September 14, 2026

The Honorable Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1848-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare Program; CY 2027 Payment Policies Under the Physician Payment Schedule and Other Changes to Part B Payment and Coverage Policies (CMS-1848-P); Accounting for E/M Resource Overlap between Stand-Alone Visits and Global Periods

Dear Administrator Oz:

Our undersigned organizations representing more than 207,000 osteopathic physicians (DOs) and medical students across the country, write to urge the Centers for Medicare & Medicaid Services (CMS) not to finalize its proposal to reduce payment when a separately identifiable evaluation/management (E/M) service is furnished on the same date as a 0-, 10-, or 90-day global procedure and appended with a Modifier -25. This policy is being proposed in a broader context of stagnant Medicare payment, rising practice costs, and practice consolidation that has been catalyzed by physicians' financial pressures to keep their doors open. Between 2001 and 2024, the cost of practicing medicine, as measured by the Medicare Economic Index (MEI), increased 52 percent, while fee schedule updates have only resulted in a 14 percent increase.[1] This means that when accounting for inflation, physician practices are delivering care with reduced payment. We are deeply concerned that this policy will intensify financial challenges for practices and will force many to close their doors or sell to larger entities, limiting access in high-need areas and preventing physicians from continuing to serve their communities.

This policy will impact the financial sustainability of physician practices across all medical specialties performing office-based services, especially physicians delivering osteopathic manipulative treatment (OMT) and family physicians practicing in rural communities. CMS has repeatedly expressed its interest in supporting independent practices and promoting whole-person care, including through many provisions and requests for information within this year's fee schedule. CMS' proposal would reduce payment when physicians appropriately address multiple, distinct healthcare needs during a single encounter, despite CMS' broader efforts to promote coordinated, patient-centered, and whole-person care, and is rooted in flawed assumptions regarding service valuation that lack an evidentiary basis. We are particularly troubled by the following:

1. **Lack of evidence regarding overlap:** We believe CMS' concerns about overlapping resources are unsound. The RUC already accounts for potential overlap in its process for valuing services, and both CMS and the RUC perform screens under the Potentially

[1] Medicare Payment Advisory Commission (MedPAC). March 2026 Report to Congress. Available here.

Misvalued Code Initiative to identify codes with potential overlap and make RVU adjustments accordingly. CMS claims that there is overlap in work and resources between nearly all E/M visits and procedures rendered on the same date, choosing to upend decades of established policy underpinning the resource-based relative value scale (RBRVS). Modifier -25 is intended to indicate when a significant and separately identifiable E/M is rendered on the same date as a procedure, and CMS provides no evidence of overlap between these services in its proposal. CMS' proposal assumes that overlap exists whenever an E/M service and procedure are furnished on the same day, despite longstanding coding rules requiring Modifier -25 only be utilized when the E/M service is significant and separately identifiable from the procedure. Rather than addressing demonstrated misuse or potential overlap in specific circumstances, CMS is proposing an across-the-board payment reduction that would apply even when physicians comply with all existing coding and documentation requirements.

2. **An inappropriately blunt approach:** CMS' proposal would reduce payment by 50 percent for the lower-valued service in all instances when an O/O E/M is billed on the same date as a 0-, 10-, or 90-day global procedure, treating potential overlap in work and resources as the same across services. However, CMS presents no evidence of this overlap, and it is unlikely that any hypothetical overlap would be of the same extent and nature across thousands of procedures under the fee schedule. The realistic outcome of this policy is that it would place financial pressure on small, rural, and independent practices.

3. **Lack of consideration for beneficiary access:** CMS previously proposed this policy in the CY 2019 Medicare Physician Fee Schedule proposed rule, but it chose not to finalize the policy, in part due to the impact on beneficiary access. Since 2018, practice costs have continued to rise while payment for most physicians has not changed commensurately. CMS does not present any discussion in its proposal regarding the potential impact this policy may have on loss of access, which should be central to CMS' decision-making.

Ultimately, the broad approach CMS is proposing to adopt will have negative consequences for nearly every physician practice across the country, harming those that are already struggling the most. For example, rural family physicians play a critical role in our healthcare system by caring for complex patients in communities with limited access to specialists. In a single visit, a physician could see a patient with hypertension, acid reflux, and chronic kidney disease and report an E/M for managing the patient's conditions. During the same visit, the patient may report a suspicious skin lesion that the physician chooses to biopsy, rather than refer to a dermatologist, who may be located a long drive away, allowing timely diagnosis and treatment. Similarly, a patient with multiple chronic conditions may see their family physician for management of these conditions, including medication adjustments, review of laboratory results, and ongoing care planning. 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 OMT, allowing the physician to address multiple healthcare needs in a single encounter. These examples demonstrate that the separately identifiable O/O E/M and the procedure involve distinct physician work and resources. Nevertheless, CMS' proposal would reduce payment

despite the absence of overlapping physician work or resources and require practices to absorb the resulting financial loss.

While the above examples are specific to rural and family medicine, physicians in communities across the country, and across medical specialties, will be expected to manage highly complex patients without appropriate payment that reflects the resources required to provide comprehensive care. **As a result, we strongly urge CMS to:**

- **Fully withdraw its proposed payment reductions for E/M services and global procedures furnished on the same date;**

- **Work with stakeholders to systematically identify misvalued services and potential overlaps in valuation; and**

- **Take a targeted, code-specific approach to addressing misvalued services rather than applying a uniform payment reduction across thousands of service combinations.**

Our organizations stand ready to assist CMS in addressing this issue. Should you have any questions regarding our comments or recommendations, please contact John-Michael Villarama, Vice President for Public Policy at jvillarama@osteopathic.org.

Sincerely,

American Osteopathic Association