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 Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Accounting for E/M Resource Overlap Between Stand-Alone Visits and Global Periods

Dear Administrator Oz:

On behalf of physicians across specialties and practice settings throughout New Jersey, the Medical Society of New Jersey (MSNJ) strongly urges the Centers for Medicare & Medicaid Services (CMS) not to finalize the proposed policy 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. The proposal rests on an unproven assumption of duplicative resources, would penalize efficient same-day care, and would further destabilize the independent physician practices where care is often delivered most conveniently and cost-effectively.

MSNJ asks CMS to withdraw the proposed reduction, decline to extend it to other E/M services, and address any demonstrated overlap on a code-specific basis through the established misvalued-code and Relative Value Scale Update Committee (RUC) processes, with direct input from physicians who furnish the affected services.

The proposal assumes duplication without demonstrating it occurs

Modifier -25 is used only when the physician furnishes a significant, separately identifiable E/M service in addition to the work of the procedure. The E/M service may involve evaluation of a

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separate problem, additional medical decision-making, counseling, coordination, or other work that is not inherent in the procedure. CMS nevertheless proposes to pay the highest-valued service at 100 percent and every other affected service at 50 percent based on what the proposed rule describes only as a likely overlap in resources. CMS has not identified the allegedly duplicated resources across the thousands of affected code combinations, quantified their value, or explained why any overlap would uniformly equal half of the lower-valued service. See 91 Fed. Reg. 43908-09.

The reduction applies to the entire value of the lower-paid service, including physician work, practice expense, and professional liability expense, although CMS has not shown overlap in every component. It also is broader than the similar CY 2019 proposal CMS declined to finalize, without new evidence supporting that change.

Existing Medicare coding and valuation mechanisms already address overlap among services. CMS guidance distinguishes routine work included in a procedure from a significant, separately identifiable E/M service furnished above and beyond that work.[1] CMS's NCCI edits likewise prevent inappropriate payment for services that should not be reported together while recognizing modifiers, including modifier -25, when separate payment is clinically appropriate.[2] Additional overlap identified through evidence can be addressed through CMS's potentially misvalued-code process. An across-the-board reduction risks removing resources already excluded from the separately reported E/M service. Any residual overlap should be evaluated in the affected codes, not assumed through a blunt payment-level adjustment.

The proposal would undermine efficient, patient-centered care

When clinically appropriate services can be safely completed during one encounter, doing so is better for patients and conserves healthcare resources. It can avoid another trip, absence from work, transportation expense, extra childcare arrangement, or reliance on a family caregiver. These burdens fall especially heavily on older adults, people with disabilities, and residents of rural or underserved communities.

The policy discourages practice models organized to address clinically distinct needs efficiently in one encounter. The physician's cognitive, coordination, documentation, and procedural work do not become half as extensive because they occur on the same date. Reducing payment while the work remains whole is simply underpayment for separately identifiable services rather than efficiency gain.

The concern in this case is systemic: payment policy shapes whether practices can maintain the staff, equipment, capacity, and workflows that make same-day services available. If that model becomes

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[1] Centers for Medicare & Medicaid Services, *Further Information on the Use of Modifier -25 in Reporting Hospital Outpatient Services*, Program Memorandum A-00-40, at 1–2 (July 20, 2000), https://www.cms.gov/regulations-and-guidance/guidance/transmittals/downloads/dwnlds/a0040pdf (last visited Aug. 29, 2026).

[2] Centers for Medicare & Medicaid Services, *Medicare National Correct Coding Initiative FAQ Library*, Questions Regarding Procedure-to-Procedure Edits and NCCI Modifiers, https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medicare-ncci-faq-library (last updated Apr. 13, 2026) (last visited Aug. 29, 2026).

financially unsustainable, more patients will face separate appointments or referrals because of operational constraints.

The reduction would push care toward higher-cost settings

The effects of this proposal would fall hardest on independent, office-based practices. Those practices bear the direct costs of clinical staff, supplies, equipment, rent, and regulatory compliance, without a separate hospital facility payment to offset the reduction, often leading to payments that fall below the direct cost of furnishing a service.

The likely result is further pressure on independent practices to discontinue in-office procedural capacity, close, or consolidate. Patients may then be referred to hospital outpatient departments that generate separate facility payments and are frequently more expensive to Medicare and its beneficiaries. CMS has recognized that Medicare often pays more for the same clinic visit in a hospital outpatient department than in a physician office,[3] and MedPAC has documented that this shift can increase program spending and beneficiary cost sharing.[4] New Jersey has already experienced substantial consolidation and loss of independent practices. Further weakening the lower-cost office setting cannot solve Medicare's larger cost pressures and may increase total costs through higher facility payments.

Further undervaluing physician work would worsen workforce instability

The E/M service reflects work patients value: listening, evaluating, making clinical decisions, counseling, coordinating care, and documenting the encounter. When the value of that work is not fully recognized, the consequences include less practice capacity, burnout, and physicians leaving independent practice. Patients want sufficient time to be heard and understood; this payment policy strains comprehensive care and makes redundant return visits more likely. Efficiency should mean appropriate care with fewer burdens and lower total cost rather than reduced payment for unchanged, separately identifiable work.

CMS should use targeted, evidence-based alternatives

MSNJ shares CMS's responsibility to ensure accurate payment and address genuine duplication, fraud, waste, and abuse. Before changing payment for modifier -25 services, CMS should identify the codes and inputs it believes are duplicative, publish the supporting evidence, assess effects on access and independent-practice viability, and use the misvalued-code and RUC processes for any warranted changes. Independent physicians who furnish the affected services should participate meaningfully in that work.

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[3] Centers for Medicare & Medicaid Services, *CMS Finalizes Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Changes for 2019 (CMS-1695-FC)* (Nov. 2, 2018) (last visited Aug. 29, 2026).

[4] Medicare Payment Advisory Commission, *Aligning Fee-for-Service Payment Rates Across Ambulatory Settings*, Meeting Brief (Apr. 13, 2023), https://www.medpac.gov/meeting/april-13-14-2023/ (last visited Aug. 29, 2026).

CMS also should decline to extend this concept to inpatient or other E/M services. Expansion would compound its access, workforce, and site-of-service consequences without showing that Medicare is paying twice for the same resources.

For these reasons, MSNJ respectfully requests that CMS withdraw the proposed reduction. We welcome the opportunity to develop targeted approaches that protect program integrity, patient access, and efficient same-day care, all while supporting the viability of independent physician practices.

Thank you for your consideration.

Respectfully submitted,



Nicole Henry-Dindial, MD
President
Medical Society of New Jersey