apma
Advancing foot and ankle medicine and surgery

Finalized 2027 Medicare Physician Fee Schedule Modifier 25 Policy

Recommendation. The American Podiatric Medical Association (APMA) strongly opposes the finalized 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) final rule. The policy is not based on evidence or empirical data, will result in payments insufficient to cover costs, and will threaten practice sustainability and patient access. APMA therefore urges Congress to enact a one-year moratorium before the end of 2026 to halt the Centers for Medicare and Medicaid Services (CMS) from implementing the 20 percent payment reduction for services provided on the same day and billed with a Modifier 25. APMA also urges Congress to require CMS to collect data that demonstrates the existence and extent of duplication across different code families during the temporary moratorium.

Background. In the CY 2027 MPFS final rule, CMS included a policy targeting services reported on the same day as an evaluation and management (E/M) visit reported with Modifier 25. The policy will 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-day global procedure; while, the most expensive service will be paid at 100 percent, all other surgical procedure(s) or E/M visit(s) will be paid at 20 percent.

Concerns. While the finalized rule included a 20% payment reduction instead of the proposed 50% reduction, APMA has significant concerns with this Modifier 25 policy. To begin, the policy is intended to target overlap when procedures are furnished on the same day as a separately identifiable E/M visit. However, CMS did not provide any clear evidence or empirical support for imposing the 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 policy 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 reasoning for the policy. Furthermore, CMS did not provide any data to support an arbitrary across-the-board reduction of 20 percent to lower-cost services, which we believe will be particularly egregious in cases where the RUC and CMS have already finalized changes in valuation to account for duplication.

Troublingly, the policy will result in payment rates that do not cover the costs of delivering care. Indeed, our analysis shows that a 20 percent reduction in the payment of several procedures commonly performed by podiatrists will 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

11400 Rockville Pike, Suite 220
Rockville, MD 20852
T 301.581.9200 | F 301.530.2752
www.apma.org

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 coding. We support efforts to identify and address inappropriate utilization. However, the finalized CMS policy will broadly reduce reimbursement for services that are appropriately billed together. The policy 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 policy will 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 will 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' Modifier 25 policy will therefore inappropriately reduce payments in a manner that will 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 final rule for podiatric services, will exacerbate practices' financial instability. Solo, small, and rural independent practices will likely experience the greatest challenges, which we anticipate will increase pressures to close or consolidate. Notably, access to podiatry services will likely also decrease as patients who rely on these practices will face reduced provider choice and increased costs.

For all of these reasons, APMA urges Congress to pass a temporary moratorium on the finalized 20% payment reduction for same-day services appropriately reported with Modifier 25 to ensure Congress and CMS have enough time to fully evaluate the policy's consequences for physicians and Medicare beneficiaries.

For more information contact:
Chad Appel, JD, APMA Vice President, Advocacy at Cappel@apma.org.