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Calendar Year 2027 Medicare Physician Fee Schedule Modifier 25 Proposal

Recommendation. The American Podiatric Medical Association (APMA) strongly opposes the proposed payment reduction for services reported on the same day with Modifier 25 that was included in the Calendar Year (CY) 2027 Medicare Physician Fee Schedule (MPFS) proposed rule. The proposal is not based on evidence or empirical data, would result in payments insufficient to cover costs, and would threaten practice sustainability and patient access. APMA therefore urges the Centers for Medicare and Medicaid Services (CMS) not to finalize the proposal and to instead maintain payment rates for same-day services. To the extent that CMS continues to hypothesize that overlap exists, APMA urges CMS to collect data that demonstrates the existence and extent of duplication across different code families, prior to advancing any future proposals.

Background. In the CY 2027 MPFS proposed rule, CMS included a proposal targeting services reported on the same day as an evaluation and management (E/M) visit reported with Modifier 25. Specifically, CMS proposed to reduce payment when a separately identifiable office and outpatient E/M visit is furnished by the same physician (or a physician in the same group practice) on the same day as a 0-, 10-, and 90-day global procedure; while, the most expensive service would be paid at 100 percent, all other surgical procedure(s) or E/M visit(s) would be paid at 50 percent.

Concerns. APMA has significant concerns with this Modifier 25 proposal. To begin, the proposal is intended to target overlap when procedures are furnished on the same day as a separately identifiable E/M visit. CMS does not provide any clear evidence or empirical support for imposing the proposed payment reductions, particularly given previous work by the RUC to remove duplication when procedures are furnished together with a E/M more than fifty percent of the time.

The Modifier 25 proposal upends existing payment policy and has major implications for physician payment, thereby requiring thoughtful consideration of relevant evidence and a detailed justification to support the change. However, CMS failed to demonstrate the existence of any overlap in its discussion of the proposal. Furthermore, CMS did not provide any data to support an arbitrary across-the-board reduction of 50 percent to lower-cost services, which we believe would be particularly egregious in cases where the RUC and CMS have already finalized changes in valuation to account for duplication.

Troublingly, the proposal would result in payment rates that do not cover the costs of delivering care. Indeed, our analysis shows that a 50 percent reduction in the payment of a several procedures commonly performed by podiatrists would result in payment for the procedure that does not even cover the direct practice expense costs, much less the physician work or indirect practice costs involved in furnishing the services (see Appendix A for examples). When a policy results in physicians being unable to recoup the direct practice expense costs to perform a procedure, it is clear that the policy is flawed.

Notably, APMA devotes significant resources to educating physicians regarding the appropriate use of Modifier 25, including documentation requirements and examples of both compliant and noncompliant

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coding. We support efforts to identify and address inappropriate utilization. However, the proposed CMS policy would broadly reduce reimbursement for services that are appropriately billed together. The proposal assumes efficiencies that often do not exist and fails to account for the complexity or medical necessity of the services furnished.

Impact on Podiatry. CMS acknowledges that the proposal would have one of the greatest negative impacts on podiatry because podiatric physicians frequently furnish medically necessary E/M services in conjunction with procedures. This disproportionate impact is largely due to the fact that most patients have two lower extremities, thereby resulting in podiatrists very often performing a medically necessary evaluation and management for one condition and performing an unrelated procedure for a totally different and unrelated condition at a separate site during the same encounter.

The following example demonstrates why a separately identifiable E/M service reported with Modifier 25 is medically necessary and why reducing payment based solely on same-day billing would fail to reflect the resources required:

> *A Medicare beneficiary presents to a podiatrist with two complaints. The first is worsening pain in the left big toe joint that has been present for more than a year. The pain has recently progressed to the point that it is causing him to limp and is affecting his ability to work and exercise. The podiatrist performs an evaluation and management (E/M) service, resulting in a diagnosis of hallux limitus deformity, a form of degenerative arthritis of the big toe joint. Medical management includes writing a prescription, making shoe recommendations, and discussing what would be involved with surgical repair. The second complaint is a dark discoloration beneath the right big toenail. Because its appearance raises concern for melanoma, a nail unit biopsy is performed (CPT 11755). Notably, the E/M is both significant in nature and separately identifiable from the procedure. Additionally, CMS revalued this code in the CY 2019 MPFS final rule to eliminate duplication when furnished on the same day as a separately identifiable E/M and to reflect the full resources required to furnish the service on the same day as the E/M.*

There is a clear distinction in resources required to furnish the procedure and the separately identifiable E/M service in this and numerous other podiatric scenarios that are appropriately reported with Modifier 25. Applying a payment reduction under CMS' proposed Modifier 25 policy would therefore inappropriately reduce payments in a manner that would undervalue the work podiatrists perform and fail to consistently cover their costs for furnishing care.

Over time, we are concerned that these effects will have a lasting, detrimental impact on podiatry practices and the podiatry workforce. Practices have already struggled with insufficient annual payment updates and rising practice expenses in recent years. Further payment cuts, as estimated under this year's proposed rule for podiatric services, would exacerbate practices' financial instability. Solo, small, and rural independent practices would likely experience the greatest challenges, which we anticipate would increase pressures to close or consolidate. Notably, access to podiatry services would likely also decrease as patients who rely on these practices would face reduced provider choice and increased costs. For all of these reasons, APMA urges CMS not to finalize this Modifier 25 proposal.

Appendix A

Procedure Code	Percent Billed with E/M in Non-Facility	Estimated 2027 Payment for Procedure Under Current Policy	Estimated 2027 "Lower-Of" Payment Under Proposed Policy	Work Time (minutes)	Total Direct Practice Expense Cost (Non-Facility)
Procedures Subject to Reduction if Billed with Level 3 E/M Code or Higher					
CPT 11720 - Debridement of nail(s) by any method(s); 1 to 5	15.0%	$33.50	$16.75	14	$20.53
CPT 11056 - Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); 2 to 4 lesions	23.0%	$83.42	$41.71	19	$65.30
Procedures Subject to Reduction if Billed with Level 4 E/M Code or Higher					
CPT 17110 - Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions	84.8%	$104.76	$52.38	29	$70.24
CPT 11730 - Avulsion of nail plate, partial or complete, simple; single	52.6%	$113.63	$56.82	33	$71.19

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