August 27, 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:

On behalf of the undersigned organizations, we urge the Centers for Medicare & Medicaid Services (CMS) not to finalize the proposed policy to reduce payment by 50 percent when a separately identifiable office/outpatient (O/O) 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. CMS advances this policy on an unsubstantiated assumption of "likely" duplication, without the evidence a change of this magnitude requires, and without addressing the concerns that led the Agency to decline a substantially similar proposal in 2019. We appreciate the Trump administration's emphasis on keeping independent physician practices sustainable, yet we believe the unintended consequence of CMS' proposed policy will make it extremely difficult for those practices to remain viable. We respectfully request that CMS:

- Not finalize the proposed 50 percent payment reduction for services furnished on the same date as a separately identifiable O/O E/M visit reported with modifier -25;
- Not extend the policy to procedures furnished on the same date as inpatient or other E/M services; and
- Address any genuine overlap through the established misvalued code and AMA/Specialty Society RVS Update Committee (RUC) valuation processes on a code-specific basis, rather than through a uniform, payment-level reduction, working with stakeholders where CMS believes specific codes do not fully account for overlap.

CMS has not substantiated the premise of this policy.

CMS characterizes the overlap it seeks to correct only as "likely," and states that it "continue[s] to believe" efficiencies exist. A payment reduction of this scope, applied across thousands of codes and every affected specialty, should rest on demonstrated duplication in identified services, not an assumption. CMS has not quantified the overlap it asserts, identified the specific resources it believes are duplicated, or shown that current payment systematically overstates the work and practice expense required to furnish these services. We urge CMS to explain, in the final rule, the specific evidentiary basis for both the existence and the 50 percent magnitude of the duplication it asserts.

CMS has not explained its departure from its 2019 determination.

This is not a new proposal. CMS proposed a substantially similar, and narrower, policy in CY 2019 rulemaking and, after considering public comments, declined to finalize it. The current proposal is broader, extending to 10- and 90-day global procedures and reducing all same-day services other than the highest-valued one. Yet in the intervening years CMS has not developed the evidentiary basis or the concrete implementation approach that its earlier decision would call for, and the proposed rule does not explain what has changed to warrant revisiting it. An agency reviving and expanding a policy it previously declined to finalize should, at a minimum, explain the basis for its changed position. We urge CMS to identify what evidence or circumstances have changed since 2019.

The valuation process already accounts for overlap where services are typically furnished together.

For procedures typically furnished on the same day as an office visit, the RUC and CMS already remove duplicative physician work and practice expense through the established valuation process. The RUC's physician work survey instructions expressly exclude work associated with a distinct E/M service reported with modifier -25; the misvalued code initiative has identified and revalued codes commonly furnished with a same-day E/M; and CMS reviews the RUC's recommendations annually and adjusts values itself where it believes overlap has not been fully addressed. CMS describes this very process in the proposed rule, acknowledging that it removes overlapping pre- and post-service time and that the RUC "now addresses the overlap in time and work when a service is typically furnished on the same day as an E/M service." Because those reductions also lower the inputs used to allocate indirect practice expense, the overlap is reflected across all components of a procedure's value. A further, across-the-board reduction would take a second reduction for overlap the valuation process has already removed. If CMS believes specific codes contain residual overlaps after this process, the appropriate response is to identify and address those codes, not to reduce payment uniformly for all.

The 50 percent reduction is disproportionate and departs from CMS's own targeted approach.

When CMS reduces payment to account for overlap, it does so with precision. Its longstanding multiple procedure payment reductions apply only to the specific component in which the efficiency occurs, for example, the technical component for diagnostic cardiovascular, and ophthalmology services. This proposal abandons that approach, applying a 50 percent reduction to the entire value of the lower-valued service—physician work, practice expense, and professional liability alike—including components in which CMS has identified no overlap at all. The reduction is borrowed from a context that does not describe the relationship between a distinct E/M service and a minor procedure, and it far exceeds any resource overlap that could plausibly exist between them.

The policy would fall hardest on the independent, office-based practices CMS seeks to support.

Because these services are frequently furnished in independent, office-based settings, the payment reduction would fall most heavily on those practices, which bear the full cost of the clinical staff, supplies, and equipment reflected in the non-facility payment and cannot offset the reduction with facility revenue. 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. A policy that pays below the cost of providing care runs counter to CMS's stated goal of sustaining independent practice and risks accelerating the consolidation CMS has identified as a concern.

We appreciate CMS's responsibility to ensure that Medicare payments accurately reflect the resources required to furnish care. Consistent with that goal, we urge CMS to address the following in the final rule:

- The specific evidence demonstrating separately identifiable, same-day E/M services systematically contain duplicative resources warranting a reduction, and the basis for setting that reduction at 50 percent;
- The analysis CMS conducted regarding the policy's impact on independent physician practices and on beneficiary access, particularly in rural and underserved communities; and
- What evidence or circumstances have changed since CMS declined to finalize a similar policy in 2019.

We urge CMS to withdraw the proposal and to work with physicians and other healthcare professionals to address any demonstrated instances of duplicative payment through targeted, evidence-based means. Thank you for your consideration.

Respectfully,

American Medical Association
American Academy of Allergy, Asthma & Immunology
American Academy of Dermatology Association
American Academy of Emergency Medicine
American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Family Physicians
American Academy of Hospice and Palliative Medicine
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Otolaryngic Allergy
American Academy of Otolaryngology–Head and Neck Surgery
American Academy of Pediatrics
American Academy of Physical Medicine & Rehabilitation
American Academy of Physician Associates
American Academy of Sleep Medicine
American Association for Geriatric Psychiatry
American Association for Hand Surgery
American Association of Clinical Endocrinology
American Association of Hip and Knee Surgeons
American Association of Neurological Surgeons
American Association of Neuromuscular & Electrodiagnostic Medicine
American Association of Oral and Maxillofacial Surgeons
American Association of Orthopaedic Surgeons
American Association of Public Health Physicians
American Burn Association
American Chiropractic Association
American Clinical Neurophysiology Society
American College of Allergy, Asthma and Immunology
American College of Chest Physicians
American College of Emergency Physicians
American College of Gastroenterology
American College of Lifestyle Medicine
American College of Medical Genetics and Genomics

American College of Medical Toxicology
American College of Mohs Surgery
American College of Obstetricians and Gynecologists
American College of Physicians
American College of Radiation Oncology
American College of Radiology
American College of Rheumatology
American College of Surgeons
American Epilepsy Society
American Gastroenterological Association
American Geriatrics Society
American Nurses Association
American Optometric Association
American Orthopaedic Foot & Ankle Society
American Osteopathic Association
American Pediatric Surgical Association
American Podiatric Medical Association
American Psychiatric Association
American Society for Dermatologic Surgery Association
American Society for Gastrointestinal Endoscopy
American Society for Laser Medicine and Surgery, Inc.
American Society for Metabolic and Bariatric Surgery.
American Society for Peripheral Nerve
American Society for Reproductive Medicine
American Society for Surgery of the Hand
American Society of Anesthesiologists
American Society of Cataract & Refractive Surgery
American Society of Colon & Rectal Surgeons
American Society of Hematology
American Society of Nephrology
American Society of Neuroradiology
American Society of Nuclear Cardiology
American Society of Plastic Surgeons
American Society of Regional Anesthesia and Pain Medicine
American Society of Retina Specialists
American Thoracic Society
American Urogynecologic Society
American Venous Forum
Association of American Medical Colleges
Congress of Neurological Surgeons
Endocrine Society
Infectious Diseases Society of America
International Pain and Spine Intervention Society
International Society for the Advancement of Spine Surgery
Korean American Medical Association
Lifeline Medical Associates
Medical Group Management Association
National Association of Social Workers
National Medical Association
North American Neuromodulation Society

Obesity Medicine Association
Orthopaedic Trauma Association
Outpatient Endovascular and Interventional Society
Post-Acute and Long-Term Care Medical Association
Society for Cardiovascular Angiography and Interventions
Society for Maternal-Fetal Medicine
Society for Pediatric Dermatology
Society for Vascular Surgery
Society of American Gastrointestinal and Endoscopic Surgeons
Society of Critical Care Medicine
Society of Hospital Medicine
Society of Interventional Radiology
The American College of Cardiology
The American Rhinologic Society
The American Society of Breast Surgeons
The American Society of Colon and Rectal Surgeons
The American Society of Dermatopathology
The OrthoForum
Undersea and Hyperbaric Medical Society

Medical Association of the State of Alabama
Alaska State Medical Association
Arizona Medical Association
Arkansas Medical Society
California Medical Association
Colorado Medical Society
Connecticut State Medical Society
Medical Society of the District of Columbia
Medical Society of Delaware
Florida Medical Association
Medical Association of Georgia
Hawaii Medical Association
Idaho Medical Association
Illinois State Medical Society
Indiana State Medical Association
Iowa Medical Society
Kansas Medical Society
Kentucky Medical Association
Louisiana State Medical Society
Maine Medical Association
MedChi, The Maryland State Medical Society
Massachusetts Medical Society
Michigan State Medical Society
Minnesota Medical Association
Mississippi State Medical Association
Missouri State Medical Association
Montana Medical Association
Nebraska Medical Association
Nevada State Medical Association
New Hampshire Medical Society

Medical Society of New Jersey
New Mexico Medical Society
Medical Society of the State of New York
North Carolina Medical Society
North Dakota Medical Association
Ohio State Medical Association
Oklahoma State Medical Association
Oregon Medical Association
Pennsylvania Medical Society
Rhode Island Medical Society
South Dakota State Medical Association
Tennessee Medical Association
Texas Medical Association
Vermont Medical Society
Medical Society of Virginia
Washington State Medical Association
West Virginia State Medical Association
Wisconsin Medical Society
Wyoming Medical Society