splitting care management into "technology-first" and "traditional" tracks and favored aligning requirements such as initiating visits, consent, and supervision across the code family. The final rule does not address our request for additional time to respond.

Bottom line. No immediate change. The harmonization theme signals that CMS may propose common staffing and initiating visit rules across care management in a future rule, which makes continued engagement important. (91 Fed. Reg. 71172-71179)

Telehealth and Virtual Care Proposals We Supported

Telehealth list additions, teaching physicians, and critical care consultations

What we said. We applauded the proposals to add five codes to the Medicare Telehealth Services List, to let teaching physicians bill when either the teaching physician or the resident is in the room with the patient, and to clarify the critical care telehealth consultation descriptors. We also asked CMS to work with Congress to extend the telehealth flexibilities before they expire.

What CMS finalized. CMS finalized all three proposals.

- Telehealth list. CMS added G0572 and G0573 (advance care planning), G0686 (shared medical appointments), G0903 (pediatric speech-language services), and G0576 (vaccine adverse effect management). It also added the new shared medical appointment add-on code G0687 and replacement codes for adaptive behavior and speech-language pathology services.
- Teaching physicians. CMS finalized the policy as proposed and confirmed that it adds to, and does not replace, the existing three-way telehealth option.
- Critical care consultations. CMS finalized the revised descriptors for G0508 and G0509.

On the flexibilities, CMS restated that Congress extended them through December 31, 2027 and that the agency lacks authority to extend them further.

Bottom line. Finalized as we supported. (91 Fed. Reg. 71022-71026)

MIPS improvement activities for AI and decision support

What we said. We supported the new Clinician Use of Artificial Intelligence improvement activity and the decision support activity, and we asked CMS to list AI-enabled digital therapeutics among the examples.

What CMS finalized. CMS finalized the Clinician Use of Artificial Intelligence to Improve Patient Care activity (IA_AHW_4) as proposed, beginning with the 2027 performance period. CMS acknowledged the request to include digital therapeutics and declined for now, explaining that it wants to keep the activity broadly applicable during a period of rapid AI development and will revisit the suggestions. CMS also proceeded with its modification of the decision support activity (IA_PSPA_16) to incorporate AI-enabled tools.

Bottom line. Finalized. The activity description does not name digital therapeutics, though nothing in the rule excludes them. (91 Fed. Reg. 71545-71547)

Medicare Diabetes Prevention Program

What we said. We asked CMS to pay Online sessions (G9871) at the same $25 rate as in-person and distance learning sessions, to consider milestone or outcome-weighted alternatives, and to extend the Online modality beyond December 31, 2029.

What CMS finalized. The final rule does not address MDPP payment rates or the Online test period. CMS made no MDPP proposals this year, and the only reference to the program is a comment CMS classified as outside the scope of the rural health clinic provisions.

Bottom line. No change. Online sessions remain at $18 and the test period still ends December 31, 2029.

Telehealth Modifiers and Provider Enrollment

Telehealth modifiers BB and BC

What we said. Congress directed CMS to implement telehealth modifiers beginning in 2027. We asked CMS to limit the requirement to virtual-only providers and telehealth platform companies, to explain with examples which arrangements each modifier captures, and to define "virtual platform" with specific exemptions.

What CMS finalized. CMS created both modifiers and requires them beginning January 1, 2027. Modifier BB applies to telehealth services furnished through a virtual platform by a practitioner that contracts with the entity that owns the platform or has a payment arrangement for its use. Modifier BC applies to telehealth services furnished incident to a practitioner's professional service. The modifiers do not affect payment.

CMS noted that it did not solicit comments on the modifiers. In response to requests for clarification, it restated the statutory definitions and pointed to its telehealth web page. The rule does not limit the modifiers to virtual-only providers, define "virtual platform," or adopt our proposed exemptions. CMS will issue any updates through sub-regulatory guidance.

Bottom line. Not responsive in the rule itself. The definitional questions now move to sub-regulatory guidance, where ATA Action will continue to seek clear examples and a narrow reading. (91 Fed. Reg. 71024)

Home address privacy for virtual-only providers

What we said. We asked CMS to develop an alternative to reporting a home address for virtual-only practitioners, such as a business address paired with a ZIP code for geographic payment adjustment.

What CMS finalized. The final rule does not address the issue.

Bottom line. No change. Current enrollment guidance remains in effect.

Clinical Software, AI, and Digital Therapeutics

Clinical software valuation and artificial intelligence

What we said. We urged CMS to avoid a one-size-fits-all approach to paying for digital tools and to weigh clinical function, risk and regulatory burden, and the fit of different payment models. On AI, we asked CMS not to assume immediate efficiency gains, to measure value across outcomes, experience, and cost, and to pay for the service delivered instead of creating a payment category for AI use. We also offered to brief CMS on the ATA AI in Virtual Care Policy Initiative.

What CMS finalized. CMS took no payment action on AI. It summarized the comments and stated that it will consider them for future rulemaking. CMS did use the final rule to clarify how AI can support the Annual Wellness Visit within existing statutory and regulatory requirements. It stressed that any use must preserve clinician autonomy and said it may propose further changes, including a beneficiary opt-out from new technology.

Bottom line. No change for 2027. The record is open, and the Annual Wellness Visit discussion indicates where CMS may act first. (91 Fed. Reg. 71176-71179)

Software as a Medical Service

What we said. We supported the move to define Software as a Medical Service (SaMS). We asked CMS to clarify whether the term covers digital therapeutics, digital mental health treatment devices, and monitoring software, and to make sure the new category does not displace existing pathways. Because CMS proposed contractor pricing, we asked for detailed guidance to the MACs by January 1, 2027.

What CMS finalized. CMS finalized the SaMS terminology with the proposed definition and said it will consider requests for more specificity in future rulemaking. In describing the term, the final rule states that these technologies differ from prescription digital therapeutics, which treat illness, and are separate from RPM and RTM. CMS did not address digital mental health treatment devices directly.

On payment, CMS reversed course. It agreed with commenters that contractor pricing would reduce predictability and finalized national pricing for 14 codes describing SaMS analyses performed on laboratory tests, using a crosswalk to hospital outpatient payment rates. The policy applies only to those laboratory analysis codes.

Bottom line. Partially responsive. CMS avoided the MAC pricing problems we flagged by setting national rates, and its description of SaMS supports keeping digital therapeutics and remote monitoring on separate pathways. The scope of the definition remains open. (91 Fed. Reg. 71124-71130)

Digital mental health treatment

What we said. We expressed disappointment that CMS proposed no refinements to the digital mental health treatment (DMHT) codes. We asked CMS to direct the MACs to pay rates that reflect acquisition costs, to commit to national payment rates by CY 2028, to issue a National Coverage Determination, and to expand the codes to three additional FDA device classifications covering gastrointestinal conditions, sleep disturbance, and fibromyalgia.

What CMS finalized. CMS made no DMHT policy changes. In response to a commenter that submitted invoices, CMS stated that it did not propose national pricing for G0552 and is not changing its contractor-priced status. CMS did update the price of the insomnia DMHT device supply input (SD386) to $400 based on those invoices, though that input does not set payment while G0552 remains contractor priced. The final rule does not discuss MAC guidance, a National Coverage Determination, a timeline for national rates, or the additional device classifications.

Bottom line. Not responsive. The MAC pricing and coverage problems members report continue into 2027. The updated supply price puts a CMS-recognized cost figure on the record that may help in MAC discussions and future national pricing. (91 Fed. Reg. 71012)

Other digital therapeutics and in-home diagnostic testing

What we said. We asked CMS to expand coverage of digital therapeutics under existing benefit categories with codes that distinguish among product types, and to make sure the ACCESS Model and the FDA TEMPO program complement the established fee schedule codes. Separately, we asked CMS to support in-home specimen collection and testing, including payment for specimen handling under CPT 99000 and an outreach incentive.

What CMS finalized. The final rule does not address either set of recommendations. CMS did respond to a related comment by confirming that RTM for cognitive behavioral therapy and collaborative care model services may be billed concurrently when reasonable and necessary.

Bottom line. No change.

Health coaching, nutrition services, and medically tailored food

What we said. We supported the proposals to pay for health coaching (CPT 0591T, 0592T, and 0593T) and to expand access to diabetes self-management training and medical nutrition therapy in rural health clinics and federally qualified health centers, and we asked CMS to clarify that these services may be delivered virtually. We also asked CMS to create distinct codes for medically tailored meals and groceries and to include nutrition and virtual lifestyle supports in any Alzheimer's intervention framework.

What CMS finalized. CMS finalized national payment for health coaching with two improvements over the proposal. It raised the values for 0591T and 0592T by crosswalking them to complex chronic care management (work RVUs of 1.81 and 1.00), and it changed the supervision level from direct to general. CMS confirmed that the codes are already on the Medicare Telehealth Services List and that audio-only delivery remains available under the current statutory extension. CMS set no frequency limits.

CMS finalized diabetes self-management training and medical nutrition therapy as stand-alone billable visits in rural health clinics, with direct supervision that may be met through real-time audio and video. When clinics furnish these services by telehealth, Medicare pays under the telehealth methodology and not the all-inclusive rate.

CMS treated a comment on referral pathways to medically tailored meal programs as outside the scope of the rule and created no new food codes. On the Alzheimer's RFI, CMS said it will consider comments for future rulemaking and noted that many commenters recommended team-based services that include hybrid and virtual delivery.

Bottom line. Largely positive on coaching and nutrition services, and virtual delivery is confirmed. No progress on medically tailored meals. (91 Fed. Reg. 71112-71116, 71191-71192, 71203-71209)

Lactation care services

What we said. The Virtual Foodcare Coalition, convened by ATA Action, submitted a separate letter on September 14, 2026 supporting payment for the two new lactation care codes, finalized as CPT 98963 (first 30 minutes) and 98964 (each additional 15 minutes). The Coalition asked CMS to add both codes to the Medicare Telehealth Services List for CY 2027 and to confirm the supervision and billing arrangements for virtual delivery. It also asked CMS to avoid payment or documentation rules that disfavor virtual care, to make sure qualified non-physician lactation professionals can participate, and to value the new Lactation Consultant staff category on actual labor cost.

What CMS finalized. CMS finalized payment for both codes and responded to each of the Coalition's requests:

- Telehealth. CMS declined to add the codes to the Medicare Telehealth Services List. It said it did not propose the addition and that the CPT codes "were not intended to be provided via telehealth."
- Who may furnish the service. CMS confirmed that lactation consultants do not need to be registered nurses and adopted the CPT standard that a professional society or other appropriate source must recognize the consultant's qualifications. CMS did not allow lactation consultants to bill Medicare directly. A physician or other qualified practitioner must order and bill the service.

- Supervision. Commenters warned that a direct supervision standard would make the codes unusable after hospital discharge. CMS did not address supervision in its response.
- Valuation. CMS raised the Lactation Consultant labor rate from the proposed $0.76 per minute to $0.90 per minute based on salary data from commenters. It kept the work RVU for 98963 at 0.18 and assigned no work RVU to 98964.
- Future review. CMS acknowledged that the RUC survey for these codes was flawed and said the times and values may warrant revisiting by CMS, the RUC, or the CPT Editorial Panel.

Bottom line. Mixed. CMS accepted the Coalition's argument on labor cost and kept the workforce broad. It rejected the central request on telehealth, so Medicare pays for these services only in person in 2027. CMS's reasoning rests on how the CPT codes were designed, which points to the CPT Editorial Panel as well as the CY 2028 telehealth list request process as the next steps. (91 Fed. Reg. 71076-71079)

What Comes Next

- January 1, 2027. The initiating visit and RTM established patient requirements, device supply and set-up payment reductions, telehealth modifiers BB and BC, health coaching payment, and the telehealth list additions take effect.
- January 2027. The RUC reviews practice expense for all 19 RPM and RTM codes. Members with invoice and cost data should prepare to share it.
- February 10, 2027. Deadline to request additions to the Medicare Telehealth Services List for CY 2028, including the lactation care codes.
- December 31, 2027. The Medicare telehealth flexibilities expire without congressional action, which would also limit telehealth initiating visits for remote monitoring.
- Before January 1, 2029. CMS will issue sub-regulatory guidance on clinical staff arrangements for remote monitoring. The direct employment requirement takes effect January 1, 2029.

ATA Action will continue to engage CMS and Congress on each of these items and will share updates with members as guidance develops.