American College of Radiology

American College of Radiology Detailed Summary of Radiology Provisions in the 2027 Medicare Physician Fee Schedule (PFS) Final Rule

The Centers for Medicare and Medicaid Services (CMS) released the calendar year (CY) 2027 Medicare Physician Fee Schedule (PFS) final rule on Wednesday, November 4, 2026. In this rule, CMS describes finalized changes to payment provisions and to policies for the Quality Payment Program (QPP) and its component participation methods – the Merit-Based Incentives Payment System (MIPS) and Advanced Alternative Payment Models (APMs).

Conversion Factor and CMS Overall Impact Estimates

Beginning CY 2026, there are two separate conversion factors resulting from the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The 2027 conversion factor for services provided by a qualifying APM participant will be $32.9548, down 1.83 percent from the current conversion factor of $33.5675. The final qualifying APM rate for 2027 is inclusive of a 0.75 percent annual update and a negative 0.12 percent budget neutrality adjustment. Services provided by non-APM participants will have a conversion factor of $32.6286, down 2.31 percent from the current conversion factor of $33.4009. The proposed non-APM participant rate for 2027 includes a 0.25 percent annual update and a negative 0.12 percent budget neutrality adjustment. Both conversion factors see an aggregate decrease due to the expiration of the one-year 2.5 percent conversion factor increase mandated by statute.

CMS did not include an overall specialty-level impact table in this year's final rule. Instead, they posted tables on the CMS website in text file format. It appears that overall impacts of changes in the final rule are positive 1 percent for diagnostic radiology, 3 percent for interventional radiology, 1 percent for nuclear medicine and 2 percent for radiation oncology. Note that actual impacts may be less due to the conversion factor decrease. ACR will request a more readable file from CMS to verify these impacts.

New and Revised Codes

For CY 2027, CMS finalized the American Medical Association (AMA) Relative Value Scale Update Committee (RUC)-recommended values for many radiology-related services, including fine needle aspiration, MRA head and neck, and CT upper extremity codes. However, for selected services, including percutaneous lumbar decompression and treatment of incompetent veins, despite stakeholder feedback in support of the RUC-recommended values, CMS proceeded with the implementation of their refined values as previously proposed.

Determination of Practice Expense (PE) Relative Value Units (RVUs)

For 2027, CMS is finalizing their proposal to allocate indirect PE using both the work RVU and clinical labor RVU for all services, except for 10- and 90-day global service codes. CMS is also finalizing an update to the PE RVU calculation that will remove the indirect practice cost index (IPCI) over a 2-year transition period. CMS acknowledged that they were unable to provide specialty or code-specific impact tables in the proposed rule, as many of their proposals were interconnected.

Accounting for Evaluation and Management (E/M) Resource Overlap Between Stand-Alone Visits and Global Periods
CMS believes that there is a duplicative payment under the current PE methodology when the same physician provides an office/outpatient evaluation and management (E/M) service for the same patient in conjunction with a procedure with a 0-, 10- or 90- day global period. CMS proposed a policy to reduce payment for the less expensive service performed on the same day (either procedure or E/M) by 50 percent.

In response to stakeholder feedback, CMS finalized a modified policy where the most expensive service will be paid at 100 percent, and all other surgical procedure(s) or E/M visit(s) will be reduced by 20 percent as opposed to the proposed 50 percent. In addition, the policy will only apply to 0-day global procedures and not 10- or 90-day global procedures.

Potentially Misvalued Services
Image-guided robotic linear accelerator stereotactic radiosurgery
CMS rejected the RUC's recommendation to delete HCPCS codes G0339 and G0340 for CY 2027, citing their continued high utilization and concerns about potential billing disruption. While the agency declined to remove the codes at this time, CMS indicated that future coding or valuation changes may still be considered as part of ongoing review efforts.

Current Procedural Terminology (CPT®) Request for Information (RFI)
CMS requested feedback from stakeholders on use of the CPT ® coding system and the AMA's ownership of it. CMS shared that most of the comments that they received "highlighted the importance of having a unified national coding standard". CMS also received an overwhelming response to their request for improvements to the CPT and RUC processes, mostly focused on the RUC. CMS indicated that they will take the comments into consideration, especially regarding transparency, improving the data used for making payment recommendations, and evaluating the retirement of low-value services, among other issues. CMS continues to express its interest in empiric data and sources. Commenters shared with CMS that using ICD-10 codes for physician payment may have drawbacks, as they are different than CPT codes.

Changes to the Medicare Telehealth Services List
CMS did not receive any requests to add or remove services from the Medicare Telehealth Services List for CY 2027.

<u>Telehealth Flexibilities and Modifiers</u>
In accordance with section 6209(g) of Consolidated Appropriations Act, 2026 (CAA, 2026) CMS is creating modifiers BB (*Claims for telehealth services that are furnished through a telehealth virtual platform by a physician or practitioner that contracts with an entity that owns such virtual platform, or for which a physician or practitioner has a payment arrangement with an entity for use of such virtual platform.*) and BC (*Telehealth services that are furnished incident to a physician's or practitioner's professional service.*). Section 6209(g) of the CAA, 2026, requires CMS to establish modifiers for telehealth services in certain instances, effective January 1, 2027. These modifiers do not affect payment and are required for claims for telehealth services that are

furnished through a virtual telehealth platform by a physician or practitioner that contracts with an entity that owns such virtual platform; or for which a physician or practitioner has a payment arrangement with an entity for use of such virtual platform; and for claims for telehealth services that are furnished incident to a physician's or practitioner's professional service.

Guidance on use of these modifiers will be available on the CMS website.

Changes to Teaching Physicians' Billing for Services Involving Residents or Teaching Physicians with Virtual Presence

In the CY 2026 PFS final rule, CMS finalized permanently allowing teaching physicians to have a virtual presence in all teaching settings, only in clinical instances when the service is a three-way telehealth visit, with the teaching physician, resident, and patient in different locations.

For CY 2027, CMS finalized its proposed modification to the previously finalized policy. Rather than requiring the teaching physician, resident, and patient to each be in a different location, CMS will allow teaching physicians to bill for services involving residents when either the teaching physician or resident is in the same physical location as the beneficiary. CMS states they generally interpret physical presence to be defined as either the teaching physician or resident in the same room as the beneficiary.

Quality Payment Program (QPP)

Advanced Alternative Payment Models (APM)

For the Advanced APM track, if an eligible clinician participates in an Advanced APM and achieves Qualifying APM Participant (QP) or Partial QP status, they are excluded from the MIPS reporting requirements and payment adjustment.

CMS finalized its proposal to apply QP and Partial QP determinations at the Taxpayer Identification Number/National Provider Identifier (TIN/NPI) level, ensuring that financial incentives are directed only to TINs actively participating in Advanced APMs.

APM Performance Pathway (APP)

The APP was designed as a reporting and scoring pathway available only to MIPS eligible clinicians identified on the Participation List or Affiliated Practitioner List of an APM Entity participating in a MIPS APM. CMS finalized its proposal to align quality measures in the APM Performance Pathway (APP), original quality measure set and the APP Plus quality measure set to reflect the proposed changes to measures specified for the quality performance category. Table C-BC1 in the final rule lists the APM Performance Pathway Quality Measure Set.

MIPS Value Pathways (MVPs)

CMS finalized its proposal to make MIPS Value Pathways (MVPs) the primary MIPS reporting framework and to retire traditional MIPS reporting beginning with the CY 2029 performance period (2031 payment year). Beginning in CY 2029, most clinicians will participate through an MVP rather than traditional MIPS.

For CY 2027, CMS finalized three new MVPs:

1. Diabetic Disease MVP
2. Hypertension MVP
3. Hospitalist MVP

CMS stated that its goal is to expand MVP coverage so that nearly all specialties have an appropriate pathway available before traditional MIPS is sunset.

Several broader MIPS changes described in the section following the Requests for Information below would also affect MVP participants because MVPs use the same underlying MIPS framework. As CMS updates quality measures, cost measures, Improvement Activities, and Promoting Interoperability requirements, those changes automatically flow into MVP reporting. This means measure additions, removals, and category-specific policy changes in traditional MIPS will also impact MVP participants.

Diagnostic Radiology MVP Updates

CMS finalized modifications to the Diagnostic Radiology MVP for CY 2027, including the addition of measures addressing dementia and amyotrophic lateral sclerosis (ALS).

Requests for Information (RFIs)

In the proposed rule, CMS requested feedback through two RFIs addressing MIPS quality measure reporting and the MVP scoring methodology. These RFIs did not themselves establish requirements, and CMS did not finalize a FHIR implementation timeline or a new MVP scoring methodology in this final rule.

Fast Healthcare Interoperability Resources (FHIR) Timeline

The FHIR RFI addressed a potential future shift from current MIPS/QPP quality reporting approaches to FHIR-based digital quality reporting. CMS sought feedback on a possible two-year transition beginning with the CY 2028 performance period that would maintain existing reporting options while supporting FHIR-based reporting for selected measures.

CMS also requested comments on potentially requiring FHIR-based reporting for applicable measures beginning with the CY 2030 performance period, at which point prior electronic reporting approaches would no longer be available for those measures. CMS did not finalize this timeline or mandatory reporting requirement in the CY 2027 final rule.

MVP Scoring Methodology

CMS requested input on a potential MVP scoring methodology that would compare clinician performance within the same MVP, recognizing that each MVP focuses on measures and activities relevant to a particular specialty or medical condition.

The agency also requested feedback on whether MVP scores should be normalized within an MVP and on the timing of any future implementation. CMS did not finalize MVP score normalization or a new MVP scoring methodology in the CY 2027 final rule.

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MIPS Scoring Overview

The category weights for the 2027 performance year will remain unchanged: Quality – 30%, Cost – 30%, PI – 25%, and IAs – 15%. Previously established reweighting formulas for non-patient-facing clinicians and small practices are set to continue with no proposed changes. In the 2026 PFS Final Rule, CMS finalized its proposal to maintain the performance threshold at 75 points through the 2028 performance year.

CMS finalized the payment adjustment of +/- nine percent for performance years 2020 and beyond. No changes were proposed to the MIPS adjustment. CMS will maintain the small practice bonus of 6 points for the Quality performance category score, and all previously finalized considerations for small practices.

Quality Performance Category

CMS finalized its proposal to remove the requirement that MIPS clinicians must submit at least one Outcome measure; this will be replaced with a requirement to report at least one MIPS "core measure," if available. Like the prior Outcome measure requirement, this will apply to MVPs as well. Small practices will be exempt from the requirement to submit a core measure.

The Diagnostic Radiology measures designated as core measures in 2027 will be:

- **#145:** Radiology: Exposure Dose Indices Reported for Procedures Using Fluoroscopy
- **#360:** Optimizing Patient Exposure to Ionizing Radiation: Count of Potential High Dose Radiation Imaging Studies: Computed Tomography (CT) and Cardiac Nuclear Medicine Studies
- **#405:** Appropriate Follow-up Imaging for Incidental Abdominal Lesions

CMS also finalized its proposal to add the QCDR measure **ACRad34: Overall Percent of CT Exams for which Dose Length Product is at or below the Size-Specific Diagnostic Reference Level** to the Diagnostic Radiology MVP, as well as a selection of Dementia measures to the Nuclear Medicine clinical grouping.

CMS will maintain the measure scoring policy established in 2025 which identifies certain measure sets affected by limited measure choice and adjusts the benchmarks of point-capped measures to allow for a maximum score of 10 points.

The diagnostic radiology measure set continues to receive this adjustment, as most of the MIPS measures in that set are topped out. The following radiology measures will receive an adjusted benchmark in 2027:

- **#145:** Radiology: Exposure Dose Indices Reported for Procedures Using Fluoroscopy
- **#360:** Count of Potential High Dose Radiation Imaging Studies: CT and Cardiac Nuclear Medicine Studies
- **#364:** Appropriateness: Follow-up CT Imaging for Incidentally Detected Pulmonary Nodules
- **#405:** Appropriate Follow-up Imaging for Incidental Abdominal Lesions
- **#406:** Appropriate Follow-up Imaging for Incidental Thyroid Nodules

Lastly, CMS finalized its proposal to remove the "high priority" designation as one of the retention criteria for measures in MIPS and the MVP inventory.

Improvement Activities Performance Category

CMS finalized its proposal to add six new Improvement Activities (IAs), modify five IAs, and remove 11 existing Ias. The six IAs added to the program are:

- **IA_CC_20:** Use of Data to Improve Practice Workflows
- **IA_CC_21:** Understand and Improve Diagnostic Performance
- **IA_AHW_2:** Systematic Screening and Intervention for Nutrition and Other Health-Impacting, Non-Clinical Issues
- **IA_AHW_3:** Advance Care Planning Conversations to Support Patient Wellness and Care Preferences
- **IA_AHW_4:** Clinician Use of Artificial Intelligence (AI) to Improve Patient Care
- **IA_AHW_5:** Lifestyle Approaches to Diabetes Remediation

The IAs finalized for removal in 2027 are:

- **IA_BMH_5:** MDD Prevention and Treatment Interventions
- **IA_CC_10:** Care Transition Documentation Practice Improvements
- **IA_CC_11:** Care Transition Standard Operational Improvements
- **IA_CC_12:** Care Coordination Agreements that Promote Improvements in Patient Tracking Across Settings
- **IA_CC_16:** Primary Care Physician and Behavioral Health Bilateral Electronic Exchange
- **IA_PSPA_2:** Participation in MOC Part IV
- **IA_BE_15:** Engagement of Patients, Family, and Caregivers in Developing a Plan of Care
- **IA_PM_19:** Glycemic Screening Services
- **IA_PM_20:** Glycemic Referring Services
- **IA_EPA_4:** Additional Improvements in Access as a Result of QIN/QIU TA
- **IA_PM_2:** Anticoagulant Management Improvements

Cost Performance Category

For the CY 2027 performance period, CMS finalized no major changes to the MIPS Cost performance category. CMS did not add or remove cost measures or make substantive changes to the scoring methodology. The existing population-based and episode-based cost measures will therefore remain in place, subject to routine annual maintenance and coding updates.

Promoting Interoperability Performance Category

CMS finalized several changes to the MIPS Promoting Interoperability (PI) performance category. Beginning with the CY 2027 performance period, the regulatory definition of certified EHR technology (CEHRT) will be revised to align with ONC's recent health IT certification changes. CMS will remove the Security Risk Analysis measure, citing existing HIPAA Security Rule requirements. CMS also finalized a new Electronic Prior Authorization for Prescription Drugs measure, which will be required beginning with the CY 2028 performance period.

Additionally, CMS finalized the discontinuation of the ONC Direct Review and ONC-ACB Surveillance attestation requirements.

Medicare Shared Savings Program
As of January 1, 2026, the Medicare Shared Savings Program (MSSP) has 511 accountable care organizations (ACOs) with over 700,000 healthcare providers and organizations providing care to over 12.6 million assigned beneficiaries. Eligible groups of providers and suppliers, such as physicians, hospitals, and other health care providers, may participate in the MSSP by forming or joining an ACO and in so doing agree to become accountable for the total cost and quality of care provided to an assigned population of Medicare FFS beneficiaries. CMS stated they are focused on developing policies that would grow the number of health care providers and beneficiaries in accountable care relationships and grow savings to the Medicare Trust Funds.

CMS finalized its proposal to revise policies for determining beneficiary assignment under MSSP. CMS also finalized its proposals to revise the quality performance standard and other quality reporting requirements and revise MSSP CEHRT use requirements by simplifying MSSP CEHRT use requirements.

CMS finalized its proposals to revise policies for MSSP financial methodology including to encourage two-sided risk models by increasing the share rate under Level E of the BASIC track and reduce the maximum weight on the regional adjustment for ACOs under the ENHANCED track for ACOs that are lower spending compared to their regional service area.

Additionally, CMS finalized its proposal to increase beneficiary engagement by allowing ACO's to reduce or eliminate Part B cost sharing and discontinue availability of the option for prepaid shared savings.

Fact Sheets
CMS published Fact Sheets on the overall PFS proposed rule and the Shared Savings Program, as well as a Press Release.

ACR staff will review the entire PFS final rule in the coming weeks and will provide a comprehensive summary of the rule.