Congress of the United States

Washington, DC 20515

September 11, 2026

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Administrator Oz:

We write to express our deep concern regarding the Centers for Medicare & Medicaid Services' (CMS) proposal in the Calendar Year (CY) 2027 Medicare Physician Fee Schedule (MPFS) to reduce payment when medically necessary, separately identifiable evaluation and management (E/M) services are furnished on the same day as procedures with 0-, 10-, or 90-day global periods. We share CMS's goal of ensuring Medicare payments accurately reflect the resources required to furnish care and safeguard taxpayer dollars. However, CMS has not demonstrated that separately identifiable same-day services systematically contain duplicative resources warranting an across-the-board 50 percent reduction. Finalizing this one-size-fits-all cut could accelerate consolidation of independent physician practices and create additional barriers for Medicare patients. We strongly urge CMS not to finalize the proposal.

Under the proposed policy, beginning January 1, 2027, Medicare would pay the highest-valued same-day service at 100 percent of the fee schedule amount and reduce payment for additional covered procedures or separately identifiable E/M services by 50 percent. The reduction would apply even when the E/M service is medically necessary, clinically distinct, and separately identifiable. For some services, payment could fall below the direct cost of the clinical staff, supplies, and equipment needed to furnish the procedure.

At a time when private practices are facing significant financial viability challenges, the proposal could have significant consequences for the sustainability of independent practices as well as beneficiary access. Practices facing sustained Medicare reductions may be forced to reduce services or staffing, limit the number of Medicare beneficiaries they can sustainably serve, consolidate with larger health systems, or close altogether. Once independent practices are lost, those care options are often difficult—if not impossible—to restore. The consequences could be particularly significant in rural communities, where practices have less ability to absorb substantial reductions and patients may already face transportation, caregiver, and travel barriers.

The proposal should also be considered in the context of budget neutrality. Although CMS identifies certain procedure-intensive specialties as experiencing the largest aggregate reductions and other specialties as receiving small increases from the redistribution of RVUs, those estimates do not mean physicians in the latter specialties are unaffected. Primary care physicians also perform medically necessary procedures, particularly in rural communities, and may furnish a significant, separately identifiable E/M service during the same encounter. In those circumstances, the same 50 percent reduction would apply. A modest specialty-wide increase from budget-neutral redistribution does not eliminate the policy's direct impact on individual physicians and their patients.

Importantly, existing Medicare valuation processes already identify and remove overlapping physician work and practice expense for services commonly furnished together. CMS acknowledges that it adjusts work RVUs and/or time where existing valuation does not adequately account for overlapping pre- and post-service activities, and the misvalued codes

initiative provides an established mechanism to revalue services where payment does not accurately reflect the resources required. Existing valuation processes likewise account for overlapping practice-expense inputs when services are commonly furnished on the same day. An additional 50 percent reduction therefore risks reducing payment a second time for efficiencies already reflected in the underlying valuation.

CMS suggests that the proposal reflects efficiencies similar to those addressed through Multiple Procedure Payment Reduction (MPPR) policies. But MPPR generally addresses efficiencies when multiple services of the same or similar type are furnished together, whereas Modifier -25 identifies a significant, separately identifiable E/M service furnished in addition to a procedure. Efficiencies associated with multiple procedures do not establish comparable efficiencies between two clinically distinct services—or justify a uniform 50 percent reduction. If CMS believes particular codes retain duplicative work or practice expense, it should identify and address those services on a code-specific, evidence-based basis through established valuation processes. A uniform reduction across thousands of services and clinical circumstances is not a substitute for identifying and quantifying the resources CMS believes are duplicative.

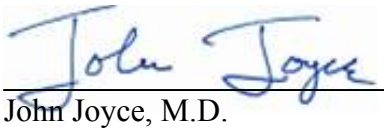
CMS considered, but declined to finalize, a substantially similar policy in the CY 2019 MPFS rulemaking after weighing concerns regarding appropriate valuation and potential disruptions to patient care. The current proposal is broader, extending to procedures with 10- and 90-day global periods, yet CMS has not demonstrated that the concerns underlying its prior decision have been resolved.

The attached appendix provides specialty-specific clinical examples demonstrating why a medically necessary procedure and a significant, separately identifiable E/M service may appropriately occur during the same encounter. They illustrate that patients often present with a symptom or clinical problem—not for a predetermined procedure—and that the E/M service may be necessary to determine the diagnosis, assess risk, and decide whether a same-day procedure is clinically appropriate. Finalizing this policy could lead to fractioning care in a way that is counter to the goals stated by this administration.

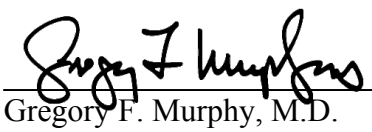
Accordingly, we respectfully urge CMS not to finalize the proposed Modifier 25 payment reduction. CMS acknowledges that the resulting budget-neutrality adjustment would be very small, meaning the proposal would provide little redistribution across the broader physician payment system while potentially imposing substantial reductions on affected practices. Where CMS identifies genuine overlap or inappropriate billing, it has more targeted tools available, including code-specific valuation, medical review, education, documentation requirements, and program-integrity interventions. We urge CMS to use those tools rather than impose an across-the-board 50 percent reduction.

Thank you for your consideration. We look forward to working with CMS to ensure Medicare payment policies continue to support high-quality, accessible care for Medicare beneficiaries.

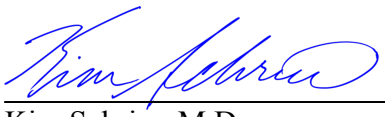
Sincerely,



John Joyce, M.D.
Member of Congress



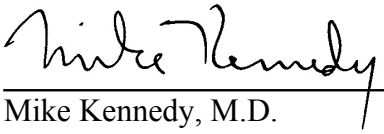
Gregory F. Murphy, M.D.
Member of Congress



Kim Schrier, M.D.
Member of Congress

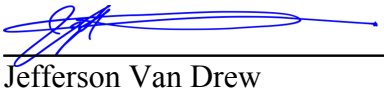
Herbert C. Conaway, Jr.
Member of Congress

Suzan K. DelBene
Member of Congress



Mike Kennedy, M.D.
Member of Congress

Andy Harris, M.D.
Member of Congress



Jefferson Van Drew
Member of Congress

Earl L. "Buddy" Carter
Member of Congress

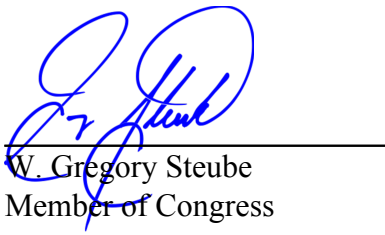
Joe Wilson
Member of Congress

Brian K. Fitzpatrick
Member of Congress

Chris Pappas
Member of Congress

Eleanor Holmes Norton
Member of Congress

Josh Gottheimer
Member of Congress



W. Gregory Steube
Member of Congress

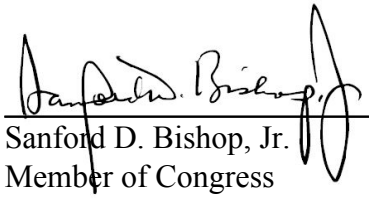
Donald G. Davis
Member of Congress

Robert E. Latta
Member of Congress

Rich McCormick, MD, MBA
Member of Congress

Robert B. Aderholt
Member of Congress

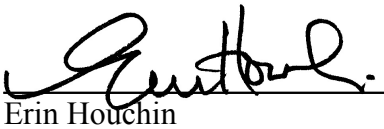
Aaron Bean
Member of Congress



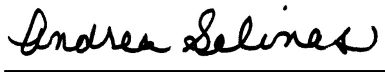
Sanford D. Bishop, Jr.
Member of Congress

Cliff Bentz
Member of Congress

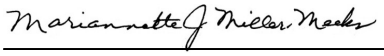
Christopher H. Smith
Member of Congress



Erin Houchin
Member of Congress



Andrea Salinas
Member of Congress

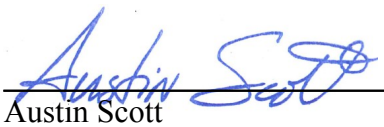


Mariannette J. Miller-Meeks, M.D.
Member of Congress

Sheri Biggs
Member of Congress

Dan Meuser
Member of Congress

Brian Babin, D.D.S.
Member of Congress



Austin Scott
Member of Congress

Jim Costa
Member of Congress

Ami Bera, M.D.
Member of Congress

Greg Landsman
Member of Congress

Troy Balderson
Member of Congress

J. Luis Correa
Member of Congress

Michelle Fischbach
Member of Congress

Maggie Goodlander
Member of Congress

August Pfluger
Member of Congress

Darin LaHood
Member of Congress

Maxine Dexter, M.D.
Member of Congress

John W. Mannion
Member of Congress

Gus M. Bilirakis
Member of Congress

Carol D. Miller
Member of Congress

Chrissy Houlahan
Member of Congress

David Rouzer
Member of Congress

Robert F. Onder, M.D.
Member of Congress

Kathy Castor
Member of Congress

Julie Johnson
Member of Congress

Marilyn Strickland
Member of Congress

Dan Goldman
Member of Congress

Sarah McBride
Member of Congress

Chris Deluzio
Member of Congress

Kelly Morrison
Member of Congress

Jared Moskowitz
Member of Congress

Diana Harshbarger
Member of Congress

André Carson
Member of Congress

Neal P. Dunn, M.D.
Member of Congress

Jimmy Panetta
Member of Congress

Raul Ruiz, M.D.
Member of Congress

Salud Carbajal
Member of Congress

Deborah K. Ross
Member of Congress

Mike Thompson
Member of Congress

Jasmine Crockett
Member of Congress

Mark E. Amodei
Member of Congress

Mike Kelly
Member of Congress

Michael K. Simpson
Member of Congress

Mike Haridopolos
Member of Congress

David P. Joyce
Member of Congress

Danny K. Davis
Member of Congress

Ronny L. Jackson, M.D.
Member of Congress

Harriet M. Hageman
Member of Congress

Rob Bresnahan, Jr.
Member of Congress

Derek T. Tran
Member of Congress

Lloyd Smucker
Member of Congress

APPENDIX A

Clinical Use Cases for Modifier -25

Examples – Family Medicine

Patient 1: A 68-year-old female presents for follow-up of hypertension, acid reflux, liver cirrhosis, and chronic kidney disease. The physician, as part of an E/M, performs a full review of systems, and physical exam of heart, lungs, abdomen, upper and lower extremities. The physician then reviews labs including a complete blood count (CBC), a comprehensive metabolic panel, and lipid panel. The patient then requested evaluation of a skin lesion on her forearm that was itching and irritated. Upon examination, the physician decides to perform an evaluation and diagnosed this as a possible skin cancer. A biopsy of the lesion is then performed. The biopsy requires a separate evaluation of the surrounding skin to rule out infection, evaluation of the proper location to perform the biopsy, and post procedure evaluation for complications. Ultimately, a 99214 (established patient, moderate medical decision-making E/M) is billed, appended with a modifier 25, and 11104 for skin biopsy is also billed. The work associated with the overall management of the patient is significant and separately identifiable from the biopsy procedure which entails work and resources not accounted for in the E/M (e.g. inspecting the lesion, selecting the most representative and appropriate site to obtain specimen, discussing the procedure with the patient and obtaining consent, removing the sample, suturing the wound, in addition to the work described above).

Patient 2: A patient with diabetes, hypothyroidism, and hyperlipidemia may see their family physician for management of these conditions, including medication adjustments, review of laboratory results, and ongoing care planning. These are all captured under the evaluation and management service, for which 99214 is billed (established patient, moderate medical decision-making E/M). During the same visit, the patient may also report persistent low-back pain that has not improved with conservative measures, and the physician may choose to perform osteopathic manipulative treatment (OMT), billing 98926 (OMT, 3-4 body regions treated). The OMT procedure is distinct from the E/M and entails separate work (e.g. Determining which osteopathic techniques are most appropriate for this patient, determining in what order the affected body regions need to be treated, explaining the procedure, obtaining consent, positioning the patient, performing a technique, observing response and repositioning, etc).

Patient 3: A 78-year old patient presents for follow-up of hypertension, diabetes, hyperlipidemia, and dementia. The physician, as part of an E/M, performs a full review of systems, a physical exam of heart, lungs, abdomen, upper and lower extremities. The physician also reviews labs. For this E/M, a 99214 is billed (established patient, moderate medical decision-making E/M). The patient also reports pain associated with their arthritis for which a cortisone injection is completed. The injection is a distinct procedure and 20610 would be billed for the injection. Separate work for the injection includes, but is not limited to, evaluation of the overlying skin to rule out infection, palpation of the anatomy to identify the proper injection point, and post procedure an evaluation for complications

Example - Ophthalmology

Patient 1: A 58-year-old is referred by her optometrist for floaters in the right eye, starting 1 day ago. The patient complains that her new floaters are like “a swarm of bugs.” She has a history of LASIK for nearsightedness 20 years ago and type II diabetes, for which she takes glyburide. Exam shows a visual acuity of 20/50 in the right eye and 20/20 in the left eye, with normal eye pressure. Her peripheral vision testing is normal. Slit lamp exam shows a clear corneal LASIK flap in good position in both eyes. The pupils are dilated for funduscopic exams. Lens exam reveals mild cataracts in both eyes with red blood cells in the anterior vitreous of the right eye. Blood has pooled at the inferior vitreous base of the right eye, and there are mild retinal hemorrhages throughout both eyes, but no retinal detachment in either eye. Scleral depression reveals a retinal tear in the superotemporal quadrant. The findings are recorded on a retinal drawing of the right eye. She is diagnosed with a retinal tear and vitreous hemorrhage in the right eye (unrelated to her diabetic retinopathy). The seriousness of her condition is explained because there is a risk that the retinal tear may progress to retinal detachment in the coming days. An urgent laser photocoagulation procedure is arranged for later that same day.

The patient returns later on the same day, and the right eye pupil is dilated again. The team reviews the patient's record, including the preoperative retinal drawing. The team discusses the procedure with the patient, and the patient signs the informed consent form. After a surgical time-out, the team marks and anesthetizes the correct eye (right eye). The chair is reclined, and the patient is positioned for treatment. The laser settings are adjusted. Two rows of laser burns are applied around the retinal tear, using the indirect scope to visualize the retinal tear and aim and focus the laser. She tolerates the procedure well. A post-op visit is scheduled in two days, reiterating the importance of follow-up to monitor for retinal detachment and/or new retinal tears, which are at highest risk over the next several days.

Examples - Otolaryngology

Patient 1: A woman in her 70s with a long history of tobacco use was referred for evaluation of a neck mass and persistent hoarseness. A comprehensive new-patient history, physical examination, and medical decision-making were required to evaluate her symptoms, assess cancer risk, and formulate an appropriate diagnostic plan (CPT Code 99203 or 99204). Based on the clinical findings, the patient underwent flexible fiberoptic laryngoscopy (CPT Code 31575), which demonstrated a large transglottic laryngeal malignancy. During the same visit, the patient underwent an ultrasound-guided fine-needle aspiration biopsy of the cervical neck mass to establish a tissue diagnosis and expedite staging and treatment planning. Laryngoscopy and biopsy allowed prompt diagnosis and timely initiation of oncologic care.

Patient 2: An established patient presented two weeks after completing chemoradiation for a base of tongue carcinoma with severe dysphagia and increasing difficulty breathing. Despite being an established patient, his recent cancer treatment and acute symptoms required a comprehensive interval history, detailed physical examination, assessment of hydration and nutritional status, and complex medical decision-making to distinguish expected treatment effects from potentially life-threatening complications (CPT Code 99213, 99214, or 99215) The patient underwent flexible fiberoptic laryngoscopy (CPT Code 31575) to evaluate the upper airway, assess for residual or recurrent malignancy, and exclude significant airway compromise. Following evaluation, he received medical management and supportive care for severe radiation mucositis and treatment-related toxicity. Performing the evaluation and laryngoscopy during the same visit allowed prompt assessment of airway safety and immediate management of complications related to his cancer treatment. This level of evaluation is not included in endoscopy alone.

Patient 3: An elderly woman was referred to an ENT physician’s office from an emergency department more than an hour away following facial trauma sustained over the weekend. She presented with facial injuries and profuse unilateral watery rhinorrhea, raising concern for a traumatic cerebrospinal fluid (CSF) leak. A comprehensive history, physical examination, and complex medical decision-making were required to assess the extent of her injuries and determine the need for urgent diagnostic evaluation. The patient underwent CT imaging followed immediately by diagnostic nasal endoscopy (CPT code 31231) to evaluate for evidence of a CSF leak and other traumatic injuries of the sinonasal cavity

and skull base. Prompt evaluation during the same visit was essential to rapidly identify or exclude a potentially serious complication of facial trauma and guide immediate management.

Patient 4: A new patient with epistaxis actively bleeding comes to the office for treatment; it is determined that a procedure is needed to control the acute nosebleed (CPT Code 30901, 30903, 30905, or 31238). A comprehensive patient history, physical examination, and medical decision-making (CPT Code 99203 or 99204) are required to address blood pressure, assess comorbid problems such as anticoagulation, and decide whether prophylactic antimicrobials are indicated for nasal packing to prevent toxic shock syndrome and future nosebleeds.

Patient 5: A returning patient with chronic rhinosinusitis with nasal polyps who has comorbid asthma presents to the office with an exacerbation with purulent drainage, wheezing, cough, and postnasal drip. A nasal/sinus scope is performed (CPT Code 31231) to obtain a culture and/or determine appropriate treatment. A comprehensive exam and medical decision-making (CPT Code 99213 or 99214) are required to select medications to address asthma, allergy, infection status, and future care.

Patient 6: A new patient presents with stridor and multiple pulmonary comorbidities. Patient requires flexible laryngoscopy (CPT Code 31575) for diagnostic evaluation of their upper airway (in an urgent setting because of airway obstruction and stridor). The patient requires a comprehensive physical exam and management of medical comorbidities (CPT Code 99203 or 99204), including coordinating care with the pulmonologist.

Examples - Rheumatology

Patient 1: A 45-year-old male patient with seronegative rheumatoid arthritis affecting multiple sites but with no organ or system involvement comes for a follow-up visit. The patient reports swelling of the left knee with throbbing left knee pain. The severity of his pain on the pain scale is 8 out of 10. The pain started four weeks ago and has gradually gotten worse. He took over-the-counter NSAIDs to relieve the pain with no success. He reports no weight change, dyspnea, skin rashes, other musculoskeletal pains, or chest pain. After discussing options with the patient, it was decided to perform a knee joint injection. A prior authorization was obtained, and 40 mg of methylprednisolone acetate was injected into the left knee. An X-ray of the left knee was ordered to confirm the diagnosis of secondary osteoarthritis. Because the patient is obese, the injection is done via ultrasound guidance, and a permanent recording of the guidance will be in the patient's medical records.

Patient 2: A 68-year-old female patient with primary osteoarthritis of the left knee returns to the practice for her knee injection. At today's visit, she reports increased pain and discomfort in her left knee since her last injection, particularly with walking and climbing the stairs. Although she initially experienced improvement following the first injection, the increased pain had begun to interfere with her usual after-dinner walks. She denied fevers or any rashes. She has tried multiple weight loss programs but has had little success as her appetite is unchanged. She denied vomiting, diarrhea, hematochezia, chest pain, dyspnea, or other complaints. Ibuprofen 800mg, Tylenol, and other NSAIDS have failed to relieve the pain in her knee. The team examined her knee for swelling, tenderness, range of motion, and other potential causes of worsening symptoms. The team decided to proceed with the next injection.

Patient 3: A 58-year-old male with an established history of severe osteoarthritis of the bilateral knees presents for a scheduled follow-up visit. While his left knee pain is stable and well-managed with his current physical therapy regimen, he reports an acute, severe exacerbation of right knee pain (8/10) that began 24 hours ago after a minor misstep. He describes severe throbbing, significant new swelling, and localized heat. He denies fever, chills, recent skin abrasions, or trauma to any other joints. He has been unable to bear weight on the right leg today. Given the acute change in symptoms, significant swelling, and examination findings, a complete diagnostic ultrasound of the right knee joint (CPT code 76881) is medically necessary and will be performed immediately. The provider discusses treatment options, then aspirates and injects the right knee with a corticosteroid.

Examples – Dermatology

Patient 1: Consider a farmer who travels over an hour to see a dermatologist for urgent evaluation of a painful rash that has been worsening and is interfering with his sleep. The clinician performs an evaluation and management (E/M) service (CPT code 99214, appended with modifier -25) to assess and manage the rash. During the visit, the dermatologist examines the patient and observes an erythematous eruption with blisters, erosions, and crusts on the base of the neck and the right shoulder. The patient confirms that this is the area that is very painful. Based on the dermatomal pattern the dermatologists diagnoses shingles and prescribes an oral antiviral, valacyclovir, to treat the infection. The dermatologists also advises the patient on gentle wound care and pain management, including how to minimize abrasion to the area by avoiding scratching or popping blisters, applying topical petrolatum, and wearing loose soft closing. At the same visit, the patient asks the dermatologist to examine a long-standing growth on his scalp that has recently changed and begun to bleed. The clinician performs a separate evaluation of the scalp lesion and on examination notes a crusted nodule that is consistent with squamous cell carcinoma. The clinician determines that an immediate skin biopsy (CPT code 11102) is medically necessary. The clinician discusses the concern with the patient and obtains informed consent; trims the hair and prepares the area; administers intralesional anesthesia; surgically removes the tissue to be tested; obtains hemostasis through cauterization; manages and dresses the wound; and labels and prepares the specimen for pathology. The E/M service for managing the acute shingles infection is significant and separately identifiable from the biopsy procedure, which entails distinct clinical work and resources not accounted for in the E/M service. Delivering care during a single visit effectively manages the infection while enabling prompt diagnosis of a suspicious lesion, ensuring timely treatment of skin cancer and prevention of advanced cancer.

Examples - Orthopaedic

Patient 1: Suspected infected knee joint — a same-day aspiration that cannot wait. A 72-year-old established patient presents with two days of a hot, swollen, painful knee and low-grade fever. The evaluation raises concern for septic arthritis, and the standard of care is immediate arthrocentesis (CPT 20610/20611) to obtain synovial fluid for cell count, Gram stain, and culture. A septic joint can destroy articular cartilage within days and can progress to sepsis; hours matter. The patient does not come in "for an aspiration" — they come in with a painful knee, and only the E/M evaluation reveals that an urgent aspiration is needed.

Patient 2: The shoulder patient who arrives with a new, acutely painful wrist. An established patient being followed for rotator cuff tendinopathy arrives for a scheduled shoulder injection (CPT 20550) but presents with a new problem: an

acutely painful wrist after a fall, with symptoms of de Quervain tenosynovitis. The wrist complaint requires its own history, examination, and decision-making. The "significant, separately identifiable" service modifier -25 describes this, and the patient is in pain enough that a same-day injection is clearly indicated.

Examples - Podiatry

Patient 1: Is a Medicare beneficiary who presents to a podiatrist with two complaints. The first is worsening pain in the left big toe joint that has been present for more than a year. The pain has recently progressed to the point that it is causing him to limp and is affecting his ability to work and exercise. The podiatrist performs an evaluation and management (E&M) service, resulting in a diagnosis of hallux limitus deformity, a form of degenerative arthritis of the big toe joint. Medical management includes writing a prescription, recommending shoes, and discussing what surgical repair would involve. The second complaint is a dark discoloration beneath the right big toenail. Because its appearance raises concern for melanoma, the provider performs a nail unit biopsy (CPT 11755).

Patient 2: Is a Medicare beneficiary who presents to a podiatrist with two complaints. The first is itching and burning on the bottom of the right foot, with associated scaling and peeling of the skin. The podiatrist performs an evaluation and management (E&M) service and diagnoses tinea pedis, a fungal skin infection. The podiatrist recommends care for the

affected area and writes a prescription. The second complaint is left ankle pain following a recent injury in which the foot turned inward beneath the leg. The podiatrist diagnosed an ankle sprain and performed a strapping procedure (CPT 29540). This involves applying overlapping adhesive strips around the foot and ankle to provide support, function as a splint, and reduce motion.