CY 2027 Hospital Outpatient Prospective Payment System (OPPS), CMS-1850-FC Final Rule Summary

Introductory Summary and Background

On November 4, 2026, the Centers for Medicare & Medicaid Services (CMS) issued the final rule for the Hospital Outpatient Prospective Payment System (OPPS) for Calendar Year (CY) 2027. The rule is in its entirety at the following link: https://www.federalregister.gov/documents/2026/11/06/2026-22739/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment.

Key Provisions for IR

- CMS finalized a 2.3% increase to the outpatient department (OPD) fee schedule for OPPS and Ambulatory Surgery Centers (ASCs) payment rates, based on the market update from the Inpatient Prospective Payment System (IPPS) of 3.2% and a 0.9% productivity adjustment decrease.
- CMS finalized a conversion factor (CF) of $99.970 for hospitals that meet the Hospital Outpatient Quality Reporting (OQR) requirements; and applying the 2 percent reduction to those that do not with a CF equal to $98.011.
- CMS finalized a CF for Ambulatory Surgery Centers (ASCs) of $57.721 for ASCs meeting quality reporting requirements, and a CF of $56.592 for ASCs not meeting quality reporting requirements.
    - Due to previous rulemaking related to the 340B Remedy Offset, the finalized 2027 CF for the hospitals in which this adjustment applies is $99.015. In addition, CMS finalized implementing a yearly 2.0 percent reduction to the conversion factor when determining payment amounts for non-drug items, a change from the previously finalized 0.5 percent, until the payment reductions reach $7.769 billion, which CMS estimates will occur in CY 2031. Details of the changes to the 340B Program are provided below.
    - Ambulatory Surgery Centers (ASCs) are not impacted by any reduction due to the 340B offset remedy.
- CMS estimates total payments to OPPS providers will be approximately $114.4 billion, which is an increase of approximately $11 billion compared to CY 2026 OPPS payments.
- CMS finalized a payment-to-cost ratio (PCR) target of 0.88 for the 11 designated cancer hospitals for CY 2027.
- CMS finalized, as proposed, to reduce payment for imaging without contrast in the excepted provider-based department by the MPFS relativity adjustment to the OPPS payment rate, a reduction of 60% of the OPPS rate. This would apply to all codes in APCs 5521-5524, through APCs 8004-8005, and 8007.
- Finalized, with some modifications from proposals, several services in New Technology APCs to be reassigned to different APCs
    - LimFlow TADV procedure CPT Code 0620T finalized change from proposal, moved to APC 1580
    - Liver Histotripsy Service CPT Code 0686T finalized, as proposed, move to APC 1575
    - Endovenous Femoral-Popliteal Arterial Revascularization with Placement of Stent Graft CPT code 0505T finalized, as proposed, moved to APC 1580
- Addressed several comments related to services which CMS did not specifically ask for input.
    - Nuclear Medicine Procedures APCs 5591–5594 CMS finalized as proposed move to lower APCs with reduced payments
    - Cardiac Magnetic Resonance Imaging, CPT codes 75557, 75559, 75561, 75563 CMS not swayed by comment to change APC assignments, finalized as proposed.

  - C-Codes Describing Percutaneous Coronary Intervention with Drug-Eluting Stents CMS finalized as proposed deletion of codes, did not finalize as requested creation of code to mirror CPT 92930
  - Venous Mechanical Thrombectomy, CPT® code 37187 (APC 5193) CMS finalized as proposed APC assignment indicating request to change proposal to higher APC was not supported.
  - Simulation Angiogram for Radioembolization of Tumors, HCPCS Code C8004 CMS finalized with modification to proposal to align APC assignment to higher level and now matches C9797.
- CMS finalized with modification the per day cost threshold of $635 for qualifying nonpass-through, separately payable diagnostic radiopharmaceuticals.
- CMS finalized the second phase of the IPO List phase-out removing 637 services for CY 2027, approximately half of the remaining 1,438 services still on the IPO list. The clinical families included in this list are auditory, digestive, endocrine, female genital, hemic and lymphatic systems, integumentary, male genital, maternity care and delivery, mediastinum and diaphragm, respiratory, and urinary.
- CMS finalized as proposed to continue the complexity adjusted payments for designated services performed in the ASC to provide a site neutral payment policy between outpatient hospital and ASC.
- CMS finalized as proposed to change the payment indicator for a service which SIR worked to create for IRs in the ASC. Based on claims data CPT code 60660 *(Ablation of 1 or more thyroid nodule(s), one lobe or the isthmus, percutaneous, including imaging guidance, radiofrequency)* is predominantly performed in the office setting, it will be permanently assigned the status indicator "P2". When payment rates are set for this code in particular, values as defined under the Medicare Physician Fee Schedule will be used to set the rate, not values defined under OPPS.

Payment Rates

CMS used the CY 2025 claims data for ratesetting for CY 2027 which follows the usual 2-year difference in data for ratesetting due to allowance for 1-year of timely filing for billing. The Outpatient Department (OPD) increase factor is equal to the hospital inpatient market basket percentage increase applicable to hospital charges.

- CMS finalized a 2.3% increase to the OPD fee schedule for HOPPS and Ambulatory Surgery Centers (ASCs) payment rates based on the market update from the Inpatient Prospective Payment System (IPPS) of 3.2% and a 0.9% productivity adjustment decrease.
- CMS finalized a conversion factor (CF) of $99.970 for hospitals that meet the Hospital Outpatient Quality Reporting (OQR) requirements; and applying the 2 percent reduction to those that do not with a CF equal to $98.011.
- CMS finalized a CF for Ambulatory Surgery Centers (ASCs) of $57.721 for ASCs meeting quality reporting requirements, and a CF of $56.592 for ASCs not meeting quality reporting requirements.
  - For CY 2027, CMS increased the annual OPPS conversion factor reduction under the 340B remedy from 0.5% to 2% for hospitals subject to the adjustment.
  - Ambulatory Surgery Centers (ASCs) are not impacted by the 2 percent reduction for the 340B offset remedy.
  - CMS finalized payment for 340B-acquired drugs at ASP minus 28%. Because the policy is implemented in a budget-neutral manner, CMS estimates a corresponding 7.50% increase to non-drug OPPS service payments.
- CMS finalized, as proposed, application of the PFS-equivalent rate to imaging-without-contrast services furnished in excepted off-campus provider-based departments, generally resulting in payment at

approximately 40% of the full OPPS rate. Rural Sole Community Hospitals are exempt from this policy. CMS estimates total payments to OPPS providers will be approximately $114.4 billion, which is an increase of approximately $11 billion compared to CY 2026 OPPS payments.

- CMS finalized establishment of a cost-of-living adjustment (COLA) for outpatient services in Alaska and Hawaii that parallels the COLA for inpatient services in these states, including any changes finalized in the FY 2027 Inpatient Final Rule to account for the exceedingly high cost of living in each of these states.

Wage Index

CMS finalized continuation of the frontier state hospital wage index policy for CY 2027, which has been in effect since CY 2011. Under this policy, hospitals located in frontier states receive a wage index of 1.0000 if their otherwise applicable wage index is less than 1.0000. This adjustment recognizes the unique challenges associated with serving sparsely populated areas and helps ensure that hospitals in frontier states are not disadvantaged in reimbursement due to their low population density compared with hospitals in other states.

Consistent with the FY 2026 IPPS proposed rule, CMS finalized the discontinuation of the low wage index hospital policy under the OPPS beginning in CY 2026 and future years. As a result, CMS will no longer apply a low wage index budget neutrality factor to the OPPS standardized payment amounts.

In the FY 2027 IPPS final rule, CMS finalized continuing this transitional payment exception, noting that some hospitals that previously benefited from the low wage index hospital policy would still experience wage index decreases of approximately 5 percent or more annually compared with the FY 2024 wage index calculated under the former policy. Accordingly, CMS finalized continuing the transitional payment exception under the OPPS for CY 2027.

Procedures Assigned to New Technology APC Groups

When new technology is assigned a billing code, the establishment of a payment rate by CMS can be difficult because there is no claims data to determine utilization and cost by the hospital. Due to this, CMS created New Technology APCs which are similar to pass-through payments for new drugs, biologicals, radiopharmaceuticals and devices. The new technology is assigned to a temporary APC until claims data is available. Typically, this is a minimum of two years, but it can be less if there is sufficient data available sooner. Once there is sufficient data, the new technology is moved to a clinically appropriate APC.

LimFlow TADV procedure, CPT Code 0620T (APC 1581)

The LimFlow Transcatheter Arterialization of the Deep Veins (TADV) procedure is an endovascular treatment for patients with chronic limb-threatening ischemia who are no longer candidates for conventional endovascular interventions or open bypass surgery to treat arterial blockages. For these patients, the only remaining treatment option is often limb amputation.

CY 2025 claims data showed 28 reported procedures, which remain below CMS's threshold of 100 annual claims for a service to no longer be considered low volume. As a result, CMS proposed to assign the procedure to APC 1581 for CY 2027 with a payment rate of $55,000.50.

For CY 2027, CMS finalized with modification assignment of CPT code 0620T to APC 1580 (New Technology—Level 43). Table 22 outlines the proposed and finalized assignments for CY 2027, a column depicting the final national rate has been added as part of this summary.

TABLE 22: PROPOSED AND FINAL CY 2027 OPPS NEW TECHNOLOGY APC AND STATUS INDICATOR ASSIGNMENT FOR CPT CODE 0620T

HCPCS	Long Descriptor	Proposed CY 2027 OPPS APC, SI	Final CY 2027 OPPS APC, SI	Final CY 2027 Rate
0620T	Endovascular venous arterialization, tibial or peroneal vein, with transcatheter placement of intravascular stent graft(s) and closure by any method, including percutaneous or open vascular access, ultrasound guidance for vascular access when performed, all catheterization(s) and intraprocedural roadmapping and imaging guidance necessary to complete the intervention, all associated radiological supervision and interpretation, when performed	1581, S	1580, S	$45,000.50

Liver Histotripsy Service (APC 1575)

Liver histotripsy is reported using Category III CPT code 0686T. The procedure was initially reimbursed under the clinical study payment designation and has since transitioned to a New Technology APC. Claims data used for CY 2027 rate-setting show that the procedure exceeded CMS's low-volume threshold of 100 claims, with a total of 166 claims reported. As a result, CMS proposed to transition the service to the standard APC rate-setting methodology and assign it to APC 1575 for CY 2027 with a payment rate of $12,500.50.

For CY 2027, CMS finalized without modification to assign CPT® code 0686T to APC 1575.

HCPCS	Long Descriptor	Proposed CY 2027 OPPS APC, SI	Final CY 2027 OPPS APC, SI	Final CY 2027 Rate
0686T	Histotripsy (i.e., non-thermal ablation via acoustic energy delivery) of malignant hepatocellular tissue, including image guidance	1576, S	1575, S	$12,500.50

Endovenous Femoral-Popliteal Arterial Revascularization with Placement of Stent Graft, CPT Code 0505T

Patients with advanced peripheral artery disease (PAD), including those with long, complex femoropopliteal artery stenoses or occlusions, may be treated using the DETOUR™ System, which is reported with Category III CPT code 0505T. When CPT code 0505T became effective, CMS established HCPCS code C1604 *(Graft, transmural transvenous arterial bypass (implantable), with all delivery system components)* to report the device as a transitional pass-through payment.

The pass-through payment for HCPCS code C1604 expires on December 31, 2026. Beginning in CY 2027, payment for the device will be packaged into the payment for the associated procedure. As a result, CMS must reevaluate the payment rate for CPT code 0505T to reflect the inclusion of the device cost.

For CY 2027, CMS finalized assignment of 0505T into APC 1580, a new technology APC.

HCPCS	Long Descriptor	Proposed CY 2027 APC, SI	Final CY 2027 APC, SI	Final CY 2027 Rate
0505T	Endovenous femoral-popliteal arterial revascularization, with transcatheter placement of intravascular stent graft(s) and closure by any method, including percutaneous or open vascular access, ultrasound guidance for vascular access when performed, all catheterization(s) and intraprocedural roadmapping and imaging guidance necessary to complete the intervention, all associated radiological supervision and interpretation, when performed, with crossing of the occlusive lesion in an extraluminal fashion	1580, S	1580, S	$45,000.50

Nuclear Medicine and Related Services APC Series (APC 5591 Through 5594)

In CY 2025, CMS finalized separate payment for diagnostic radiopharmaceuticals with per-day costs above the applicable packaging threshold. As a result, CMS analyzed the APC assignments for nuclear medicine services to account for the costs of separately payable diagnostic radiopharmaceuticals. CMS observed that costs across APC Levels 3 and 4 had become less distinct and therefore proposed reassigning several CPT codes to different APC levels.

For CY 2027, after consideration of comments received, CMS finalized the assignments of CPT codes 78075, 78454, 78811, 78830, and 78831 from APC 5593 to APC 5592 as proposed. This results in an approximately 52% reduction in the APC payment rate compared with CY 2026.

HCPCS	Long Descriptor	Final CY 2027 APC	Final CY 2027 Rate
78075	Adrenal imaging, cortex and/or medulla	5592	$629.02
78454	Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection	5592	$629.02
78811	Positron emission tomography (PET) imaging; limited area (eg, chest, head/neck)	5592	$629.02
78830	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT) with concurrently acquired computed tomography (CT) transmission scan for anatomical review, localization and determination/detection of pathology, single area (eg, head, neck, chest, pelvis) or acquisition, single day imaging	5592	$629.02
78831	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT), minimum 2 areas (eg, pelvis and knees, chest and abdomen) or separate acquisitions (eg, lung ventilation and perfusion), single day imaging, or single area or acquisition over 2 or more days	5592	$629.02

Cardiac Magnetic Resonance (CMR) Imaging, CPT Codes 75557, 75559, 75561, 75563 (APCs 5523, 5524, 5572, and 5573)

CMS proposed to continue assigning the cardiac MRI CPT codes to APC 5523 (Level 3 Imaging without Contrast), APC 5524 (Level 4 Imaging without Contrast), APC 5572 (Level 2 Imaging with Contrast), and APC 5573 (Level 3 Imaging with Contrast).

CMS received one comment on this proposal. The commenter argued that the *"current modality-based APC structure creates a substantial and increasingly difficult-to-justify payment disparity between clinically comparable advanced cardiac imaging services,"* and asserted that contrast-enhanced cardiac MRI (CMR) requires more hospital resources than SPECT or PET imaging. The commenter also pointed to the historical assignment of CPT code 75563 to APC 5593 (Level 3 Nuclear Medicine and Related Services), which predates the CY 2017 APC restructuring, and stated that cardiac MRI codes are now paid approximately 40 to 60 percent less than comparable services despite what the commenter views as greater resource intensity.

In response, CMS noted it has addressed this issue in prior rulemaking, most recently for CY 2026. The agency maintained that cardiac MRI codes with stress imaging are not comparable to myocardial perfusion imaging simply because both are performed under a stress protocol and reiterated that it does not believe MRI services should be assigned to nuclear medicine APCs.

For CY 2027, CMS finalized, as proposed, to maintain assignment of the cardiac MRI codes into APCs 5523, 5524, 5572, and 5573.

HCPCS	Long Descriptor	Final CY 2027 APC	Final CY 2027 Rate
75557	Cardiac magnetic resonance imaging for morphology and function without contrast material;	5523	$266.71
75559	Cardiac magnetic resonance imaging for morphology and function without contrast material; with stress imaging	5524	$614.24
75561	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences;	5572	$393.93
75563	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with stress imaging	5573	$901.43

C-Codes Describing Percutaneous Coronary Intervention with Drug-Eluting Stents

In CY 2013, CMS created several HCPCS C-codes describing percutaneous coronary intervention (PCI) procedures performed with drug-eluting stents, mirroring the corresponding PCI CPT® codes, which did not distinguish drug-eluting stents. Effective January 1, 2026, the AMA CPT® Editorial Panel deleted several of those CPT codes.

For CY 2027, CMS proposed to delete HCPCS codes C9601, C9603, C9605, and C9608, which mirrored the deleted CPT codes, by revising their status indicators to "D" (Discontinued Codes).

Several commenters supported the deletions but asked CMS to create a new C-code mirroring CPT code 92930 (Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed, single major coronary artery and/or its branch(es); 2 or more distinct coronary lesions with 2 or more coronary stents deployed in 2 or more coronary segments, or a bifurcation lesion requiring

angioplasty and/or stenting in both the main artery and the side branch) for reporting when two or more drug-eluting stents are placed in two or more distinct lesions.

CMS declined the request. The agency explained that the original C-codes were created when drug-eluting stents carried a substantially higher cost and a mechanism was needed to capture that cost. CMS believes the cost difference between drug-eluting and bare-metal stents is no longer significant.

For CY 2027, CMS finalized the deletion of HCPCS codes C9601, C9603, C9605, and C9608 without modification and will not create any new codes in this category.

Venous Mechanical Thrombectomy, CPT code 37187 (APC 5193)

CMS received a comment requesting a change in how claims data are used in ratesetting for venous mechanical thrombectomy, CPT® code 37187 (Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance).

The commenter stated that the current payment rate does not adequately reflect the geometric mean cost of the procedure, citing variation in coding, patient complexity, and site of service. The commenter also pointed to growing Medicare utilization of venous thrombectomy in the outpatient setting as reason for CMS to consider additional data when establishing the CY 2027 rate.

CMS responded that it reviewed the most recent updated claims data for CY 2027 and continues to believe the code is appropriately assigned to APC 5193 (Level 3 Endovascular Procedures). The agency noted that certain claims are excluded from the geometric mean calculation because they are packaged into complexity-adjusted claims for C-APCs. CMS acknowledged the claims variation the commenter described but stated that variation alone does not indicate the cost data are inaccurate or that the code is inappropriately assigned.

For CY 2027, CMS finalized the assignment of CPT® code 37187 to APC 5193 as proposed, without modification.

CPT® Code	Long Descriptor	Final CY 2026 APC, SI	Final CY 2027 APC, SI	Final CY 2027 Rate
37187	Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance	5193, J1	5193, J1	$13,086.12

Simulation Angiogram for Radioembolization of Tumors, HCPCS Code C8004 (APC 5194)

In April 2024, CMS created HCPCS code C9797 (Vascular embolization or occlusion procedure with use of a pressure-generating catheter (e.g., one-way valve or occlusion balloon, intermittently or temporarily occluding), inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction) to describe vascular embolization or occlusion performed with a pressure-generating catheter.

In April 2025, CMS followed with HCPCS code C8004 *(Simulation angiogram with use of a pressure-generating catheter (e.g., one-way valve or occlusion balloon, intermittently or temporarily occluding), inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the angiogram, for subsequent therapeutic radioembolization of tumors)* to describe the simulation angiogram performed with a pressure-generating catheter. C8004 was assigned to APC 5193 with status indicator "J1," making it a comprehensive APC (C-APC) service. According to CMS, the simulation procedure follows a nearly identical workflow to the embolization procedure and uses the same

pressure-generating catheter. A diagnostic radioactive tracer is introduced to plan delivery so that radiation to the tumor is maximized while nearby normal liver tissue is spared. The simulation is typically performed 3 to 14 days before the embolization procedure.

The catheter used in these procedures is reported with HCPCS code C1982 *(Catheter, pressure-generating, (e.g., one-way valve or occlusion balloon, intermittently or temporarily occluding)),* which is packaged and not separately paid.

CMS proposed to maintain the current payment assignments for all three codes, revising only the long descriptors, effective October 2026, to expand the definition of a pressure-generating catheter. In parallel, under the Medicare Physician Fee Schedule (MPFS), CMS created HCPCS code G0577 *(Vascular embolization or occlusion procedure with use of a pressure-generating catheter (e.g., one-way valve, intermittently occluding), inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction performed in the non-facility setting)* to capture the expenses of performing these procedures in the non-facility, office-based lab (OBL) setting. G0577 is effective retroactively to July 1, 2026.

CMS received a comment requesting that C8004 be moved from APC 5193 to APC 5194, citing its similarity to C9797. The commenter stated the two procedures are identical except that C8004 uses a diagnostic radiopharmaceutical for the simulation angiogram, while C9797 uses a brachytherapy source for the embolization treatment.

For CY 2027, CMS finalized, with modification, the reassignment of HCPCS code C8004 from APC 5193 (Level 3 Endovascular Procedures) to APC 5194 (Level 4 Endovascular Procedures). Table 34 outlines the proposed and final CY 2027 assignments, with a column added showing the final national payment rate for this summary.

TABLE 34: PROPOSED AND FINAL CY 2027 APC AND STATUS INDICATOR ASSIGNMENT FOR HCPCS CODE C8004

HCPCS	Long Descriptor	Proposed CY 2027 OPPS APC, SI	Finalized CY 2027 OPPS APC, SI	CY 2027 Final Rate
C8004	Simulation angiogram with use of a pressure-generating catheter (e.g., one-way valve, intermittently occluding), inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the angiogram, for subsequent therapeutic radioembolization of tumors	5193, J1	5194, J1	$20,909.96

New Device Pass-Through Applications for CY 2027

CMS received 19 timely applications for new device pass-through payment status, including one from AngioSafe®, Inc. for the Santreva™-ATK Endovascular Revascularization Catheter.

The Santreva™-ATK Catheter is an energy-free, wire-free platform for simultaneous intraplaque crossing and revascularization of complex occlusive peripheral artery disease (PAD), intended to facilitate intraluminal placement of guidewires beyond stenotic lesions. CMS noted that it maintains separate device categories for catheters that treat or modify vascular lesions through different mechanisms, and that the added

capabilities of the Santreva™-ATK Catheter do not distinguish it from devices already described by existing categories in a way that would warrant a new category.

For CY 2027, after consideration of public comments, CMS did not approve pass-through status for the Santreva™-ATK Catheter, finding that it does not meet the device eligibility criterion.

Comprehensive Ambulatory Payment Classifications (C-APCs)

In the CY 2014 OPPS final rule, CMS adopted the Comprehensive Ambulatory Payment Classification (C-APC) policy, under which a single payment is made for the primary procedure and all adjunctive and ancillary services reported on the claim are packaged into it. The primary procedure is identified by status indicator (SI) "J1," and services reported with it, including those that would otherwise be separately payable under SIs such as "S" or "T," are packaged into the C-APC payment. Most C-APCs describe single-day, surgical encounters.

In response to the proposed rule, CMS received multiple comments recommending additional code combinations for complexity adjustment. Table 1 reflects the only code combinations specific to interventional radiology recommended complexity adjustment.

TABLE 1: C-APC COMPLEXITY ADJUSTMENTS REQUESTED BY COMMENTERS FOR CY 2027

Primary "J1" HCPCS/CPT Code	Secondary "J1" HCPCS/CPT code	Primary C-APC Assignment	Requested complexity adjusted C-APC assignment
37187 (Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance)	**37248** (Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein; initial vein)	5193	5194
	37252 (Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; initial noncoronary vessel)	5193	5194

For CY 2027, CMS finalized a complexity adjustment for claims reporting CPT® code 37187 when reported with CPT® code 37248. The requested combination of CPT® codes 37187 and 37252 did not meet CMS's cost or frequency criteria and therefore did not qualify for a complexity adjustment. When this code combination is reported on the same claim, the claim is paid under the next higher-level APC, APC 5194, at a CY 2027 rate of $20,909.96, rather than APC 5193 at $13,086.12. The codes are not paid separately; the combination itself triggers the single APC 5194 payment.

Several commenters also raised concerns about code pairings and C-APC assignments for lower extremity revascularization services. They noted that while CMS used predecessor code data to establish the CY 2026 complexity adjustments, the CY 2027 proposed rule listed some now-deleted codes in the complexity

adjustment combinations instead of the new replacement codes. CMS responded that Addendum J to the final rule reflects the corrected data.

Payment for Diagnostic Radiopharmaceuticals

In the CY 2025 HOPPS/ASC final rule, CMS finalized to pay for qualifying nonpass-through, separately payable diagnostic radiopharmaceuticals with per day costs above the threshold of $630. CMS proposed to continue this payment policy with a threshold amount for CY 2027 of $665; however, using updated Producer Price Index data available for the final rule, CMS finalized a threshold of $635 per day.

CMS included Table 7 which reflects the qualifying diagnostic radiopharmaceuticals with per day costs exceeding $635 and are assigned a status indicator of "K", which indicates a separate payment to be made based on the HCPCS code's arithmetic MUC.

TABLE 7: FINAL QUALIFYING DIAGNOSTIC RADIOPHARMACEUTICALS WITH PER DAY COSTS EXCEEDING $635

HCPCS Code	Short Descriptor	Finalized CY 2027 Status Indicator Assignment
A4642	In111 satumomab	K
A9507	In111 capromab	K
A9508	I131 iodobenguate, dx	K
A9515	Choline C 11, diagnostic	K
A9521	Tc99m exametazime	K
A9532	I125 serum albumin, dx	K
A9547	In111 oxyquinoline	K
A9548	In111 pentetate	K
A9551	Tc99m succimer	K
A9554	I125 iothalamate, dx	K
A9557	Tc99m bicisate	K
A9569	Technetium TC-99m auto WBC	K
A9570	Indium In-111 auto WBC	K
A9572	Indium In-111 pentetreotide	K
A9582	Iodine I-123 iobenguane	K
A9584	Iodine I-123 ioflupane	K
A9586	Florbetapir F18	K
A9587	Gallium Ga-68	K
A9588	Fluciclovine F-18	K
A9591	Fluoroestradiol F 18	K
A9592	Copper cu 64 dotatate diag	K
A9593	Gallium ga-68 psma-11 ucsf	K
A9594	Gallium ga-68 psma-11, ucla	K
A9595	Piflu f-18, dia 1 millicurie	K
A9596	Gallium illuccix 1 millicure	K
A9601	Flortaucipir inj 1 millicuri	K
A9602	Fluorodopa f-18 diag per mci	K
A9608	Flotufolastat f18 diag 1 mci	K
A9800	Gallium locametz 1 millicuri	K

C9067	Gallium ga-68 Dotatoc	K
Q9982	Flutemetamol F18	K
Q9983	Florbetaben F18	K

Expansion of Site-Neutral Payment Policy

CMS continues to express concern that certain services are being furnished in the higher-cost hospital outpatient department (HOPD) setting when they could be safely and effectively provided in a physician office. According to CMS, the payment differential between these settings may create a financial incentive for providers to furnish services in provider-based departments (PBDs), resulting in unnecessary utilization of the outpatient hospital setting.

To address these concerns, CMS previously implemented a site-neutral payment policy by applying a Medicare Physician Fee Schedule (MPFS) equivalent relativity adjustment to services furnished in nonexcepted off-campus PBDs. Under this policy, which has been in effect since 2017, nonexcepted PBDs receive approximately 40% of the full OPPS payment rate, representing a 60% reduction.

More recently, CMS expanded this policy to excepted off-campus PBDs for drug administration services assigned to APCs 5691–5694. Rather than targeting individual HCPCS codes, CMS applied the payment adjustment to the entire APC family to better control utilization across all drug administration services.

For CY 2027, CMS finalized its proposal to expand the site-neutral payment policy to include imaging services performed without contrast. CMS analyzed claims data and identified substantial growth in the use of these services in excepted off-campus PBDs. The proposal includes imaging procedures that do not require contrast administration and use standard imaging modalities, including radiography, ultrasound, computed tomography (CT), magnetic resonance imaging (MRI), and dual-energy x-ray absorptiometry (DXA). CMS believe these services are generally low to moderate complexity and can be safely performed in multiple settings, including physician offices and hospital outpatient departments. CMS indicated that rural Sole Community Hospitals (SCHs) are exempt from this payment policy. The agency believes this will assist in maintaining access to care in rural areas by ensuring providers are paid at the same rate as on-campus departments.

HCPCS code 77080 *(Dual-energy X-ray absorptiometry (DXA), bone density study, axial skeleton)* was identified as the most frequently billed imaging service without contrast in excepted PBDs. In CY 2025, the physician office payment rate for this service was approximately $30, compared with an OPPS payment rate of approximately $106, resulting in the hospital outpatient payment being more than three times higher. CMS also found that utilization of this service in excepted PBDs increased by more than 55 percent between 2016 and 2025, while utilization in physician offices declined by less than one-half percent. Based on these findings, CMS concluded that the payment differential, not population growth, is the primary driver of the increased outpatient volume.

Accordingly, CMS finalized applying the MPFS equivalent relativity adjustment to services assigned to the APCs in the following table when furnished in excepted off-campus PBDs. Note, off-campus nonexcepted PBDs are already subject to the relativity adjustment.

TABLE 82: PROPOSED NEW APCS PAID THE PFS-EQUIVALENT RATE FOR SERVICES PROVIDED AT EXCEPTED OFF-CAMPUS PBDS FOR CY 2027

APC	APC Description
5521	Level 1 Imaging without Contrast
5522	Level 2 Imaging without Contrast
5523	Level 3 Imaging without Contrast
5524	Level 4 Imaging without Contrast
8004	Ultrasound Composite
8005	CT and CTA without Contrast Composite
8007	MRI and MRA without Contrast Composite

CMS indicated the estimated cost savings by implementing relativity adjuster equitable to the PFS-equivalent payment rate would be $260 million, $190 million saved by Medicare and $70 million saved by Medicare beneficiaries just in CY 2027. CMS' goal of this policy is to help ensure beneficiaries are not impacted by higher premiums and cost sharing based on the site of service, as well as a decrease in the volume of imaging without contrast services provided in the excepted off-campus PBD setting.

Eliminating the Inpatient Only (IPO) List

CMS believes that advances in medical practice and technology continue to allow more procedures to be performed safely in the outpatient setting with shorter recovery times. To expand beneficiary access and provide greater flexibility in selecting the most appropriate site of care, while potentially reducing out-of-pocket costs, CMS is continuing the phase-out of the Inpatient Only (IPO) List that was finalized in the CY 2026 OPPS/ASC final rule. The phase-out began in CY 2026 with the removal of 285 primarily musculoskeletal procedures and is scheduled for completion by January 1, 2029.

Procedures removed from the IPO List may be reimbursed by Medicare when furnished in the hospital outpatient setting, when clinically appropriate. This change provides physicians with greater flexibility in determining the most appropriate setting for patient care.

Commenters expressed concerns that certain services removed from the IPO List may not be appropriate for all patients in the outpatient setting. CMS reiterated that removal from the IPO List does not require a service to be performed on an outpatient basis. Rather, it allows Medicare payment under the OPPS when the service is furnished in the outpatient setting and clinically appropriate, while preserving physician judgment to determine the most appropriate setting based on the individual patient's clinical needs.

For CY 2027, CMS finalized the second phase of the elimination of the IPO list by removing 637 services, approximately half of the remaining 1,438 services still on the IPO list. The clinical families included in this list are auditory, digestive, endocrine, female genital, hemic and lymphatic systems, integumentary, male genital, maternity care and delivery, mediastinum and diaphragm, respiratory, and urinary. These clinical families were chosen based on stakeholder feedback and concerns regarding appropriate APC placement.

The procedures finalized for removal from the IPO List for CY 2027, along with their finalized status indicators and APC assignments (when applicable), are included in Addendum B of the final rule. The complete list of services that remain designated as inpatient only for CY 2027 is available in Addendum E, both of which are posted on the CMS website.

For interventional radiology, one procedure was finalized for removal from the IPO List effective January 1, 2027. The table below identifies the interventional and diagnostic radiology code CMS finalized for removal from the IPO List. Although the procedure currently has low utilization, particularly within interventional

radiology, removal from the IPO List provides greater flexibility in site-of-service selection and may support increased outpatient utilization over time.

HCPCS	Short Descriptor	CY 2027 Proposed SI	CY 2027 Proposed APC	CY 2027 Final SI	CY 2027 Final APC	CY 2027 Final Rate
47380	Open ablate liver tumor rf	J1	5341	J1	5342	$ 7,601.71

340B Drug Discount Program

The 340B Program allows qualifying safety-net hospitals to purchase outpatient drugs at discounted prices. Historically, however, Medicare Part B reimbursed these drugs under the OPPS at standard rates without accounting for the lower acquisition costs, allowing 340B hospitals to retain the difference between reimbursement and purchase price.

For CY 2027, CMS proposed to pay hospitals for drugs purchased under the 340B Drug Discount Program an average sales price (ASP) -33.4% based on hospital pricing survey data, rather than continuing the ASP +6%. After consideration of feedback from stakeholders, CMS finalized the policy with modification, establishing payment for drugs purchased under the 340B Program atASP-28% with no additional add-on payment. The monies saved from the reduced payments for drugs purchased under the 340B Drug Discount Program are redistributed to non-drug services (e.g., interventional radiology items and services) paid under OPPS.

Unfortunately, CMS must still address the payment reductions provided 2018-2022 and redistributed to non-drug services under OPPS as required by the Supreme Court. The court rulings outlined that CMS must pay back monies from this original decrease to affected hospitals for CYs 2018–2022. To do this, CMS released the 340B Final Remedy Rule, which outlined how payments would be restored and established a budget-neutral method to recover the associated costs.

Under the Final Remedy Rule, CMS finalized a 0.5 percent annual reduction to the OPPS conversion factor for non-drug items and services beginning in CY 2026, with the expectation that the estimated $7.8 billion would be recovered over approximately 16 years. CMS later concluded this timeline was too lengthy because many hospitals that benefited from the higher payments may no longer participate in the program by the time recovery is complete.

Although CMS proposed increasing the annual reduction to 2% for CY 2026, the proposal was not finalized. For CY 2027, CMS proposed a 3% reduction to the OPPS conversion factor for non-drug items and services. After consideration of comments received, CMS has finalized with modification to their proposal a 2% reduction to the conversion factor to recover the remaining $7.769 billion, which is expected to now be completed by the end of CY 2031.

Modifications to the Provider-Based Regulations

As part of the CY 2027 OPPS final rule, CMS codified section 6225 of the Consolidated Appropriations Act, 2026 (CAA, 2026) in the provider-based status regulations at §§ 413.65 and 419.23. Beginning January 1, 2028, Medicare will not pay under the OPPS for services furnished by an off-campus outpatient department of a provider unless the department bills under its own National Provider Identifier (NPI), separate from the main provider's, and the main provider has submitted an initial attestation, within the 2-year period ending on the date of service, that the department meets the requirements of § 413.65, along with subsequent attestations within the timeframe CMS specifies. The statute also directs CMS to establish, through rulemaking, the process for submitting and reviewing attestations, including determinations through site

visits, remote audits, or other means. Previously, compliance with the provider-based requirements was mandatory, but attestation was voluntary and payment was not conditioned on verified compliance.

To implement section 6225, CMS finalized the following changes to § 413.65 without modification from the proposal unless noted. CMS adopted a new definition of "off-campus outpatient department of a provider" as a department not located on the main provider's campus or within 250 yards of a remote location of a hospital (a facility furnishing inpatient services off the main provider's campus). In response to comments, CMS clarified that departments within 250 yards of a remote location are excluded from the definition and are therefore not subject to the attestation or separate NPI requirements. Conforming revisions to § 413.65(b)(3)(ii), (e), (g)(1)(i), and (h) add "or within 250 yards of a remote location of a hospital" to references to the main provider's campus, and a technical change to § 413.65(g)(1)(i) and (ii) replaces "treated by Medicare" with "treated by CMS."

CMS also finalized the attestation timeline.

1. Off-campus departments furnishing services on or before January 1, 2028, must submit initial attestations between January 1, 2026, and December 31, 2027.
2. Departments that begin furnishing services after January 1, 2028, must attest within 2 years before the billed services are furnished.
3. Subsequent attestations are due at an interval CMS will specify, not to exceed 5 years.

Based on comments, CMS added language clarifying that a provider satisfies the submission requirement even if CMS has not made a provider-based determination before the department's first day of service. Attestations will be submitted through a centralized electronic system using a standardized attestation statement and supporting documentation.

Addressing concerns about the separate NPI requirement, CMS stated it is taking steps to allow multiple NPIs on a single claim, so that both the hospital NPI and the service-line NPI for services furnished on a given day can be reported.

CMS clarified that Maryland hospitals participating in the AHEAD Model, critical access hospitals, rural health clinics, and Indian Health Service and Tribal facilities are excluded from these requirements.