Illinois Health and Hospital Association

On Nov. 9, the Centers for Medicare & Medicaid Services (CMS) published its calendar year (CY) 2027 Medicare Physician Fee Schedule (PFS) final rule. CMS finalized several policies that will impact practitioner reimbursement and hospital operations. This fact sheet outlines 10 policies we want IHA members to be aware of. See CMS' final rule fact sheet for additional information.

1. CY 2027 Rate Update: CMS finalized physician rate cuts, reflecting the expiration of the one-year 2.5% payment increase for 2026 enacted in last year's budget reconciliation act (P.L. 119-21). The cuts are implemented through two conversion factors: one for qualifying alternative payment model participants (QPs) and one for all other physicians and practitioners (non-QPs):

	Current CY 2026	Proposed July 2026	Final CY 2027	Change
QPs	$33.57	$33.17	$32.95	-$0.62 (-1.83%)
Non-QPs	$33.40	$32.84	$32.63	-$0.77 (-2.31%)

   The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 required two separate conversion factors beginning in 2026, with annual updates of 0.75% for QPs and 0.25% for non-QPs. The final factors are lower than proposed in July because the final rule applies an estimated −0.12% budget-neutrality adjustment for work relative value unit (RVU) changes, rather than the +0.53% adjustment CMS proposed.
2. Same-Day E/M & Global Procedure Rule: CMS narrowed its proposed payment reduction for a separately identifiable office/outpatient evaluation and management visit (O/O E/M, modifier 25) furnished on the same day as a global procedure. The reduction now applies only to visits paired with 0-day global procedures, and the lower-valued service will be paid at 80% rather than the proposed 50%.
3. O/O E/M Visit Complexity Add-On Code Replaced: The agency finalized its proposal to replace the O/O E/M visit complexity add-on code with a modifier. CMS states this will increase payment for all levels of the base E/M code by 16%, and by 32% for practitioners participating in accountable care organizations.
4. 340B Reporting Requirement: CMS finalized its proposal to make it mandatory, rather than voluntary, for 340B-covered entities to submit Part D claims data elements to the 340B claims data repository.
5. Obstetric Codes Restructured: CMS adopted the new Current Procedural Terminology (CPT) maternity codes. CMS did not adopt its proposed set of Healthcare Common Procedure Coding System (HCPCS) codes that would have preserved the old global obstetric rate structure alongside the new unbundled CPT codes. The new CPT codes were developed by the American Medical Association's CPT Editorial Panel, the American College of Obstetricians and Gynecologists, and other national medical specialty societies to reflect modern obstetric practice and enable accurate reporting across the pregnancy spectrum.
6. Remote Monitoring Restrictions: CMS finalized requirements that remote therapeutic monitoring (RTM) services be furnished only to established patients, that practitioners billing RTM and remote physiologic monitoring (RPM) services furnish a separately reportable initiating visit, and updates to how these services are valued under the PFS. CMS delayed until Jan. 1, 2029 the requirement that clinical staff performing these services be employed by the billing practitioner rather than a third-party contractor.
7. Physician Oversight & Care Flexibility: CMS finalized its policy to permit teaching physicians to bill for services when either the teacher or resident is in the same location as the patient, whereas current policy only permits billing when the teaching physician, resident and patient are all in separate locations. This is only applicable to services on the Medicare Telehealth Services List and documentation must continue to demonstrate whether the teaching physician was physically present or

present through audio/video real-time communications technology. CMS also finalized two new HCPCS codes (G0572 and G0573) to describe advance care planning (ACP) services furnished by clinical staff under the direct supervision of the billing physician or other practitioner, while isolating use of existing ACP CPT codes (99497 and 99498) to time spent by the billing practitioner.

8. Ambulatory Specialty Model Refinements: The CMS Innovation Center's Ambulatory Specialty Model (ASM) is a mandatory five-year model (2027-2031) focused on heart failure and low back pain. Several refinements were finalized to ASM for cardiology and pain management practices, including participant exceptions, quality measures, and a new rural scoring adjustment, largely as proposed with some modifications.
9. Practice Expense Payments: CMS finalized a two-year phaseout of the indirect practice cost index and replaced it with a practice expense (PE) stabilizer, meant to reduce abrupt payment shifts. The agency also finalized allocation of indirect PE on both work RVUs and clinical labor PE RVUs for all codes (rather than the maximum of the two), excluding 10- and 90-day global codes.
10. Global Surgery Data Collection Pause: CMS finalized its proposal to pause the post-operative visit data collection initially required by section 523 of the Medicare Access and CHIP Reauthorization Act (P.L. 114-10).
