American College of Radiology

**Calendar Year 2027 Hospital Outpatient Prospective Payment System Proposed Rule**
**ACR Detailed Summary**

On July 2nd, 2026, Centers for Medicare and Medicaid Services (CMS) released the calendar year (CY) 2027 Hospital Outpatient Prospective Payment System (HOPPS) proposed rule. This rule provides for a 60-day comment period ending on August 31st, 2026. The finalized changes are effective January 1st, 2027.

**Proposed Conversion Factor Update – pg. 78**
CMS proposes to increase the CY 2026 HOPPS conversion factor (CF) by 2.4 percent bringing it up to $102.004 for CY 2027. This increase is based on the proposed hospital inpatient market basket percentage increase of 3.2 percent for inpatient services paid under the hospital inpatient prospective payment system (IPPS) reduced by a proposed productivity adjustment of 0.8 percentage point.

CMS proposes to further adjust the conversion factor to ensure that any revisions made to the wage index and rural adjustment are made on a budget neutral basis. CMS proposes calculating an overall budget neutrality factor of 1.0098 for wage index changes. CMS proposes to calculate an additional budget neutrality factor of 0.9951 to account for the proposed policy to cap wage index reductions for hospitals at 5 percent on an annual basis. CMS proposes to maintain the current rural adjustment policy and therefore proposes the budget neutrality factor for the rural adjustment to be 1.0000.

CMS proposes to establish a cost-of-living adjustment (COLA) for hospitals in Alaska and Hawaii in the CY 2027 HOPPS. CMS proposes a budget neutrality factor of 0.9993. This policy adjusts the nonlabor share of outpatient hospital service payments provided in Alaska and Hawaii for CY 2027 and future years and is based on the IPPS COLA. This policy is proposed to be budget neutral across the HOPPS and is projected to increase payments to hospitals in these states by $55 million in CY 2027.

CMS proposes that the hospitals that fail to meet the requirements of the Hospital OQR Program will use a reduced OPD fee schedule update factor of 0.4 percent (that is, the proposed OPD fee schedule increase factor of 2.4 percent further reduced by 2.0 percentage points). The reduced conversion factor for hospitals failing to meet the Hospital Outpatient Quality Reporting (OQR) Program requirements is proposed to be $100.015 for CY 2027.

Under the proposed 340B remedy offset, payments for services at hospitals subject to the 340B remedy offset would be reduced by 3 percentage points, making the proposed CY 2027 conversion factor for those affected hospitals $99.015.

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**Data Used for Ratesetting – pg. 23**
CMS proposes to use CY 2025 claims data to set the proposed CY 2027 HOPPS rates, except where otherwise indicated. CMS proposes to use the most recently available cost report data from the Healthcare Cost Report Information System (HCRIS).

**Estimated Impact on Hospitals – pg. 670**
CMS estimates that OPPS expenditures, including beneficiary cost-sharing and estimated changes in enrollment, utilization, and case mix will be approximately $110.9 billion, which is approximately $9.5 billion higher than estimated CY 2026 OPPS expenditures. CMS estimates a 3.0 percentage point reduction to the OPPS payment update, the 340B recoupment payment adjustment, for non-drug OPPS services for most hospitals will reduce OPPS payments by $2.3 billion. The reduction in payment for imaging without contrast in off-campus provider-based department will reduce payment $260 million ($190 million in Medicare spending and $70 million in reduced beneficiary copayments).

## Proposed Ambulatory Payment Classification (APC) Group Policies

**Imaging Ambulatory Payment Classifications**
CMS does not propose any new changes to the APC structure for imaging codes. The seven payment categories remain. However, CMS has moved codes within these payment categories which would cause changed pricing for 2027. CMS is making reassignments to the codes within the series to resolve and/or prevent any violations of the two-times rule.

**Proposed CY 2027 Imaging APCs**

| APC | APC Group Title | SI | CY 2026 Relative Weight | CY 2027 Proposed Relative Weight | CY 2026 Payment Rate | CY 2027 Proposed Payment Rate |
|---|---|---|---|---|---|---|
| 5521 | Level 1 Imaging without Contrast | S[1] | 0.9726 | 0.9599 | $88.91 | $97.91 |
| 5522 | Level 2 Imaging without Contrast | S | 1.1684 | 1.1613 | $106.81 | $118.46 |
| 5523 | Level 3 Imaging without Contrast | S | 2.6666 | 2.6580 | $243.77 | $271.13 |
| 5524 | Level 4 Imaging without Contrast | S | 6.1068 | 6.1032 | $558.25 | $622.55 |
| 5571 | Level 1 Imaging with Contrast | S | 1.9603 | 1.9563 | $179.20 | $199.55 |
| 5572 | Level 2 Imaging with Contrast | S | 3.8990 | 3.9071 | $356.43 | $398.54 |
| 5573 | Level 3 Imaging with Contrast | S | 8.7611 | 8.9716 | $800.90 | $915.14 |

**Comprehensive APCs – pg. 33**
CMS conducted an annual review within this rule and proposes no changes to the current number of 74 Comprehensive- APCs (C-APCs). Table 2 lists all C-APCs for CY 2027.

[1] S - Procedure or Service, Not Discounted When Multiple; separate APC payment

**Proposed APC Placements for Imaging Services**

CMS proposes CPT code 71271 for low dose CT lung cancer screening to remain in APC 5522 with payment rate of $118.46. The proposed placement for code G0296 (visit to determine lung LDCT eligibility) is APC 5822, with a payment rate of $118.75.

CMS proposes to assign CPT code 74263 for screening CT colonography (CTC)/virtual colonoscopy a status indicator of "S" and APC 5523 (Level 3 Imaging Without Contrast) with a payment rate of $271.13 for CY 2027.

CMS proposes to place 76145 for medical physics dose evaluation for radiation exposure that exceeds institutional review threshold (including reports) in its existing APC of 5723 with payment rate $435.61 for CY 2027.

**Proposed Payment for 3D Printing Services**

For CY 2027, CMS proposes to update the APC placement for code C8001 from the CY 2026 APC 5721 (Level 1 Diagnostic Tests and Services) to APC 1503 (New Technology Level 3) and to designate the service as Software as a Medical Service (SaMS) with newly proposed status indicator O1. CMS does not propose any APC changes for codes 0559T-0562T. Codes 1030T through 1035T are newly established beginning July 1, 2026 and are proposed to be placed into APC 5721.

**Proposed 2027 Payment Rates for 3D Printing Services**

| Code | Short Descriptor | CY 2027 Proposed APC | CY 2027 PR SI | CY 2027 PR Rate |
|---|---|---|---|---|
| C8001 | 3d anat seg imaging preop | 1503 - New Technology Level 3 | O1[2] | $150.50 |
| 0559T | Antmc mdl 3d print 1st cmpnt | 5734 - Level 4 Minor Procedures | Q1[3] | $152.43 |
| +0560T | Antmc mdl 3d print ea addl | N/A | N[4] | N/A |
| 0561T | Antmc guide 3d print 1st gd | 5734 - Level 4 Minor Procedures | Q1 | $152.43 |
| +0562T | Antmc guide 3d print ea addl | N/A | N | N/A |
| 1030T | Crtj dig 3d mdl surf mesh 1 | 5721 - Level 1 Diagnostic Tests and Related Services | S[5] | $146.93 |
| +1031T | Crtj dig 3d mdl surf mesh ea | N/A | N | N/A |
| 1032T | Crtj dig 3d mdl mesh&sim 1 | 5721 - Level 1 Diagnostic Tests and Related Services | S | $146.93 |

[2] O1 – Software as a Medical Service – Paid under OPPS; separate APC payment

[3] Q1 – Conditionally packaged; separate APC payment when certain conditions are met

[4] N – Items and Services Packaged into APC rates; no separate APC payment

[5] S - Procedure or Service, Not Discounted When Multiple; separate APC payment

| | | | | |
|---|---|---|---|---|
| +1033T | Crtj dig 3d mdl mesh&sim ea | N/A | N | N/A |
| 1034T | Crt dig 3d mdl msh sim&aly 1 | 5721 - Level 1 Diagnostic Tests and Related Services | S | $146.93 |
| +1035T | Crt dig 3dmdl msh sim&aly ea | N/A | N | N/A |

**Proposed Payment Adjustments to Cancer Hospitals – pg. 90**

The ACA requires an adjustment to cancer hospitals' outpatient payments to bring each hospital's payment-to-cost ratio (PCR) up to the level of the PCR for all other hospitals, the target PCR. The changes in additional payments from year to year are budget neutral. The 21st Century Cures Act reduced the target PCR by 1.0 percentage point and excludes the reduction from OPPS budget neutrality. The cancer hospital adjustment is applied at cost report settlement rather than on a claim-by-claim basis.

Table 7, below, shows the estimated percentage increase in OPPS payments to each cancer hospital for CY 2027, due to the cancer hospital payment adjustment policy.

**Table 7: Estimated CY 2027 Hospital-Specific Payment Adjustment for Cancer Hospitals to be Provided at Cost Report Settlement**

| Provider Number | Hospital Name | Estimated % Increase in OPPS Payments for CY2027 due to pmt. adj. |
|---|---|---|
| 050146 | City of Hope Comprehensive Cancer Center | 35.2% |
| 050660 | USC Norris Cancer Hospital | 19.8% |
| 100079 | Sylvester Comprehensive Cancer Center | 31.3% |
| 100271 | H. Lee Moffitt Cancer Center & Research Institute | 16.3% |
| 220162 | Dana-Farber Cancer Institute | 45.4% |
| 330154 | Memorial Sloan-Kettering Cancer Center | 42.5% |
| 330354 | Roswell Park Cancer Institute | 7.8% |
| 360242 | James Cancer Hospital & Solove Research Institute | 27.1% |
| 390196 | Fox Chase Cancer Center | 5.3% |
| 450076 | M.D. Anderson Cancer Center | 52.9% |
| 500138 | Seattle Cancer Care Alliance | 41.8% |

**Proposed APC Exceptions to the 2 Times Rule – pg. 132**

CMS proposes exceptions to the 2-times rule based on the following criteria: resource homogeneity; clinical homogeneity; hospital outpatient setting utilization; frequency of service (volume); and opportunity for up-coding and code fragments. Table 12, found below, lists the 27 APCs that CMS proposes to exempt from the 2 times rule for 2027 based on CY 2025 available claims data.

**Table 12: Proposed CY 2027 APC Exceptions to the 2 Times Rule**

| APC | APC Group Title |
|---|---|
| 5012 | Clinic Visits and Related Services |
| 5054 | Level 4 Skin Procedures |
| 5071 | Level 1 Excision/ Biopsy/ Incision and Drainage |
| 5301 | Level 1 Upper GI Procedures |
| 5521 | Level 1 Imaging without Contrast |
| 5522 | Level 2 Imaging without Contrast |
| 5523 | Level 3 Imaging without Contrast |
| 5524 | Level 4 Imaging without Contrast |
| 5572 | Level 2 Imaging with Contrast |
| 5573 | Level 3 Imaging with Contrast |
| 5611 | Level 1 Therapeutic Radiation Treatment Preparation |
| 5612 | Level 2 Therapeutic Radiation Treatment Preparation |
| 5613 | Level 3 Therapeutic Radiation Treatment Preparation |
| 5627 | Level 7 Radiation Therapy |
| 5671 | Level 1 Pathology |
| 5674 | Level 2 Pathology |
| 5691 | Level 1 Drug Administration |
| 5692 | Level 2 Drug Administration |
| 5722 | Level 2 Diagnostic Tests and Related Services |
| 5731 | Level 1 Minor Procedures |
| 5734 | Level 4 Minor Procedures |
| 5735 | Level 5 Minor Procedures |
| 5741 | Level 1 Electronic Analysis of Devices |
| 5743 | Level 3 Electronic Analysis of Devices |
| 5791 | Pulmonary Treatment |
| 5821 | Level 1 Health and Behavior Services |
| 5822 | Level 2 Health and Behavior Services |
| 5823 | Level 3 Health and Behavior Services |

**Biology Guided Radiation Therapy (BgRT) – pg. 144**

BgRT uses positron-emitting radiopharmaceuticals to control delivery of radiation therapy to treat primary and metastatic lung or bone tumors. Beginning with CY 2025, codes C9794 and C9795 were replaced by codes G0562 (Therapeutic radiology simulation-aided field setting; complex, including acquisition of PET and CT imaging data required for radiopharmaceutical-directed radiation therapy treatment planning) and G0563 (Stereotactic body radiation therapy,

treatment delivery, per fraction to 1 or more lesions, including image guidance and real-time positron emissions-based delivery adjustments to 1 or more lesions, not to exceed 5 lesions).

Since HCPCS codes G0562 and G0563 became effective on January 1, 2025, CY 2027 ratesetting is the first time CMS has claims data available for these services. Based on low claims volume (24 claims for G0562 and 47 claims for G0563), CMS proposes to classify both codes under its low volume APC policy.

For code G0562, CMS uses the median cost of $1,601 under the low volume APC policy, which falls within the cost band of New Technology APC 1518. As a result, CMS proposes assigning G0562 to APC 1518 with payment rate of $1,650.50 for CY 2027.

For code G0563, CMS uses the arithmetic mean cost of $2644 under the low volume APC policy, which falls within the cost band of New Technology APC 1523. As a result, CMS proposes assigning G0563 to APC 1523 with payment rate of $2,750.50 for CY 2027. CMS will reevaluate both codes using updated claims data in the CY 2027 final rule and revise the APC assignments if needed.

**Table 15: Final CY 2026 and Proposed CY 2027 OPPS APC Assignments for Biology Guided Radiation Therapy**

| HCPCS Code | Long Descriptor | CY 2026 OPPS Final APC, SI, Payment Rate | CY 2027 OPPS Proposed APC, SI, Payment Rate |
|---|---|---|---|
| G0562 | Complex simulation w/pet-ct | 1521 New Technology Level 21, S, $1950.50 | 1518 New Technology Level 18, S, $1650.50 |
| G0563 | Sbrt w/positron emission del | 1524 New Technology Level 24, S, $3250.50 | 1523 New Technology Level 23, S, $2750.50 |

**Cardiac Positron Emission Tomography (PET)/Computed Tomography (CT) Studies (APC 5594) – pg. 147**

For CY 2026, CMS continued to assign the three CPT codes for cardiac PET/CT studies (78431, 78432, and 78433) to New Technology APCs due to continued low claims frequency and fluctuations in the geometric mean costs over the past several years, despite being considered clinically similar to services within the Nuclear Medicine and Related Services APC series.

For CY 2027, CMS proposes changes to APCs 5591-5594 (Nuclear Medicine and Related Services) that includes the shifting of the APC assignments for several codes in that APC series. As a result of these proposed changes, the proposed geometric mean costs of the Nuclear Medicine and Related Services APC series have also shifted. CMS states in the rule that they believe that the new geometric mean costs of the proposed Nuclear Medicine and Related Services APC series more closely align with the costs reflected in the claims data for CPT codes 78431 through 78433. Therefore, CMS proposes to assign CPT codes 78431 through 78433 to APC 5594 (Level 4 Nuclear Medicine and Related Services) with a payment rate of $2452.09 and status indicator S.

**Table 16: Final CY 2026 and Proposed CY 2027 OPPS APC Assignments for Cardiac PET/CT CPT Codes 78431, 78432, and 78433**

| HCPCS Code | Short Descriptor | CY 2026 OPPS Final APC, SI, Payment Rate | CY 2027 OPPS Proposed APC, SI, Payment Rate |
|---|---|---|---|
| 78431 | Myocrd img pet rst&strs ct | 1522 New Technology Level 22, S, $2250.50 | 5594 Level 4 Nuclear Medicine and Related Services, S, $2452.09 |
| 78432 | Myocrd img pet 2rtracer | 1517 New Technology Level 17, S, $1550.50 | 5594 Level 4 Nuclear Medicine and Related Services, S, $2452.09 |
| 78433 | Myocrd img pet 2rtracer ct | 1522 New Technology Level 22, S, $2250.50 | 5594 Level 4 Nuclear Medicine and Related Services, S, $2452.09 |

**Universal Low Volume APC Policy for Clinical and Brachytherapy APCs – pg. 179**
Beginning with the CY 2022 HOPPS final rule, CMS adopted and implemented a universal low volume APC policy for CY 2022 and subsequent calendar years. This policy states when a clinical or brachytherapy APC has fewer than 100 single claims that can be used for ratesetting, under the low volume APC payment adjustment policy CMS determines the APC cost as the greatest of the geometric mean cost, arithmetic mean cost, or median cost based on up to 4 years of claims data.

For CY 2027, CMS proposes to designate five brachytherapy APCs as low volume APCs as well as four clinical APCs. Table 23 in the proposed rule lists the proposed low volume APCs using comprehensive (OPPS) ratesetting methodology for CY 2027.

**Proposed Low Volume Brachytherapy APCs for CY 2027**

| APC | APC Description | CY 2025 Claims Available for Rate Setting | Proposed CY 2027 APC Payment Rate |
|---|---|---|---|
| 2635 | Brachytx, non-str, HA, P-103 | 28 | $100.33 |
| 2642 | Brachytx, stranded, C-131 | 41 | $123.23 |
| 2643 | Brachytx, non-stranded, c-131 | 78 | $121.45 |
| 2645 | Brachytx, non-stranded, gold-198 | 87 | $1,195.13 |
| 2647 | Brachytx, NS, Non-HDRIr-192 | 13 | $420.96 |

**Payment for Drugs, Biologicals, and Radiopharmaceuticals**
CMS pays drugs, biologicals, and radiopharmaceuticals under the HOPPS using three payment approaches: packaged payment, separate payment for products that exceed the cost threshold, or transitional pass-through payment. When an item is packaged, its cost is included in the payment for the related procedure or service, and hospitals do not receive a separate

payment. Beneficiaries also cannot be billed separately for packaged items because those costs are incorporated into the OPPS payment rate for the associated outpatient service.

Proposed Packaging of Payment for HCPCS Codes that Describe Certain Drugs, Certain Biologicals, and Certain Radiopharmaceuticals Under the Cost Thresholds – pg. 285
CMS proposes to package drugs, biologicals, and therapeutic radiopharmaceuticals with a per day cost less than or equal to $140 and identify items with a per day cost greater than $140 as separately payable unless they are policy packaged.

Proposed Payment for Non-Pass-Through Drugs, Biologicals, and Radiopharmaceuticals with HCPCS Codes but Without OPPS Hospital Claims Data – pg. 304
For CY 2027, CMS proposes to maintain the existing payment policy for non-pass-through drugs, biologicals, and radiopharmaceuticals that have HCPCS codes but lack OPPS hospital claims data. Because claims data are unavailable, CMS estimates the average number of units typically provided to a patient in a single day in the hospital outpatient setting to determine whether the product exceeds the per-day cost threshold. CMS then applies ASP plus 6 percent (or WAC or AWP when applicable) to assign the appropriate payment status indicator.

Prospective Adjustment to Payments for Non-Drug Items and Services to Offset the Increased Payments for Non-Drug Items and Services Made in CY 2018 Through CY 2022 as a Result of the 340B Payment Policy – pg. 305
The Remedy for the 340B-Acquired Drug Payment Policy for Calendar Years 2018-2022 (88 FR 77150) codified an annual 0.5 percent reduction in the OPPS conversion factor applicable to non-drug items and services, excluding hospitals that enrolled in Medicare after January 1, 2018, until CMS estimated that the reduction had fully offset the additional $7.8 billion in non-drug services payments made as part of the prior 340B drug payment policy. This reduction was effective January 1, 2026. For CY 2027, CMS proposes to increase the annual percent reduction to the OPPS conversion factor used to determine the payment amounts for non-drug items and services for hospitals for whom this adjustment applies from 0.5 percent to 3 percent.

CMS is seeking comments on their proposal to increase the annual percent reduction to 3 percent. CMS is also specifically seeking feedback on the advisability of increasing the annual percent reduction to 2 percent. Table 48 in the proposed rule illustrates the proposed 3 percent and alternative 2 percent CF annual reduction to the OPPS non-drug items and services beginning in CY 2027 to maintain budget neutrality.

CY 2027 OPPS Payment Methodology for 340B Purchased Drugs Based on Survey Results – pg. 354
CMS proposes to use its authority under section 1833(t)(14)(A)(iii)(I) of the Social Security Act to pay 340B-acquired drugs at ASP minus 33.4% and non-340B drugs at ASP plus 6% beginning in CY 2027 and beyond. The proposed 340B payment rate is based on data from the agency's drug acquisition cost survey and incorporates several data adjustments, including volume-weighted estimates, outlier removal using the OPPS geometric mean trimming methodology, and

exclusions for anomalous data. If finalized, the policy would take effect on January 1, 2027. CMS also proposes to exempt rural sole community hospitals (SCHs), PPS-exempt cancer hospitals, and children's hospitals from the 340B payment reduction.

Separate Payment for Diagnostic Radiopharmaceuticals – pg. 285

In the CY 2025 HOPPS final rule, CMS finalized a policy to pay separately for any diagnostic radiopharmaceutical with a per day cost greater than $630 for 2025. For CY 2027, CMS proposes to update the CY 2025 $630 threshold amount by the four-quarter moving average PPI levels for Pharmaceuticals for Human Use, Prescription to trend the $630 threshold forward. Based on this methodology, CMS trended the $630 threshold forward and rounded the resulting dollar amount ($667.44) to the nearest $5 increment.

For 2027, CMS proposes to pay separately for diagnostic radiopharmaceuticals with a per-day cost above $665. The proposed list of diagnostic radiopharmaceuticals that CMS calculated as having per day costs that exceeded $665 and their proposed status indicators can be found in Table 4 of this rule.

CMS proposes paying qualifying diagnostic radiopharmaceuticals based on the arithmetic Mean Unit Cost (MUC) in CY 2027 while continuing to encourage manufacturers to submit Average Sales Price (ASP) data for possible future payment use. For new diagnostic radiopharmaceuticals with HCPCS codes that do not have pass-through status, claims data or ASP, CMS will use Wholesale Acquisition Cost (WAC). If WAC also is unavailable, CMS will base payment on 95 percent of Average Wholesale Price (AWP).

**Proposed CY 2027 Changes to IPO List – pg. 413**

For CY 2026 and subsequent years, CMS proposes to eliminate the Inpatient Only (IPO) List through a 3-year transition, completing the elimination by January 1, 2029. Currently, there are 1,438 services remaining on the IPO list. For CY 2027, CMS proposes to remove 637 services from the following clinical families: auditory, digestive, endocrine, female genital, hemic and lymphatic systems, integumentary, male genital, maternity care and delivery, mediastinum and diaphragm, respiratory, and urinary.

CMS expects the remaining services to be removed from the list in CY 2028, as CMS believes they are more complicated in nature and will require additional considerations due to their complex clinical nature and resources required.

**Expanding the Method to Control Unnecessary Increases in the Volume of Outpatient Services – pg. 418**

In the CY 2026 OPPS/ASC proposed and final rules, CMS indicated they had concerns about the services within the imaging without contrast APCs (APCs 5521-5524). CMS stated that imaging without contrast services are often high-volume, low-intensity services that can be provided in OPDs or freestanding offices. In the CY 2026 OPPS/ASC proposed rule, CMS stated they had concerns these services had experienced unnecessary growth and that a volume

control method may be appropriate to apply in the future. CMS did solicit comments on this issue in last year's proposed rule.

Payment for Imaging Without Contrast Services at PBDs

For CY 2027, CMS proposes to include imaging without contrast services furnished in excepted off-campus PBDs. CMS states that imaging without contrast services can be safely and effectively furnished in multiple settings, including freestanding physician offices and hospital OPDs, without compromising diagnostic quality or patient safety. CMS used the example of echocardiograms (93306) that this service was frequently provided in OPDs and freestanding physician offices, Medicare paid 294 percent more in an OPD than in a freestanding office.

Specifically, CMS proposes to use the agency's authority under section 1833(t)(2)(F) of the Social Security Act to apply the Physician Fee Schedule equivalent payment rate for any HCPCS codes assigned to the imaging without contrast ambulatory payment classifications (APCs) when provided at an off-campus PBD excepted from section 603 of the Bipartisan Budget Act of 2015. As with the existing volume control method for off-campus clinic visits and drug administration services, CMS proposes to exempt rural Sole Community Hospitals from this proposed policy.

For CY 2027, CMS estimates this provision would reduce Medicare Part B expenditures by approximately $260 million in the first year, including approximately $190 million in Part B savings and approximately $70 million in reduced beneficiary premiums. In addition, beneficiary cost-sharing obligations are estimated to decrease by approximately $70 million in the first year.

CMS does not believe that the imaging payment limitation established under section 5102 of the Deficit Reduction Act (DRA) of 2005 (Pub. L. 109-171), codified at section 1848 of the Act), constrains their ability to implement a volume control method for imaging without contrast services furnished in excepted off-campus PBDs.

Impact of Unnecessary Increases in Volume on the OPPS

CMS highlight trends in the increase of volume of services since 2019. As shown in Table 58 in the rule, from 2019 through 2027, hospital outpatient costs per FFS enrollee are projected to grow at a mean annual rate of approximately 7.7 percent and a median annual rate of 9.2 percent. As seen in Table 59, over this period outpatient hospital spending per FFS enrollee is projected to increase from $1,738 in 2019 to $3,238 in 2027, an increase of about 86 percent. CMS states that this level of growth exceeds that observed in other categories of Part B services in dollar terms and occurs despite relatively stable or declining FFS enrollment over much of the period.

Multiple Procedure Discounts

CMS believes it is also appropriate to apply the volume control methodology to APCs 8004 (Ultrasound Composite), 8005 (CT and CTA without Contrast Composite), and 8007 (MRI and

MRA without Contrast Composite). APCs 8004, 8005, and 8007 are comprised of HCPCS codes assigned to the imaging without contrast APCs that would be subject to the volume control methodology when paid separately.

Payment for Imaging without Contrast Services for CY 2027 and Subsequent Years

CMS believes that paying for imaging without contrast services provided at excepted off-campus PBDs at the PFS-equivalent rate could be an effective method to control the volume of these unnecessary services because the payment differential that is driving the site-of-service decision will be removed. CMS states that this method will control unnecessary volume increases both in terms of the number of covered OPD services furnished and costs associated with those services.

CMS proposes to apply the PFS-equivalent payment rate to HCPCS codes assigned to the imaging without contrast APCs and to services paid through APCs 8004 (Ultrasound Composite), 8005 (CT and CTA without Contrast Composite), and 8007 (MRI and MRA without Contrast Composite) when furnished at an off-campus PBD excepted from section 1833(t)(21) of the Act (departments that bill modifier "PO" on claim lines). Under the authority in section 1833(t)(2)(F) of the Act, CMS would implement this proposal by applying an amount equal to the site-specific PFS payment rate for non-excepted items and services furnished by a non-excepted off-campus PBD (the PFS-equivalent payment rate). Table 60 shows the specific APCs that CMS would identify for this proposal, which are APCs 5521 through 5524, 8004, 8005, and 8007. Off-campus PBDs that are not excepted from section 603 (departments that bill the modifier "PN") already receive a PFS-equivalent payment rate for any HCPCS codes assigned to the imaging without contrast APCs.

**OPPS Payment for Software as a Medical Service (SaMS) – pg. 448**

CMS proposes the following changes regarding software-based medical services with algorithmic analyses:

- CMS proposes changing the terminology from Software as a Service (SaaS) to Software as a Medical Service (SaMS).
- CMS proposes to use CY 2027 as a transitional period to take an incremental step toward developing a more comprehensive and appropriate payment methodology for services CMS proposes to identify as SaMS.
- For SaMS that are currently assigned to New Technology APCs for CY 2026, CMS proposes to maintain the current New Technology APCs for CY 2027 rather than assigning payment rates based on current claims data.
- CMS proposes to assign SaMS assigned to a New Technology APC to a proposed new status indicator "O1" – Software as a Medical Service, paid under OPPS; separate APC payment.

Atherosclerosis Imaging-Quantitative Computer Tomography (AI-QCT) – pg. 165
Code 75577 describes AI-QCT: a software-based service with algorithmic analysis that assesses the extent of coronary artery disease severity.

For CY 2027, CMS proposes to designate 75577 as a SaMS procedure and maintain the existing New Technology APC placement using their authority at 1833(t)(2)(E) of the Act. Therefore, for CY 2027, CMS proposes to maintain the APC assignment for CPT code 75577 to APC 1511 (New Technology - Level 11) with a payment rate of $950.50. Additionally, CMS proposes to assign CPT code 75577 to proposed new status indicator "O1" to designate the service as SaMS.

Quantitative Magnetic Resonance for Analysis of Tissue Composition – pg. 170
Codes 0648T and 0649T (trade name LiverMultiScan) help evaluate and manage chronic liver disease with by using algorithmic analysis software that measures liver tissue characteristics.

For CY 2027, CMS proposes to designate 0648T (and its add-on code 0649T) as a SaMS procedure and maintain the existing New Technology APC placement using their authority at 1833(t)(2)(E) of the Act. Therefore, for CY 2027, CMS proposes to maintain the APC assignment of APC 1511 (New Technology - Level 11) with a payment rate of $950.50. Additionally, CMS proposes to assign CPT codes 0648T and 0649T to proposed new status indicator "O1" to designate the services as SaMS.

Lung Cancer Prediction (LCP) – pg. 171
Codes 0721T and 0722T describe quantitative computed tomography tissue characterization, used in products such as Optellum's lung cancer prediction (LCP) technology.

For CY 2027, CMS proposes to designate codes 0721T and 0722T as SaMS procedures and maintain the existing New Technology APC placement using their authority at 1833(t)(2)(E) of the Act. Therefore, for CY 2027, CMS proposes to maintain the APC assignment of APC 1505 (New Technology - Level 8) with a payment rate of $650.50. Additionally, CMS proposes to assign CPT codes 0721T and 0722T to proposed new status indicator "O1" to designate the services as SaMS.

Quantitative Magnetic Resonance (QMR) for Analysis of Tissue Composition – pg. 173
Codes 0697T and 0698T are used to report services such as CoverScan, software that analyzes MR data and provides quantified metrics of multiple organs such as the heart, lungs, liver, spleen, pancreas, and kidneys.

For CY 2027, CMS proposes to designate codes 0697T and 0698T as SaMS procedures and maintain the existing New Technology APC placement using their authority at 1833(t)(2)(E) of the Act. Therefore, for CY 2027, CMS proposes to maintain the APC assignment of APC 1511 (New Technology - Level 11) with a payment rate of $950.50. Additionally, CMS proposes to assign CPT codes 0697T and 0698T to proposed new status indicator "O1" to designate the services as SaMS.

Quantitative Magnetic Resonance Cholangiopancreatography (QMRCP) – pg. 176
Codes 0723T and 0724T describe quantitative magnetic resonance cholangiopancreatography (QMRCP) services that perform quantitative assessment of the biliary tree and gallbladder.

For CY 2027, CMS proposes to designate codes 0723T and 0724T as SaMS procedures and maintain the existing New Technology APC placement using their authority at 1833(t)(2)(E) of the Act. Therefore, for CY 2027, CMS proposes to maintain the APC assignment of APC 1511 (New Technology - Level 11) with a payment rate of $950.50. Additionally, CMS proposes to assign CPT codes 0723T and 0724T to proposed new status indicator "O1" to designate the services as SaMS.

Augmentative Analysis of CT Chest Data for Interstitial Lung Disease – pg. 177
Codes 0877T and 0878T describe augmentative analysis of chest CT imaging data to assess for interstitial lung disease and idiopathic pulmonary fibrosis, also known by the trade name Fibresolve.

For CY 2027, CMS proposes to designate codes 0877T and 0878T as SaMS procedures and maintain the existing New Technology APC placement using their authority at 1833(t)(2)(E) of the Act. Therefore, for CY 2027, CMS proposes to maintain the APC assignments for CPT codes 0877T and 0878T to APC 1508 (New Technology - Level 8) with a payment rate of $650.50. Additionally, CMS proposes to assign CPT codes 0877T and 0878T to proposed new status indicator "O1" to designate the services as SaMS.

Quantitative MRI (qMRI) Services – pg. 453
Codes 0865T and 0866T are used to report services for quantitative magnetic resonance imaging (MRI) software analysis of the brain.

For CY 2027, CMS proposes to assign codes 0865T and 0867T SaMS procedures and change the APC placement to APC 1504 (New Technology – Level 4) with a payment rate of $250.50. Additionally, CMS proposes to assign CPT codes 0865T and 0867T to proposed new status indicator "O1" to designate the services as SaMS.

Fractional Flow Reserve Derived from Computed Tomography (FFRCT) – pg. 453
Code 75580 is used to report fractional flow reserve derived from computed tomography (FFRCT). Also known by the trade name HeartFlow, FFRCT measures coronary artery disease using coronary CT scans.

For CY 2027, CMS proposes to assign 75580 as a SaMS procedure and change the APC placement to APC 1510 (New Technology – Level 10) with a payment rate of $850.50. Additionally, CMS proposes to assign CPT code 75580 to proposed new status indicator "O1" to designate the service as SaMS.

3D Anatomical Segmentation Imaging – pg. 453

Code C8001 is used to report 3D anatomical segmentation imaging for preoperative planning, data preparation and transmission, obtained from previous diagnostic computed tomographic or magnetic resonance examination of the same anatomy.

For CY 2027, CMS proposes to assign C8001 as a SaMS procedure and change the APC placement to APC 1503 (New Technology – Level 3) with a payment rate of $150.50. Additionally, CMS proposes to assign CPT code C8001 to proposed new status indicator "O1" to designate the service as SaMS.

Table 61 in this proposed rule contains the full list of proposed new technology APC and SI assignments for proposed SaMS HCPCS codes for CY 2027. CMS requests comment on the proposals, including the list of HCPCS codes being proposed to designate as SaMS and that CMS proposes to reassign to new technology APCs for CY 2027, including whether there are any additional HCPCS codes CMS should consider.

**Proposed SaMS HCPCS Codes for CY 2027**

| HCPCS Code | Short Descriptor | CY 2026 OPPS Final APC, SI, Payment Rate | CY 2027 OPPS Proposed APC, SI, Payment Rate |
|---|---|---|---|
| 75577 | Quan&char c athrosclrtc plaq | APC 1511 - New Technology Level 11, S[6], $950.50 | APC 1511 New Technology Level 11, O1[7], $950.50 |
| 0648T | Quan mr tis wo mri 1orgn | APC 1511 New Technology Level 11, S, $950.50 | APC 1511 New Technology Level 11, O1, $950.50 |
| 0649T | Quan mr tiss w/mri 1orgn | APC 1511 New Technology Level 11, S, $950.50 | APC 1511 New Technology Level 11, O1, $950.50 |
| 0697T | Quan mr tis wo mri mlt orgn | APC 1511 New Technology Level 11, S, $950.50 | APC 1511 New Technology Level 11, O1, $950.50 |
| 0698T | Quan mr tiss w/mri mlt orgn | APC 1511 New Technology Level 11, S, $950.50 | APC 1511 New Technology Level 11, O1, $950.50 |
| 0721T | Quan ct tiss charac w/o ct | APC 1508 New Technology Level 8, S, $650.50 | APC 1508 New Technology Level 8, O1, $650.50 |
| 0722T | Quan ct tiss charac w/ct | APC 1508 (New Technology Level 8), S, $650.50 | APC 1508 New Technology Level 8, O1, $650.50 |
| 0723T | Qmrcp w/o dx mri sm anat ses | APC 1511 New Technology Level 11, S, $950.50 | APC 1511 New Technology Level 11, O1, $950.50 |
| 0724T | Qmrcp w/dx mri same anatomy | APC 1511 New Technology Level 11, S, $950.50 | APC 1511 New Technology Level 11, O1, $950.50 |
| 0865T | Quan mri alys brn w/o dx mri | APC 5523 Level 3 Imaging without Contrast, S, $243.77 | APC 1504 New Technology Level 4, O1, $250.50 |
| 0866T | Quan mri alys brn w/dx mri | APC 5523 Level 3 Imaging without Contrast, S, $243.77 | APC 1504 New Technology Level 4, O1, $250.50 |

[6] S - Procedure or Service, Not Discounted When Multiple; separate APC payment

[7] O1 – Software as a Medical Service – Paid under OPPS; separate APC payment

| | | | |
|---|---|---|---|
| 0877T | Augmnt alys ch ct ild w/o ct | APC 1508 New Technology Level 8, S, $650.50 | APC 1508 New Technology Level 8, O1, $650.50 |
| 0878T | Augmnt alys ch ct ild w/ct | APC 1508 New Technology Level 8, S, $650.50 | APC 1508 New Technology Level 8, O1, $650.50 |
| 75580 | N-invas est c ffr sw aly cta | APC 5724 Level 4 Diagnostic Tests & Related Services, S, $877.34 | APC 1510 New Technology Level 10, O1, $850.50 |
| C8001 | 3d anat seg imaging preop | APC 5721 Level 1 Diagnostic Tests & Related Services, S, $131.46 | APC 1503 New Technology Level 3, O1, $150.50 |

**Request for Information (RFI) on Strengthening the Standardization and Comparability of Hospital Price Transparency (HPT) Data – pg. 634**
CMS is requesting information regarding potential approaches to improve comparability and standardization of the HPT information reported in machine-readable files (MRFs) and consumer-friendly displays. CMS is particularly interested in comments regarding the reporting of contract mechanisms such as outlier payments, stop-loss provisions, rate tiering, and carve-outs.

The RFI also seeks public comment on potential approaches to enhance the comparability and usefulness of the consumer-friendly display requirements, including feedback on whether to modify or eliminate the current deemed compliance policy for internet-based price estimator tools, update the required list of shoppable services, and provide additional clarification regarding the items and services included in displayed prices, such as ancillary and bundled services.

**Hospital Quality Reporting Programs**
The following summarizes the proposed updates to the Hospital Outpatient Quality Reporting (OQR) Program, Rural Emergency Hospital Quality Reporting (REHQR) Program, and the Request for Information (RFI) on New Measure Concepts.

**Hospital Outpatient Quality Reporting (OQR) Program – pg. 541**
CMS proposes several updates to the Hospital OQR Program's validation and reconsideration processes, including the incorporation of electronic clinical quality measure (eCQM) validation into the program's existing framework. In other words, CMS would audit and verify hospitals' submitted eCQM data against medical record documentation to confirm accurate quality reporting once a full year of measure data is available.

As proposed, reconsideration would continue to provide hospitals with an opportunity to appeal agency determinations regarding program compliance. It would also change how hospitals and cases are picked and reviewed, as well as how records, scores, and reviews are handled. The agency states these changes are intended to improve the accuracy, reliability, and accountability of electronically reported quality data as it continues its transition toward digital quality measurement (dQM) and future FHIR-based reporting frameworks. CMS anticipates

that the proposed validation and reconsideration changes would improve the accuracy of reported quality data while reducing overall burden for participating hospitals. A more detailed discussion of the proposed validation policies can be found on page 229 of this proposed rule.

CMS is also proposing to remove the *Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients* measure from the program beginning with the CY 2027 reporting period/CY 2029 payment determination. CMS states that an existing measure, the *Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy*, is more closely associated with patient outcomes and therefore better aligns with the agency's quality measurement priorities. This proposal is consistent with CMS's broader effort to emphasize measures that demonstrate clinical outcomes and value over those focused primarily on care processes or documentation practices.

Although neither proposal directly affects radiology quality reporting requirements, both signal broader changes in CMS's approach to quality measurement. While no imaging-specific measures are proposed in this rule, these developments could influence future radiology measure development, reporting requirements, registry participation, and the infrastructure needed to support quality reporting in an increasingly digital environment.

**Rural Emergency Hospital Quality Reporting (REHQR) Program – pg. 567**
Because CMS is not proposing any changes to the REHQR Program, the proposed rule does not directly affect radiology facilities, imaging departments, or imaging services operating within Rural Emergency Hospitals. ACR will continue to monitor future rulemaking affecting the REHQR Program, particularly as the agency advances broader initiatives related to quality measurement, interoperability, dQMs, and electronic reporting across its quality reporting programs. Future changes in these areas could have implications for imaging services furnished in rural settings.

**Requests for Information (RFI) – pg. 543**
CMS is seeking stakeholder feedback on whether an Advance Care Planning (ACP) measure should be considered for future inclusion in the OQR Program. As more care shifts to hospital outpatient departments (HOPDs), the agency is evaluating whether these settings should play a larger role in documenting patients' care goals, advance directives, and surrogate decision-makers. It specifically references existing ACP measure concepts, including MIPS Quality Measure #047: Advance Care Plan, and asks whether that concept could be adapted for use in the OQR Program and applied within the HOPD setting, either in its current form or with modifications.

The relevance of an ACP measure would likely vary across radiology subspecialties because it is generally not part of routine diagnostic imaging and is typically conducted by providers responsible for a patient's longitudinal care, while interventional radiologists and breast imagers may have more direct patient interaction, they are not generally responsible for leading or documenting ACP discussions. CMS's request for information on whether the measure

should be limited to certain populations, procedures, or departments is therefore especially relevant for radiology.

If CMS pursues this concept, attribution should be limited to providers and settings with a meaningful opportunity to conduct and document ACP activities. Broad application across all outpatient hospital services could create challenges for specialties, including radiology, with limited involvement in these discussions.

Because the OQR Program is facility-level it is unclear how accountability for a future ACP eCQM would be attributed within the HOPD setting. Moreover, broad application across all outpatient hospital services could present challenges for specialties, including radiology, that generally have limited involvement in these discussions.

**The ACR's Hospital Reimbursement Committee and staff will review these proposed changes and will draft comments during the 60-day comment period. Comments are due to CMS by August 31st, 2026.**