Revascent

THE BUSINESS BEHIND THE IMAGE

A Radiology Leader's Guide to RSNA 2026

What to watch, what to ask and what to plan for 2027.

For independent radiology groups, imaging centers and the leaders who run them.

02

At a glance

RSNA is where radiology sees what comes next in imaging. This guide is about the work that makes that imaging pay off: the operational and financial infrastructure behind every study. It is written for the people who run independent radiology groups and imaging centers, and it is meant to be useful whether you walk the show floor or follow from home.

Five things to know before RSNA 2026

1. **AI will dominate the conversation.** FDA's radiology review panel handled 1,094 of the 1,430 AI-enabled medical devices the agency authorized through 2025, or 76.5%.[1] The business question is what each tool changes after the image is read.

2. **Imaging volume keeps climbing.** U.S. imaging use is projected to be 16.9% to 26.9% higher in 2055 than in 2023, depending on modality.[2] Radiologist supply is projected to grow 25.7% if residency positions stay flat, and substantially less if higher post-COVID attrition persists.[3] Time lost to administrative rework is time radiology teams cannot spare.

3. **2027 Medicare payment is still a proposal.** CMS has proposed lower 2027 physician fee schedule conversion factors,[4] and the final rule is expected in November, shortly before RSNA.[5] Plan for a range, not a single number.

4. **Imaging revenue lives in the details.** One study can generate two claims under two payment systems. Component billing, place of service, mammography rules and authorization accuracy decide what gets paid.

5. **Evaluate the infrastructure, not just the technology.** The most valuable RSNA conversations cover how orders, images, reports and claims move between systems and teams.

How to use this guide

Read pages 3 to 9 before you travel. Take the checklist on page 10 to Chicago. Use the 30/60/90-day plan on page 11 the week you return. Not attending? The same questions work for vendor calls in December.

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> *Imaging keeps advancing. The business behind the image has to keep pace.*

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RSNA 2026 at a glance

RSNA's program is mostly clinical and technical. Business leaders get the most from it by arriving with specific decisions to inform and with meetings already booked.

Dates	November 29 to December 3, 2026[6]
Technical exhibits	November 29 to December 2, 2026[6]
Location	McCormick Place, Chicago[7]
Official theme	"At the Center of Care," exploring the central role of radiologists and imaging scientists in patient care[6]
Scale	RSNA 2025 drew nearly 38,000 registrants and 720 exhibitors[8]
Opening session, November 29	"Seeing Beyond the Image: Leadership Lessons from the Reading Room to the Boardroom," Jonathan S. Lewin, MD[6]
Breast radiology plenary, November 30	"Breast Radiology at the Center of Care: Advancing Patient-Centered Innovation, Collaboration, and Community Impact," Gwendolyn M. Bryant-Smith, MD[6]
AI programming	AI at the Annual Meeting, including Radiology Reimagined[6]

720

exhibitors at RSNA 2025[8]

Book meetings before you arrive.

Topics likely to matter to radiology executives

- **AI in everyday workflow,** and how it gets paid (page 5)
- **2027 Medicare payment and site-of-care policy** (page 6)
- **Capacity:** rising imaging volume and an uncertain workforce (page 4)
- **Breast imaging,** from the plenary stage to the billing office (page 8)
- **Leadership:** the opening session takes on the path from the reading room to the boardroom[6]

Getting business value from RSNA

1. **Name the decisions RSNA should inform.** An AI purchase, a scanner replacement, a new site, a billing or systems review. Two or three is enough.
2. **Book meetings before you arrive.** The exhibit floor is open for four days;[6] scheduled conversations get focused time.
3. **Split the team.** Clinical leaders cover sessions and AI exhibits; administrators and finance leaders cover vendor meetings and business conversations.
4. **Bring your own numbers.** Volumes by modality and site, payer mix, days in A/R and top denial reasons. Vendor claims mean more against your own baseline.
5. **Preview the program in Meeting Central** and mark sessions on economics, operations and breast imaging.[6]
6. **Capture each conversation on one page,** using the questions on page 10.

Planning ahead: RSNA 2027 moves two weeks earlier, to November 14 to 18, 2027.[6]

Meeting vendors at RSNA? Add a revenue cycle conversation to your list. **Schedule an RSNA conversation with Revascent's radiology team.**

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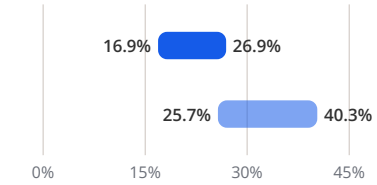
What is shaping radiology going into 2027

Four forces will run through most RSNA conversations this year. Each has a clinical side that will get plenty of attention and a business side that will get less.

1. Capacity and imaging demand

What is changing. U.S. imaging use is projected to be 16.9% to 26.9% higher in 2055 than in 2023, driven mostly by population growth.[2] Radiologist supply is projected to grow 25.7% to 40.3%, depending on residency growth, but would be substantially smaller if higher post-COVID attrition persists.[3]

Projected growth by 2055 vs. 2023



Projections. Higher post-COVID attrition would lower the workforce range.[2,3]

Why it matters. With volume rising and workforce growth uncertain, every hour lost to missing information, rework or avoidable denials is capacity the business cannot spare.

What to watch. Residency expansion, referrer expectations on turnaround, and whether new tools actually change studies per radiologist.

2. AI and technology

What is changing. Of the 1,430 AI-enabled medical devices FDA authorized from 1995 through 2025, 1,094 (76.5%) were reviewed by FDA's radiology panel.[1] Payment is arriving code by code: for 2027, CMS has proposed treating certain software services in the hospital outpatient setting as "Software as a Medical Service."[9]

76.5% of FDA-authorized AI-enabled devices were reviewed by FDA's radiology panel (1,094 of 1,430, 1995 to 2025)[1]

Why it matters. A clinically strong tool can still add cost without adding revenue if no code, coverage or workflow supports it.

What to watch. Which AI services gain billable codes and payer coverage, and how tools fit into worklists and reports (page 5).

3. Payment and margin pressure

What is changing. Adjusted for inflation, Medicare physician payment fell 33% from 2001 to 2025.[10] In 2026, CMS began applying an efficiency adjustment of minus 2.5% to work RVUs for non-time-based services.[11]

Why it matters. When rates do less of the work, results depend more on capturing and collecting what each study earns.

What to watch. The final 2027 physician fee schedule and hospital outpatient rules (page 6).

> *Clinical sophistication does not automatically create financial or operational efficiency.*

4. Where imaging happens

What is changing. CMS has proposed physician fee schedule-equivalent rates for imaging without contrast at excepted off-campus hospital outpatient departments in 2027.[12] In the ACR Bulletin, Lauren Nicola, MD, notes that shifting payment differentials may influence site development and hospital acquisitions.[13]

Why it matters. Site-of-care economics shape where new imaging capacity is built and who owns it, including independent imaging centers.

What to watch. Whether the proposal is finalized, and whether site-neutral payment later extends to more imaging services, which Dr. Nicola says CMS seems likely to consider.[13]

An AI tool can be clinically impressive without producing operational or financial value.

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AI and workflow: evaluate beyond the algorithm

FDA's radiology review panel accounts for 76.5% of the AI-enabled medical devices the agency has authorized,[1] so RSNA's exhibit floor will be full of tools that detect, measure and prioritize. Whether a tool pays off depends mostly on questions the demo won't answer: where its output lands, who acts on it, and how it is documented and paid.

Five tests for business value

Test	What to ask	A weak answer sounds like
Workflow fit	Where do results appear (worklist, viewer, report), and how many steps does the tool add or remove for the radiologist?	*"It runs in the background"*
Documentation	How does the output reach the final report, and does billing need specific language from it?	*Results stored outside the report*
Code and payment	Is there a billable code, and is payment set for our settings?	*"Payment is coming"*
Payer coverage	Which commercial and Medicare Advantage plans cover the service, and is prior authorization required?	*No payer list*
Measurable value	What baseline will we measure against: turnaround time, studies per radiologist, follow-up completion?	*Results quoted only from other sites*

Where AI payment stands

As of October 7, 2026, payment for AI is still set code by code. For 2027, CMS has proposed treating certain software services in the hospital outpatient setting as "Software as a Medical Service," as a transitional step toward a fuller payment approach; AI-based coronary plaque analysis (CPT 75577), for example, would keep its current payment assignment, at $950.50.[9] For any other tool, the payment question belongs in the first conversation, not the contract review.

Integration is part of the price

Every AI tool adds an interface to systems you already run, such as PACS, worklists and reporting. Ask who builds and maintains that connection after go-live, and what happens to the workflow when it breaks.

A simple budgeting rule. If a vendor cannot say which code applies, which payers cover it in your settings and what the report must document, budget the tool as a cost and judge it on operational value alone.

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Reimbursement and margin: what is current and what is proposed

Most 2027 Medicare changes, on both the physician and hospital outpatient sides, are still proposals. Separate what is in effect from what is not, and treat every PROPOSED row as a planning scenario, not a forecast.

Medicare policy status

as of October 7, 2026

POLICY AND STATUS	WHAT IT IS	WHY IT MATTERS	WHAT TO DO
2026 conversion factor CURRENT	$33.40 (non-APM) and $33.57 (APM), including a one-year 2.5% statutory increase.[11] CMS estimated a 2% overall decrease for radiology.[14]	The one-year increase ends with 2026	Model 2027 without it
Efficiency adjustment CURRENT since 2026	Minus 2.5% to work RVUs for non-time-based services, which include radiology; CMS says it will apply it periodically.[11,15]	Lowers work values on many imaging codes; ACR disputes the premise[16]	Check the effect on your highest-volume codes
2027 conversion factor PROPOSED	$32.84 (non-APM, down 1.68%) and $33.17 (APM, down 1.19%) as the one-year increase expires.[4] CMS's estimated 2% increase for radiology does not reflect the conversion factor cut.[17,18]	Net effect depends on code mix and the final rule, expected in November[5]	Model a range: 2026 actuals, the proposal, the final rule
2027 practice expense PROPOSED	Routinely updated cost data, with a stabilizer to limit short-term swings;[4] ACR describes a 5% annual cap on changes.[18]	Could move technical component values	Recheck top technical and global codes in the final rule
Site-neutral imaging PROPOSED hospital outpatient rule	Physician fee schedule-equivalent payment for imaging without contrast at excepted off-campus hospital outpatient departments; rural sole community hospitals exempt; about $260 million less Part B spending in year one.[12] ACR cautions against it.[19]	Narrows one gap between hospital and freestanding payment	If finalized, revisit site plans and hospital agreements
Prior authorization FINAL RULE	Medicare Advantage, Medicaid and CHIP plans must decide urgent requests within 72 hours and standard requests within 7 calendar days, primarily from 2026; API requirements begin January 1, 2027.[20]	Faster decisions help only if status reaches scheduling and billing	Ask payers and vendors how you will receive electronic status

Planning with a moving target

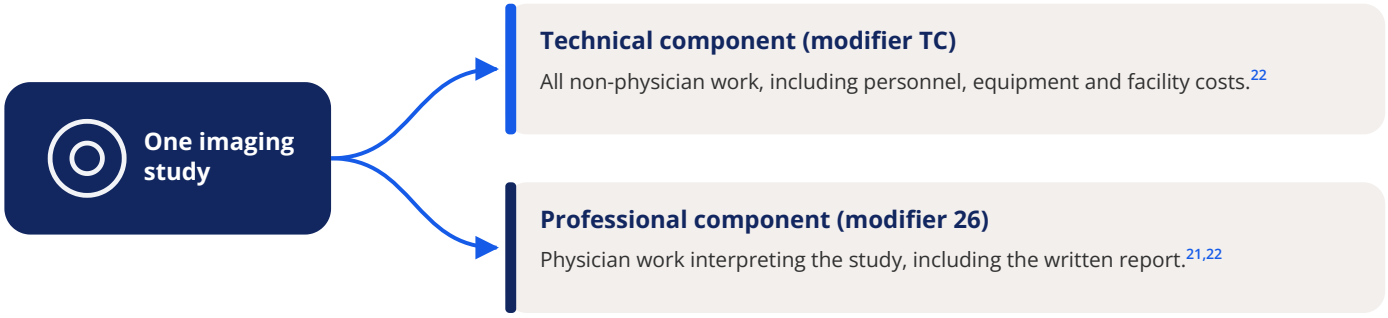
- Run the model on your 20 highest-volume codes by component: technical, professional and global.
- Include any commercial contracts indexed to Medicare rates.
- Rerun the model the week the final rules publish.

> *"Any efficiencies theorized by CMS are outweighed by the increased images and reconstructions now performed per study."*
>
> Gregory Nicola, MD, then chair of the ACR Commission on Economics, November 2025[16]

07

Why imaging revenue is more complex than it looks

One imaging study can produce two claims, from two organizations, under two Medicare payment systems.[21] That single fact explains much of why radiology billing is not generic medical billing.



Global billing: one claim for both components, with no modifier, when one organization furnishes both.[23]

WHO BILLS WHAT, BY SETTING (MEDICARE)

Setting	Technical component	Professional component
Hospital outpatient department	Hospital, under the hospital outpatient payment system	Radiologist or group, with modifier 26
Hospital inpatient	Hospital, as a hospital service	Radiologist or group, with modifier 26
Physician office or freestanding imaging center	The practice or center, under the physician fee schedule (technical-only or global)	The same organization (global) or the reading group, with modifier 26

Sources: CMS Medicare Claims Processing Manual, Chapter 13; Noridian Medicare JF Part B.[21,22,23]

Where component revenue slips. A reading arrangement changes but the billing setup does not. Place of service does not match where the study was done. A correct reduction is mistaken for an underpayment, or a real one is missed. These are process gaps, not coding mysteries.

Place of service. Every claim carries a place-of-service code, such as 11 (office), 19 (off-campus outpatient hospital), 22 (on-campus outpatient hospital) or 21 (inpatient hospital).[24] A group that reads for several hospitals and runs its own centers may bill professional-only claims in one setting and global claims in another on the same day.

Payment rules written for imaging. Under Medicare's multiple procedure payment reduction, when certain imaging procedures are performed on the same patient in the same session, the highest-priced procedure is paid in full and additional procedures are paid at 50% of the technical component and 95% of the professional component, even across physicians in the same group.[25] A correct claim can pay less than the fee schedule amount, so measure underpayments against expected payment, not the fee schedule.

Where Revascent fits.

Revascent's radiology services include coding and billing for the technical and professional components of diagnostic services, across multiple places of service, for MRI, CT, ultrasound and mammography.[26]

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Coding, documentation and denials: where imaging revenue quietly slips

SIX HANDOFFS WHERE EARNED IMAGING REVENUE CAN BE DELAYED OR LOST WITHOUT ANYONE NOTICING

Point of exposure	What can go wrong	What to check
The order	Medicare does not pay imaging center claims for ordered procedures if the ordering provider is missing, not enrolled in PECOS or not of a specialty eligible to order.[27]	*Is the ordering provider validated at scheduling?*
Prior authorization	The authorization no longer matches the claim if contrast, body part or laterality changes before scanning.	*Is authorization re-checked when the protocol changes?*
The final signed report	Codes come from the final report (contrast, views, laterality, complete or limited); an unsigned report holds the claim.	*How long do claims wait on signatures, by site?*
Charge capture	An exam that never becomes a charge never denies, so it never appears in a denial report.	*Are exams reconciled to charges daily?*
Mammography	Medicare covers screening every 12 months for women 40 and older, at no cost when the provider accepts assignment; diagnostic exams carry the Part B deductible and 20% coinsurance.[28] Since September 10, 2024, FDA has required a density assessment in reports and a density statement in patient summaries.[29]	*Does everyone follow one playbook when screening becomes diagnostic?*
Equipment	Technical component reductions: 15% for CT on equipment not meeting NEMA XR-29 (modifier CT), 20% for X-rays on film (FX) and 10% for computed radiography from 2023 (FY).[21]	*Is equipment status current in billing setup?*

Prior authorization: faster rules, same volume. CMS's decision timeframes now apply (page 6),[20] but volume remains high: Medicare Advantage insurers made 52.8 million prior authorization determinations in 2024 and denied 7.7%. Only 11.5% of denials were appealed, and 80.7% of appeals were overturned in whole or in part. These figures cover all services, not imaging alone.[30]

Denials: measure the cause, not just the count. In a 2024 MGMA poll, 60% of medical group leaders reported higher denial rates than a year earlier; MGMA's 2023 DataDive data showed an 8% first-submission denial rate for single-specialty groups. Neither figure is radiology-specific.[31] Medicare claims must be filed within one calendar year of the date of service,[32] so every claim on hold uses up that window.

Group denials by where they started:

Front end: eligibility, authorization, ordering provider, medical necessity from the order

Middle: documentation, coding, component or place-of-service setup, equipment modifiers

Back end: timely filing, payer processing errors, coordination of benefits

Where Revascent fits.

Revascent's AAPC- and AHIMA-certified team members handle radiology charge capture, coding and documentation, claims submission and denial management, including screening and diagnostic mammography.[26] Its revenue cycle reporting tracks key metrics, revenue trends and claim denials.[33]

> *A denial that can be overturned is still revenue delayed.*

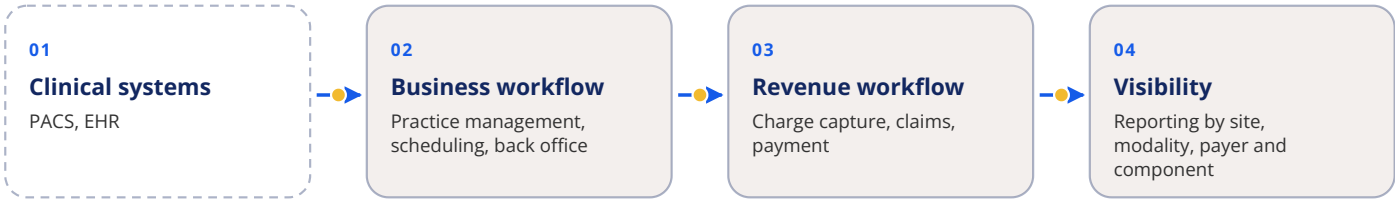
09

Imaging center economics and connected operations

Sophisticated imaging technology should not be surrounded by fragmented business infrastructure. Independent imaging centers and multi-site organizations carry both sides of the business: producing images and getting paid for them.

The economics are shifting. CMS's site-neutral proposal (page 6) would narrow one payment gap between hospital and freestanding sites.[12] In the ACR Bulletin, Lauren Nicola, MD, notes that radiologist-owned imaging centers already face year-over-year Medicare fee schedule cuts, rising labor costs and continued workforce challenges.[13] Patients not using insurance are entitled to a good faith estimate of expected charges if they ask or schedule at least three business days ahead.[34]

From clinical systems to visibility



Each dot marks a handoff between stages.

These stages can span different systems, sites and teams, and each handoff that depends on re-entering information slows work and invites errors. CMS's 2027 physician fee schedule proposal notes that "diagnostic imaging and laboratory test results are frequently siloed within acquiring electronic health record systems."[4]

Signs the business infrastructure is not keeping pace

- Staff re-enter demographics or authorization numbers from one system into another.
- Authorization status lives somewhere other than the schedule.
- Revenue reporting arrives as totals, not by site, modality, payer and component.
- Each new site brings its own workarounds.
- Interface problems are discovered by the billing team rather than prevented.

Every new imaging center, hospital contract or radiologist adds fee schedules, component arrangements, place-of-service rules, payer enrollment and credentialing that must be right before the first claim goes out. When setup lags growth, the gaps surface later as aging A/R.

Where Revascent fits.

Revascent supports the systems your practice already relies on, with vendor-agnostic technology services across EHR, practice management, hosting, interfaces, security and end-user support.[35] For radiology, that includes integration between PACS, EHR and practice management systems, cloud-based server hosting, and practice administration covering accounting and finance, HR, recruiting and staffing, and credentialing.[26]

Map your handoffs before RSNA. List every point where a person copies information from one system into another. That list is your integration agenda for the show floor.

Questions to ask at RSNA

Twenty questions that get past the demo and into how a product or partner will change your operations and your revenue. Use them with vendors, and with your own team before you go.

AI + TECHNOLOGY

- [ ] Where exactly do results appear for the radiologist, and how many steps does the tool add or remove per study?
- [ ] Which codes apply to this service, and is payment established in our settings today?
- [ ] Which commercial and Medicare Advantage plans cover it, and do any require prior authorization?
- [ ] What must the final report contain for the service to be billed, and does your output put it there?
- [ ] Who builds and maintains the interface with our PACS, worklist and reporting systems after go-live, and at what cost?

OPERATIONS + WORKFLOW

- [ ] Which of our systems do you integrate with in production today, not on a roadmap?
- [ ] How do orders, demographics and authorization numbers reach billing without anyone re-keying them?
- [ ] Where does authorization status live, and can scheduling and billing both see it?
- [ ] When an interface fails, who finds out first, and how quickly is it fixed?
- [ ] What reporting will we see by site, modality, payer and component, and how often?

REVENUE + REIMBURSEMENT

- [ ] How do you set up technical, professional and global billing for each site and reading arrangement, and how do you catch changes?
- [ ] How do you handle a screening mammogram that becomes diagnostic, from documentation to what the patient owes?
- [ ] How do you calculate expected payment, including imaging-specific reductions, so true underpayments stand out?
- [ ] How do you define clean claim rate, initial denial rate and days in A/R, and are your figures for radiology clients or your whole client base?
- [ ] How will you help us model the final 2027 Medicare rules against our own code mix?

SCALABILITY + PARTNERSHIPS

- [ ] How many independent radiology groups or imaging centers like ours do you support, and can we speak with one?
- [ ] What happens to fee schedules, payer enrollment and credentialing when we add a site or a hospital contract?
- [ ] Who is our day-to-day contact, and how quickly do they respond?
- [ ] Which work stays with our team and which moves to you?
- [ ] If we part ways, what does the transition look like, and who keeps our data and reports?

Want to work through these with people who know imaging billing and operations? **Schedule an RSNA conversation with Revascent.** Booth 8035

After RSNA: a 30/60/90-day plan

The weeks after RSNA decide whether the trip changes anything. This plan turns conversations into decisions by the end of the first quarter of 2027.

First 30 days

Prioritize findings and find the gaps

- [ ] Debrief within a week: one page per conversation, ranked against the two or three decisions RSNA was meant to inform.
- [ ] Rerun your 2027 model when the final Medicare rules publish (page 6), using your 20 highest-volume codes by component.
- [ ] Pull a 12-month baseline: denials by payer, root cause, site and modality; days in A/R; charge lag; time from exam to signed report.
- [ ] Map your order-to-payment handoffs (page 9) and mark every point where information is re-entered by hand.

Days 31 to 60

Validate opportunities, owners and dependencies

- [ ] For each AI tool on the shortlist, confirm code, payer coverage, documentation and integration cost (page 5) before building a business case.
- [ ] Review technical, professional and global billing setup for every site and reading arrangement, including place of service.
- [ ] Walk a screening-to-diagnostic mammogram through scheduling, documentation, coding and patient billing.
- [ ] Assign an owner to each initiative and list its dependencies: IT, scheduling, billing, payer contracting.

Days 61 to 90

Begin implementation and set up measurement

- [ ] Make the decisions RSNA was meant to inform.
- [ ] Start with the three largest upstream causes of denials, by dollars.
- [ ] Begin a monthly scorecard review, with targets set against your own baseline.
- [ ] Put a mid-year checkpoint on the calendar to compare results with the final 2027 rules.

Radiology revenue cycle scorecard

Metric	What it tells leadership	Cut it by
Clean claim rate	Share of claims accepted on first submission without correction	Payer and site
Initial denial rate	How often claims fail the first time; points to gaps upstream	Root cause
Days in A/R	How quickly service turns into cash	Payer
A/R over 90 days	How much revenue is aging and getting harder to collect	Payer and site
Charge lag	Days from exam to claim; a delay you control	Modality and site
Net collection rate	Share of what is contractually owed that is actually collected	Payer
Actual vs. expected payment	Whether payers pay what contracts and imaging payment rules say they should	Payer and code

Set targets from your own baseline. This guide deliberately does not supply benchmarks.

After the show, **talk with a radiology RCM specialist** at Revascent about what your scorecard shows.

How Revascent supports radiology

The first eleven pages cover decisions every radiology group and imaging center faces going into 2027, whoever they work with. This page explains where Revascent can help. Revascent works with radiologists and independent imaging centers and brings 40+ years of medical practice and specialty-service revenue cycle expertise.[26]

Revenue Cycle Management

The core of Revascent's radiology work: getting each study from exam to payment.

- Charge capture, coding and documentation, claims submission, denial management, patient engagement and payment processing.[26]
- Coding and billing for the technical and professional components of diagnostic services, across multiple places of service.[26]
- Coding and billing for screening and diagnostic mammography, MRI, CT and ultrasound.[26]
- Team members certified by AAPC and AHIMA.[26]
- Revenue cycle reporting that tracks key metrics, revenue trends and claim denials, with a revenue management dashboard.[33]

Practice Administration

Business operations support for groups and centers that want to focus on imaging.

- Revascent can serve as your CFO/COO, setting up and running daily operations with a focus on profitability.[26]
- Accounting and finance, HR, recruiting and staffing, and credentialing.[26]

Software & Technology Services

Support for the systems your practice already relies on.[35]

- Vendor-agnostic services across EHR, practice management, hosting, interfaces, security and end-user support.[35]
- Integration between PACS, EHR and practice management systems.[26]
- Cloud-based server hosting.[26]

Clinical Informatics

Support for day-to-day ambulatory operations focused on provider efficiency, workflows, documentation and compliance.[37]

- Clinical and front-office workflows, from scheduling through checkout.[37]
- Documentation and charge capture that support better care and cleaner revenue cycle performance.[37]
- Prescribing and privacy controls that support compliant, reliable operations.[37]

Why Revascent

40+ **years** of medical practice and specialty-service revenue cycle expertise[26]

$1B+ in accounts receivable managed (company-wide figure, not radiology alone)[36]

Clients work with dedicated account managers,[36] supported by a team that understands CMS guidelines, compliance requirements and the nuances of imaging billing.[26]

Schedule an RSNA conversation **Talk with a radiology RCM specialist**

Visit Revascent at Booth 8035, McCormick Place, Chicago. Technical exhibits are open November 29 to December 2, 2026.[6]

Frequently asked questions

When and where is RSNA 2026?

RSNA 2026 runs November 29 to December 3, 2026, at McCormick Place in Chicago.[6,7] Technical exhibits are open November 29 to December 2.[6] The theme, "At the Center of Care," explores the central role of radiologists and imaging scientists in patient care.[6]

How should radiology business leaders prepare for RSNA 2026?

Name the two or three decisions the show should inform, such as an AI purchase or a new site. Bring a baseline of denials, days in A/R and volume by site and modality. Book vendor meetings before you arrive, split the floor across your team and schedule a debrief.

What trends will shape radiology business planning in 2027?

Imaging use is projected to be 16.9% to 26.9% higher in 2055 than in 2023,[2] and radiologist supply hinges on residency growth and attrition.[3] FDA's radiology panel reviewed 76.5% of authorized AI-enabled devices.[1] Medicare physician pay fell 33% from 2001 to 2025 after inflation.[10] Proposed site-neutral rules could change outpatient imaging payment.[12] Each raises the cost of administrative friction.

Are the 2027 Medicare payment changes final?

Not as of October 7, 2026. CMS has proposed 2027 physician fee schedule conversion factors of $32.84 (non-APM, down 1.68%) and $33.17 (APM, down 1.19%) as a one-year increase expires.[4] The final rule is expected in November.[5] The hospital outpatient rule, including site-neutral imaging payment, is also still proposed.[12]

How should a radiology group budget for 2027 while the rules are still proposed?

Model a range: 2026 actuals, the 2027 proposal and the final rule once published, applied to your highest-volume codes by component. CMS's estimated 2% increase for radiology[17] does not account for the proposed conversion factor cut, ACR notes.[18] Include payer contracts tied to Medicare rates, and set a mid-year checkpoint.

How should leaders evaluate an AI tool beyond diagnostic accuracy?

Ask what changes after the image is read: where the output lands, who acts on it, and whether a billable code and payer coverage exist. For 2027, CMS has proposed treating certain hospital outpatient software services as "Software as a Medical Service," a transitional step.[9] Count integration and support in the total cost.

What is the difference between the technical and professional components?

The professional component is the physician's interpretation, which includes a written report (modifier 26).[21,22] The technical component covers non-physician work, including personnel, equipment and facility costs (modifier TC).[22] A global claim covers both.[23] Medicare Part B pays the professional component in all settings; for hospital patients, the hospital is paid for the technical component.[21]

What does site-neutral payment mean for imaging centers?

It pays similar rates regardless of where a service is performed. CMS has proposed paying imaging without contrast at excepted off-campus hospital outpatient departments at physician fee schedule-equivalent rates in 2027, exempting rural sole community hospitals.[12] Lauren Nicola, MD, writes in the ACR Bulletin that shifting payment differentials may influence site development and hospital acquisitions.[13]

What does a connected imaging workflow look like?

Information entered once moves from order to payment without being re-keyed. Authorization status reaches the front desk, signed reports reach coding, and denial causes reach the team that can fix them. CMS notes that diagnostic imaging results are "frequently siloed within acquiring electronic health record systems."[4]

How can a radiology group tell whether its revenue cycle is ready for 2027?

Test how quickly you can answer four questions. What is your denial rate by payer and root cause? How many days pass from exam to claim? Do payers pay what contracts and imaging rules say they should? How would the 2027 proposals affect your top codes? Slow answers point to the gaps.

Sources

Policy information is current as of October 7, 2026. Items labeled PROPOSED may change when CMS publishes final rules.

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