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September 1, 2026

The Honorable Mehmet C. Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1848-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: File Code CMS-1848-P; Medicare Program; CY 2027 Payment Policies Under the Physician Payment Schedule and Other Changes to Part B Payment and Coverage Policies; (July 16, 2026). Accounting for E/M Resource Overlap Between Stand-Alone Visits and Global Periods

Dear Administrator Oz:

The Tennessee Medical Association (TMA), with nearly 10,000 members, is the largest volunteer advocacy organization for physicians in Tennessee. We represent physicians in every medical specialty, residents, and medical students across our state.

TMA vociferously opposes the policy proposed by the Centers for Medicare & Medicaid Services (CMS) that would reduce payment by 50 percent when a separately identifiable office/outpatient evaluation and management (E/M) service reported with modifier -25 is furnished on the same day as a procedure with a 0-, 10-, or 90-day global period. We urge CMS *not* to adopt it.

CMS's own definition states Modifier -25 identifies a "significant, separately identifiable" E/M service performed on the same day as a procedure.[1] In other words, physicians are not supposed to bill Modifier -25 for the routine evaluation inherent in performing the procedure. CMS's justification for the proposed policy is that there are nevertheless efficiencies or overlapping resources when the two services occur during the same encounter. But the proposed 50% reduction is categorical, rather than based upon evidence that 50% of the physician work or practice expense actually overlaps in a particular E/M/procedure combination. This is arbitrary without any medical record review of actual services.

Physician cognitive work: history, examination, review of records, assessment of multiple conditions, medical decision-making, medication management, counseling, risk assessment, documentation, etc. does not become 50% less "efficient" merely because the physician also freezes a lesion, performs an injection, removes a foreign body, performs a biopsy, or does another minor procedure during the patient visit.

[1] CMS, Medicare Claims Processing Manual, Pub. 100-04, Ch. 12, § 30.6.6(B).

CMS' proposal creates a perverse incentive. Suppose a dermatologist evaluates a Medicare patient for several skin problems and determines during that visit that two lesions should be removed. The clinically efficient approach is to perform all medically necessary procedures during the same visit so vulnerable Medicare patients will not have to wait for another appointment weeks later while their condition worsens. Under the proposal, CMS's own example shows a 99212 plus two lesion-removal procedures. CMS would pay the highest-valued procedure (one of the excisions) at 100% but cut both the second excision and the E/M service by 50%.

In the above scenario, the physician could theoretically avoid at least some of the payment reduction by telling the patient to schedule another appointment for the treatment that can efficiently be done then. Specialist appointments can take weeks or months to get. For the patient, that means another appointment, another trip, potentially another copay, time away from work or family, transportation difficulties, and delayed treatment. Medicare patients often have medical co-morbidities that make an extra trip to the doctor's office difficult on them and their caregivers.

CMS recognized this exact problem when it considered a similar policy in 2018 for CY 2019. Commenters warned that it could encourage physicians to bring patients back on another day. CMS itself acknowledged that separating medically appropriate services could impose "undue burden" and "potential medical risk" on beneficiaries—and CMS ultimately did not finalize the proposal. The patient's condition is not going to improve while waiting for another appointment. Nothing about this has changed since 2018. Thus, the proposal redistributes Medicare dollars away from specialties whose normal practice patterns involve evaluating a condition and appropriately performing an office procedure during the same encounter. What has changed for CMS regarding the "undue burden" it recognized eight years ago?

CMS also proposes applying the reduction when the E/M and procedure are furnished by the same physician "or a physician in the same group practice." This is even more egregious. That treats separate physicians' work as overlapping merely because they practice in the same group. Each physician's work may actually involve separate physician time and separate clinical decision-making. In fact, in a large orthopedic practice, there may be subspecialists available to treat separate problems.

The proposal is a blunt admission that CMS favors administrative convenience for the giant health insurers that administer Medicare rather than the physicians who treat our most vulnerable patients at rates far below commercial insurance rates. CMS essentially admits that reviewing thousands of individual global codes is not practical, so it favors a broad payment rule that fails to take into account that there is not likely to be any abuse in the claim submission at all because physicians are well aware how Modifier -25 is used.

Administrative convenience does not establish that every Modifier -25 encounter contains 50% duplicative resources. There are already mechanisms to address inappropriate Modifier -25 billing such as medical-record review, claims edits, comparative billing reports, outlier analysis, audits, and program-integrity enforcement. Your contractors are quite adept at using these tools. If CMS believes physicians

are improperly using Modifier -25, enforce the improper Modifier -25 billing; do not reduce payment for the vast majority of physicians who correctly use Modifier -25 for genuinely separate services.

TMA opposes CMS' proposal that establishes a precedent under which properly coded, medically necessary, separately identifiable physician work is automatically discounted simply because the physician delivered another medically necessary service efficiently during the same encounter.

The proposal disproportionately hits office-based procedural medicine at a time when Medicare should be encouraging clinically appropriate care in lower-cost physician offices rather than creating additional financial pressure toward consolidation and hospital-based care. The proposal adds nothing to patient care but penalizes efficient physicians. For some common procedures, the reduced payment would fall below the direct cost of furnishing the service: for CPT code 11300, the example CMS cites in the proposed rule, the policy would leave roughly $45 for the procedure against approximately $60 in clinical staff, supply, and equipment cost, before any physician work.

For these reasons, TMA strongly urges CMS to withdraw the proposal and to work with physicians and other stakeholders to address any demonstrated instances of duplicative payment through targeted, evidence-based means and education. Thank you for your consideration.

Respectfully,

Yarnell Beatty
General Counsel