

September 14, 2026

The Honorable Mehmet C. Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016
Attention: CMS-1848-P

Re: CMS-1848-P, Medicare Program; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies

Dear Administrator Oz:

On behalf of the undersigned Arizona physician organizations, we respectfully submit these comments on the Calendar Year (CY) 2027 Medicare Physician Fee Schedule proposed rule. Together, we represent thousands of physicians practicing across Arizona and caring for Medicare beneficiaries in urban, rural, and underserved communities.

We appreciate the Centers for Medicare & Medicaid Services' (CMS) responsibility to ensure that Medicare payments accurately reflect the resources required to provide care. We are concerned, however, that several proposals in the CY 2027 rule would significantly reduce physician payment, create instability for practices, and ultimately threaten timely access to care for Arizona Medicare beneficiaries. These concerns are particularly significant for independent and office-based practices, which already face increasing costs for staff, supplies, technology, compliance, and other practice expenses.

We urge CMS to reconsider the following provisions before finalizing the rule.

I. The proposed 50% reduction for same-day services reported with Modifier 25 should be withdrawn.

CMS proposes that when a separately identifiable office or outpatient evaluation and management (E/M) service is furnished on the same day as a procedure with a 0-, 10-, or 90-day global period, the highest-valued service would be paid at 100%, while every other service on the claim would be reduced by 50%, including a separately identifiable E/M service appropriately reported with Modifier 25.

We strongly oppose this proposal. Modifier 25 already requires that an E/M service be significant, separately identifiable, and medically necessary beyond the work inherent in the procedure. Applying an across-the-board 50% reduction would therefore penalize legitimate, distinct patient care rather than simply addressing inappropriate billing.

CMS has not provided sufficient evidence to support a reduction of this magnitude. The proposed rule characterizes the potential overlap between services as "likely," but does not quantify the alleged duplication, identify the specific resources that are duplicated, or demonstrate that current payment systematically overstates the work and practice expense required to provide these

services. A 50% reduction affecting thousands of codes and numerous specialties should be based on demonstrated duplication, not an assumption.

The proposed policy would also undermine efficient, patient-centered care. Same-day evaluation and treatment allows a patient to have a new symptom assessed and a necessary procedure performed during a single visit. For an Arizona senior or rural patient who may travel substantial distances to see a specialist, requiring separate appointments could mean additional travel, longer wait times, delayed diagnosis or treatment, and additional cost-sharing.

The policy could also have particularly harmful consequences for independent practices. For some procedures, CMS's own examples demonstrate that a 50% reduction could bring payment below the direct cost of clinical staff, supplies, and equipment required to furnish the service—before accounting for physician work. A policy that pays less than the cost of providing care threatens the viability of office-based practices and could accelerate the consolidation CMS has identified as a concern.

We urge CMS to withdraw the proposed 50% payment reduction for appropriately reported Modifier 25 services. The AMA/Specialty Society RVS Update Committee (RUC) and CMS remove duplicative physician work and practice expense through established valuation and misvalued-code processes. The RUC's valuation instructions specifically exclude work associated with a distinct E/M service reported with Modifier 25, and CMS reviews and adjusts valuations annually. If CMS identifies specific services where residual overlap remains, those services should be evaluated individually through the established valuation process. A uniform 50% reduction is neither targeted nor evidence-based.

II. The continued decline in the Medicare conversion factor is unsustainable and must be updated to reflect the inflation-adjusted realities of providing care.

CMS proposes a CY 2027 conversion factor of \$32.8409 for physicians who are not qualifying Alternative Payment Model participants, a decrease of 1.68% from CY 2026, and \$33.1693 for qualifying APM participants, a decrease of 1.19%.

These reductions come at a time when physician practices continue to face significant increases in the cost of delivering care. Payment has increasingly fallen behind the Medicare Economic Index and the actual cost of maintaining a medical practice. Physician practices must absorb rising costs for clinical and administrative staff, rent, supplies, technology, insurance, regulatory compliance, and other operational expenses. Further reductions in payment, particularly when combined with the specialty-specific reductions described below, are not sustainable.

We urge CMS to work with Congress and use its available administrative authority to support a positive payment update that more accurately reflects the real, inflation-adjusted cost of providing physician services.

III. CMS should pause the proposed changes to practice expense methodology until appropriate feedback from physicians is incorporated.

CMS proposes significant changes to the practice expense methodology, including phasing down the Indirect Practice Cost Index and ultimately eliminating it beginning in CY 2028, while

reallocating indirect practice expense using code-level inputs. CMS acknowledged that these changes would redistribute practice expense RVUs among specialties, with particularly significant effects on office-based specialties.

Independent and specialty practices have limited ability to absorb sudden, methodology-driven changes in payment. While CMS proposes a stabilization adjustment intended to limit annual practice expense RVU changes, that safeguard does not eliminate the potential for substantial cumulative payment changes as the new methodology is phased in.

We urge CMS to pause elimination of the Indirect Practice Cost Index and the broader practice expense methodology changes until CMS has incorporated meaningful specialty-specific physician input and validated the underlying cost data. Major payment shifts among specialties should not be implemented without sufficient evidence and stakeholder review.

Conclusion

These policies should not be considered in isolation. The conversion factor reduction, proposed Modifier 25 reduction, and practice expense changes will compound one another, creating substantial payment pressure for individual practices.

CMS projects significant RVU reductions for several specialties represented by the organizations joining this letter, including approximately:

- 9% for dermatology, where biopsies, lesion destruction, excisions, injections, and management of chronic skin conditions frequently involve a separately identifiable E/M service on the same day as a procedure;
- 9% for otolaryngology-head and neck surgery, where nasal endoscopy, flexible laryngoscopy, cerumen removal, biopsies, and treatment of epistaxis commonly occur following a medically necessary evaluation during the same visit; and
- 7% for orthopedic surgery, where joint injections, aspirations, fracture care, casting, and other procedures frequently accompany evaluation and management of complex musculoskeletal conditions.

For these specialties, the proposed policies could result in multiple reductions affecting the same practice and, in some cases, the same patient encounter.

Arizona has significant rural and medically underserved areas where patients may travel substantial distances to receive specialty care. Many independent practices serve broad geographic regions and provide comprehensive evaluation and treatment during a single visit precisely because doing so is more convenient and efficient for patients.

When Medicare payment policies make comprehensive same-day care financially difficult, practices may be forced to reduce clinical support staff, limit the services provided during a visit, defer investments in their practices, or separate evaluation and procedures into multiple appointments.

The consequences are predictable: more visits, more travel, longer wait times, delayed diagnoses and treatment, and potentially higher costs for beneficiaries and the Medicare program.

Arizona physicians share CMS's goal of ensuring that Medicare payment accurately reflects the resources necessary to provide high-quality care. We respectfully believe that the proposed policies, particularly when considered together, risk undermining that goal by placing additional financial pressure on the practices responsible for delivering care to Medicare beneficiaries.

We urge CMS to withdraw or substantially revise these proposals and to work collaboratively with physicians and other healthcare professionals to develop targeted, evidence-based approaches that protect both the sustainability of physician practices and access to care for Medicare beneficiaries.

Thank you for your consideration and for the opportunity to comment. We welcome the opportunity to serve as a resource to CMS as it evaluates the CY 2027 Physician Fee Schedule.

Respectfully submitted,

On behalf of the undersigned Arizona physician organizations:

Arizona Medical Association

Arizona Osteopathic Medical Association

Arizona Healthcare Advocacy Coalition

Arizona Society of Anesthesiologists

Arizona Chapter of the American College of Physicians

Arizona Dermatology Society

Arizona Orthopedic Society

Arizona Society of Otolaryngology

Arizona Radiological Society

Phoenix Dermatological Society