# FY 2027 IPPS final rule: What hospitals need to know

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News & Insights

CMS released the fiscal year (FY) 2027 Inpatient Prospective Payment System (IPPS) final rule last week, outlining upcoming changes to Medicare payment rates and policies for inpatient services. Overall, the agency estimates that the updates will generally increase hospital payments by $2.1 billion.

CMS finalized a 2.3% increase to IPPS payments for FY 2027 (beginning October 1, 2026), reflecting a 3.2% hospital market basket increase and -0.9% productivity adjustment. The finalized payment rate is slightly lower than the agency's initial proposal of 2.4%.

The rule also details CMS' plans for a nationwide expansion of its Comprehensive Care for Joint Replacement (CJR) model. The CJR Expanded (CJR-X) model will hold hospitals responsible for spending and care during a patient's lower extremity joint replacement procedure through 90 days post-discharge. While CMS originally intended to launch the CJR-X model on October 1, 2027, it postponed implementation until January 1, 2028, in response to stakeholder feedback. Most IPPS hospitals will be required to participate in the new model, although CMS noted several exceptions, including Transforming Episode Accountability Model (TEAM) participants and Maryland facilities.

Revenue cycle professionals should take note of updates related to TEAM, a five-year, mandatory, episode-based payment model that launched on January 1, 2026. TEAM is designed to improve care coordination for original Medicare beneficiaries undergoing certain procedures by holding hospitals accountable for costs associated with the surgery through 30 days post-discharge. The FY 2027 IPPS final rule includes updates to several policies affecting episode category triggers, quality measure assessments, and target price construction.

The rule also includes graduate medical education payment updates, clarification of organ acquisition reimbursement policies, and numerous changes to quality reporting measures.

The FY 2027 IPPS final rule updates take effect on October 1, 2026, unless otherwise noted. Revenue cycle professionals can view CMS' fact sheet for more information. The agency also published a press release on the CJR-X model.

Related Topics:
Billing and reimbursement, Coding, IPPS, Medicare news

# CMS launches Medicare GLP-1 Bridge program

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CMS recently launched the Medicare GLP-1 Bridge, a short-term demonstration that provides eligible Part D beneficiaries with access to certain glucagon-like peptide-1 (GLP-1) drugs. Between July 1, 2026, and December 31, 2027, eligible patients can get these medications for $50 per month through the bridge program.

Announced in December 2025, the demonstration serves as a bridge to the Better Approaches to Lifestyle and Nutrition for Comprehensive hEalth (BALANCE) model. Under BALANCE, CMS plans to expand beneficiaries' access to GLP-1s and lower drug costs through negotiations with manufacturers on behalf of Medicaid and Part D plans. While the Medicaid portion of the model launched in May, the agency delayed implementation of the Part D initiative until 2027. In the meantime, the Medicare GLP-1 Bridge will cap eligible beneficiaries' monthly out-of-pocket costs at $50 for these drugs and allow CMS to gather additional utilization data.

Part D beneficiaries who are enrolled in eligible plan types, use GLP-1 drugs for weight loss and management, and meet certain clinical criteria are eligible for the Medicare GLP-1 Bridge program. Eligible beneficiaries must have met the clinical criteria when GLP-1 therapy was initiated. This includes patients who initiated therapy before enrolling in Part D and/or prior to the launch of the bridge program, according to CMS.

Individuals who already receive these medications through Part D or are otherwise eligible for Part D coverage of GLP-1s do not qualify for the payment cap. Patients who have type 2 diabetes, moderate-to-severe obstructive sleep apnea, or fatty liver disease do not qualify, as they can receive GLP-1 coverage through their Part D plan.

Foundayo® (tablets), Wegovy® (injection and tablets), and Zepbound® (KwikPen®) qualify for coverage under the initiative when used for weight loss and management. Pen needles are not covered under the Medicare GLP-1 Bridge and should not be billed to the demonstration or the patient's Part D plan.

Although providers are not required to include diagnosis code information and/or a pharmacy annotation on the claim, CMS recommends it. A Part D denial is not required to submit a claim to the bridge program.

CMS released a fact sheet to instruct prescribers on clinical criteria, prior authorization processes, and more. The agency also released a series of FAQs to provide additional information for providers, pharmacies, and Part D plans. The provider FAQs list the National Drug Codes (NDC) for the formulations available to beneficiaries through the Medicare GLP-1 Bridge, but CMS noted that the list of products and NDCs may be updated over the course of the demonstration.

***Editor's note:*** *This article originally appeared in* Revenue Integrity Insider, *NAHRI's weekly e-newsletter.*

Related Topics:
Billing and reimbursement, Denials and appeals, Medicare news

# Q&A: Documentation challenges in single-path coding

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**Q: How do you personally define single-path coding, and how has that definition evolved from the traditional dual-path or siloed models of the past?**

**Lolita Jones, MSHS, RHIA, CCS, CRC, CPC, CPC-I, product owner, professional coding for TruBridge:** For a patient encounter, [single-path coding means that] one coder assigns the codes for the facility, and for any practitioner whose coding and billing is performed by the facility.

Traditional coding involves a patient encounter being coded by two different coders working in separate departments, neither one of them knowing if their coding is aligned or not. The burgeoning increase in hospital acquisitions of private practices, and the increase in practitioners employed by hospitals, has driven many hospitals to rethink the siloed model of separate coding departments.

**Q: What documentation challenges tend to surface when one coder is responsible for both facility and professional coding for the same encounter?**

**Jones:** Documentation challenges surface for outpatient evaluation and management (E/M) services, when one coder is responsible for both facility and professional coding for the same encounter.

For example, when one coder is responsible for only facility coding of outpatient E/M services, Healthcare Common Procedure Coding System (HCPCS) Level II code G0463 is the only code that Medicare requires, and it has no specific clinical documentation requirements.

However, when one coder is responsible for both facility and professional coding of outpatient E/M services, the coder also has to choose from over 10 Current Procedural Terminology® (CPT®) E/M codes for the professional coding, and there are documentation requirements regarding the following E/M elements:

- Complexity of the patient's medical problems
- Extent of patient data that was reviewed/analyzed
- Level of patient risk associated with the care provided/planned

When any of these three E/M elements are missing or poorly documented, the professional coding for the encounter might be delayed until a provider query can be written, communicated, and resolved.

***Editor's note**: This Q&A was excerpted from our* HIM Briefings *newsletter.*

Related Topics:
Coding, Documentation improvement, HIM/HIPAA

# New CPT coding conventions for prenatal care to take effect in 2027

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Revenue cycle professionals should be gearing up for the upcoming changes to Current Procedural Terminology (CPT®) coding for maternity care services.

Beginning January 1, 2027, services for antepartum care, labor management, delivery, and postpartum care will be coded separately. The change moves away from the traditional global maternity care model toward a framework designed to better reflect how, when, where, and by whom obstetric care is delivered.

The update consists of 12 new codes, 17 deleted codes, and six revised codes. It also includes significant revisions to subsection guidelines and relocates some existing codes.

By definition, antepartum (prenatal) care encompasses all visits from the diagnosis of pregnancy to the onset of labor. Starting in 2027, these services will be coded with the appropriate evaluation and management (E/M) service code for each encounter. This approach will allow care to be reported based on the patient's individual needs, medical co-morbidities, pregnancy complications, social determinants of health, and preferences rather than using the traditional one-size-fits-all model.

Prenatal services will be reported with the following CPT codes:

- Office or other outpatient services: 99202–99205, 99211–99215
- Home or residence services: 99341–99345, 99347–99350
- Initial or subsequent hospital inpatient or observation services: 99221–99223, 99231–99233
- Hospital inpatient or observation care services, including admission and discharge services: 99234–99236
- Critical care services: 99291, 99292
- Telemedicine services: 98000–98015
- Virtual check-in: 98016

Diagnostic and therapeutic procedures performed during this period will be reported in addition to E/M services when appropriate. Diagnostic imaging services, such as obstetrical ultrasound evaluation (76801–76828) and fetal magnetic resonance imaging (74712–74713), will also be separately reportable in addition to antepartum E/M visits when applicable.

CPT code 59050, which is used to report fetal monitoring during labor by a consulting physician, will be deleted, with instructions to document code 59051 for interpretation and report of fetal heart tracing. Consultations requested for evaluation of a pregnant patient and/or the fetus, outside of fetal heart monitoring, should be reported with the appropriate E/M codes.

Visits for other than obstetric or labor management provided on the same date of service as an obstetric visit by the same provider will require the addition of modifier -25 (significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service). Services outside of normal obstetric care provided on the same calendar date should be supported by appropriate diagnosis coding, including diagnoses unrelated to the pregnancy when applicable, to demonstrate the medical necessity of the separate service.

Lastly, visits for surveillance of a high-risk pregnancy should include the appropriate diagnosis code to support medical necessity and frequency of care.

***Editor's note:*** *This article includes reporting from* Part B News.

Related Topics:
Billing and reimbursement, Coding, Documentation improvement, Medicare news