apma
Advancing foot and ankle medicine and surgery

September 14, 2026

The Honorable Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: File Code CMS-1848-P; Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program

Dear Administrator Oz:

On behalf of the members of the American Podiatric Medical Association (APMA), the national organization representing the vast majority of the nation's estimated 18,000 doctors of podiatric medicine (DPMs), also known as podiatric physicians and surgeons, or podiatrists, we appreciate the opportunity to comment on the proposed rule CMS-1848-P; Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program; etc. issued by the Department of Health and Human Services (HHS) Centers for Medicare & Medicaid Services (CMS) and referenced above.

Proposals Related to the CY 2027 Medicare Physician Fee Schedule

I. Medicare Physician Fee Schedule (MPFS) Conversion Factor

For CY 2027, CMS proposes two Medicare Physician Fee Schedule (MPFS) conversion factors, as required by statute:

- $33.1693 for services furnished by Qualifying Alternative Payment Model Participants (QPs), representing a 1.19 percent decrease from CY 2026; and
- $32.8409 for services furnished by all other clinicians, representing a 1.68 percent decrease from CY 2026.

APMA estimates that the combined impact of the reduction in the conversion factor and other policies included in the proposed rule will result in an approximate 6-percent reduction in Medicare payments across all podiatric physicians in CY 2027.

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

As APMA has emphasized in previous comments, continued reductions of this magnitude are untenable for many physician practices. Medicare physician payments have consistently failed to keep pace with inflation and the rising costs of operating a medical practice. Moreover, because many private payers establish payment rates based on Medicare, reductions under the MPFS can have consequences well beyond the Medicare program. These financial pressures may force practices to reduce services, consolidate, sell to larger health systems, or close altogether—ultimately threatening beneficiaries' access to community-based care.

APMA's concern extends beyond the payment reductions proposed for CY 2027. These reductions reflect longstanding structural problems within the MPFS, including budget-neutrality requirements and inadequate statutory annual payment updates that are not tied to inflation in practice costs. Without meaningful reform, these policies will continue to create downward pressure on physician payment and recurring uncertainty for practices.

In recent years, physicians have repeatedly faced significant scheduled Medicare payment reductions that Congress has acted—often at the last minute—to partially mitigate. While Congress' provision of payment increase for CY 2026 was much needed and appreciated, it was an outlier that – due to its temporary nature – has contributed to the reductions we are seeing for 2027. This cycle is neither sustainable nor responsible. Physicians should be able to rely on stable and predictable Medicare payments that appropriately account for increases in the cost of delivering care.

APMA therefore urges CMS to pursue all available opportunities to mitigate the CY 2027 payment reductions, including working with Congress on an appropriate legislative remedy. More broadly, APMA urges CMS to work with Congress and physician stakeholders to enact meaningful reforms to the MPFS that provide stable, sustainable annual payment updates and ensure continued beneficiary access to physician care.

II. Proposed Changes to Payments Using Modifier -25

CMS proposes to reduce payment 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. Specifically, while CMS would pay the most expensive service at 100 percent, other procedures and E/M visits would only be paid at 50 percent. CMS advances this policy on an unsubstantiated assumption of "likely" duplication, without the evidence a change of this magnitude requires and in the face of evidence to the contrary.

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;***

- ***If CMS believes resource duplication may exist, the agency should undertake a transparent, data-driven analysis of specific services before considering any future changes. We also asked that CMS conduct analysis on any potential future policy's impact on independent practices, beneficiary access, beneficiary outcomes, and Medicare spending;***
- ***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; and***
- ***Not extend the policy to procedures furnished on the same date as inpatient or other E/M services.***

The Proposal Is Not Supported by Evidence
CMS has not provided sufficient evidence demonstrating that duplication exists when procedures are furnished on the same day as a separately identifiable E/M code or that a 50-percent reduction would appropriately reflect the extent of duplication. Modifier 25 is used specifically when an E/M service is significant and separately identifiable from the procedure performed.

A payment change of this magnitude, which would upend existing payment policy and have major implications for physician payment, should be based on clear data demonstrating where overlap exists and the extent of that overlap. CMS has not provided such data or provided any evidence-based justification for pursuing this policy. Given the lack of data or analysis identifying duplication, we believe the proposed 50-percent reduction is arbitrary in nature and not reflective of the resources required to furnish care.

Accordingly, CMS' proposed policy would reduce payment accuracy, an outcome that we believe would be contrary to the Administration's priorities. Accurate payments help to mitigate incentives that could distort provider behavior and increase risk of fraud, waste, or abuse. Inappropriately high payment rates can contribute to delivery of unnecessary care and higher spending. Inappropriately low payment rates, on the other hand, can discourage appropriate care, reduce patient access, and undermine delivery of high-quality care. We are therefore concerned about the unintended consequences of CMS' proposal, which would apply a blunt, across-the-board payment reduction to reduce overlap that is not reflective of the extent of duplication that exists.

The Proposal Would Remove Duplication that Has Already Been Addressed
The AMA RUC and CMS have previously addressed duplication when procedures are commonly furnished with an E/M service. The RUC process begins with clear instructions to exclude work associated with a distinct E/M service. Further, the RUC also recommends removal of direct practice expenses that are likely overlapping across the E/M service and same-day procedure – such as clinical labor time associated with greeting the patient and obtaining vital signs.

Notably, this de-duplication effort is not in the hands of the RUC alone. Rather, CMS plays the determining role in ensuring that duplicative resources are removed. Indeed, CMS regularly proposes and finalizes departures from RUC recommendations to remove duplication that it believes the RUC has

not adequately addressed. That is, the finalized direct PE inputs, physician time, and work relative value units (RVUs) reflect CMS' determination on the extent to which duplication existed and needed to be removed. Applying an additional across-the-board 50-percent reduction would therefore adjust valuation when a service has already been adjusted to account for efficiencies associated with same-day care.

The Proposal Would Remove Duplication from Services Where No Duplication Is Possible
CMS proposes to apply to the proposal to 10- and 90-day global codes that include follow-up E/M visits that occur in the days and weeks following the procedure that was furnished on the same day as a separately identifiable E/M visit. As a result, payments for the follow-up E/M visits that are bundled into these global codes would also be reduced in half, when the value of the global services is less than the same-day E/M visit. However, there is no possibility of duplication between the same-day E/M visit and the bundled follow-up E/M visit that would take place on a different day, meaning that the policy would indiscriminately reduce payment even when the likelihood of duplication is completely precluded.

The Proposal Would Reduce Payment Below the Cost of Care
Given that CMS is proposing payment reductions that seek to eliminate duplication that has already been removed, payments will necessarily fall below the cost of furnishing care if CMS finalizes this proposal. However, we are particularly concerned with analysis demonstrating that – in too many cases – the proposed 50-percent reduction would result in Medicare payments that do not even cover the direct practice expense costs associated with furnishing several procedures commonly performed by podiatrists—much less the physician work or indirect practice expenses.

For example, considering proposed 2027 payment rates:

- CPT 17110 for destruction of up to 14 lesions, when reported with a higher valued, significant and separately identifiable E/M for a different problem, would be reduced from approximately $104.76 to $52.38, compared with approximately $70.24 in direct practice expense costs.
- CPT 11730 for avulsion of the nail plate, when reported with a higher valued, significant and separately identifiable E/M for a different problem, would be reduced from approximately $113.63 to $56.82, compared with approximately $71.19 in direct practice expense costs.
- CPT 11755 for biopsy of the nail, when reported with a higher valued, significant and separately identifiable E/M for a different problem, would be reduced from approximately $120.85 to $60.43, compared with approximately $68.47 in direct practice expense costs.

It is unclear how CMS would expect podiatrists to continue to perform services if their costs cannot even be recouped. A policy that results in physicians receiving less than the direct cost of furnishing a procedure is fundamentally flawed and unsustainable.

Podiatric Physicians and Their Patients Would Be Disproportionately Affected
CMS acknowledges that podiatry would experience one of the greatest negative impacts from this proposal. Podiatric physicians frequently furnish medically necessary E/M services in conjunction with

procedures because patients commonly present with multiple, distinct conditions with one condition on one foot and a second condition on the other foot.

Consider the following two examples:

> ***Example 1:***
> *A Medicare beneficiary presents to a podiatrist with two separate complaints. The first is worsening pain in the left big toe joint that has been present for more than a year and has progressed to the point that it causes the patient to limp and interferes with work and exercise. The podiatrist performs an E/M service and diagnoses hallux limitus, a degenerative arthritic condition of the big toe joint. Management includes prescribing medication, recommending footwear modifications, and discussing potential surgical treatment. The patient also has a dark discoloration beneath the right big toenail that raises concern for melanoma. The podiatrist therefore performs a nail unit biopsy, CPT 11755.*
>
> ***Example 2:***
> *A Medicare beneficiary again presents to a podiatrist with two complaints, but this time with two different complaints. The first is itching and burning on the bottom of the right foot, with associated scaling and peeling of the skin. The podiatrist performs an E/M service and diagnoses tinea pedis, a fungal infection of the skin. Recommendations are made regarding care of the affected area, and a prescription is written. The second complaint is left ankle pain following a recent injury in which the foot turned inward beneath the leg. The podiatrist diagnoses an ankle sprain and performs a strapping procedure (CPT 29540). This involves applying overlapping adhesive strips around the foot and ankle to provide support, function as a splint, and reduce motion.*

In both examples, there are two distinct conditions being addressed, with each affecting different feet and requiring separate clinical decision-making and treatment. As a result, the E/M service is significant and separately identifiable from the procedure and is appropriately reported with modifier 25.

Importantly, CMS recently revalued both CPT 11755 and CPT 29540 to account for duplication when the service is furnished on the same day as a separately identifiable E/M service. As a result, the current valuations for both codes reflect the full resources required to furnish each respective service on the same day. Imposing another 50-percent reduction to either code would therefore discount a service for efficiencies that have already been incorporated into their valuation and fail to reflect the resources required to furnish care.

Because the above scenarios reflect a common pattern of care that podiatrists deliver – with our internal analysis showing that more than 40 percent of O/O E/M services furnished by podiatrists are reported with modifier 25 – the impact on podiatry is particularly severe. Indeed, as a result of this and other policies in the proposed rule, roughly 9 percent of podiatrists are expected to see payment cuts of 12

percent or more, and another 18 percent are expected to see payment cuts of 7 to 11 percent.[1] Such reductions are not sustainable for podiatry practices, which – like any other small business – must generate enough revenue to cover their costs and maintain reasonable profitability to justify ongoing operations.

The Proposal Threatens Practice Sustainability, Patient Access, and Medicare Spending

Podiatry practices continue to face rising staffing, supply, technology, and other operating costs while Medicare physician payment has failed to keep pace with the cost of running a practice. Additional reductions for commonly furnished same-day services would further destabilize practices, particularly when they result in payments that do not cover the costs of delivering care. Solo, small, independent, and rural practices would likely face the greatest challenges, and over time, these pressures could contribute to practice closures and consolidation.

As a result, patients who rely on these practices would suffer from reduced access, reduced provider choice, and increased costs, with patients in rural areas likely to be hardest hit. We would, in turn, expect to see worse patient outcomes – and higher Medicare costs – as patients face greater difficulty in accessing the foot and ankle care that they need.

We believe this will be particularly true in the case of reduced access to podiatry services, as podiatrists furnish care that can address problems like diabetic foot ulcers before they escalate to infection, hospitalization, amputation, or even death. For example, a recent study published in JAMA found that among the health-care factors studied, greater access to podiatrists was the only factor significantly associated with fewer major amputations for diabetic patients with lower extremity wounds.[2] In areas with the lowest podiatrist supply, adding just one podiatrist per 10,000 Medicare beneficiaries was associated with a 19% reduction in the odds of major amputation. Separately, when Arizona Medicaid eliminated podiatry coverage, diabetic foot ulcer hospitalizations increased 36.7%, severe outcomes increased 49%, and researchers estimated that every $1 "saved" on podiatry was associated with $48 in additional hospitalization charges.[3]

We also note concerns regarding the proposal's expected impact on the podiatry workforce and recruitment of new students into the profession, given longstanding projections of an expected shortage. A workforce analysis commissioned by APMA found that the supply of podiatric physicians is not expected to keep pace with growing demand for foot and ankle care, driven in significant part by an aging population and the increasing prevalence of diabetes and obesity.[4] The study warned that, without a substantial increase in the number of podiatric physicians, the United States could face a significant and growing shortfall in the availability of podiatric services, potentially resulting in patients going

[1] Note that this translates to 12 percent and 20 percent of podiatry RVUs, respectively.
[2] Popescu I, Hernandez H, Plasencia G, et al. Geographic variation in amputations for Medicare patients with diabetic lower-extremity wounds. *JAMA Network Open.* 2026;9(5):e2613616. doi:10.1001/jamanetworkopen.2026.13616
[3] Skrepnek GH, Mills JL, Armstrong DG. Foot-in-wallet disease: Tripped up by "cost-saving" reductions? *Diabetes Care.* 2014;37:e196-e197.doi:10.2337/dc14-0079
[4] Wing P, Forte GJ, Dionne MG, Cristina JR. Projections of the supply of and demand for podiatric physicians in the United States, 2005 to 2030. *J Am Podiatr Med Assoc.* 2008;98(4):330-336.

without needed care. Against this backdrop, CMS should avoid payment policies that could further strain podiatric practices, reduce their capacity to provide comprehensive care, or create additional barriers to timely access for Medicare beneficiaries. The proposed 50-percent reduction for appropriately reported same-day services moves in precisely the wrong direction.

Appropriate Coding Should Be Addressed Without Penalizing Appropriate Care
We support efforts to identify and address inappropriate utilization of modifier 25. APMA devotes significant resources to educating podiatric physicians about proper coding and documentation, including examples of both compliant and noncompliant reporting. However, concerns regarding inappropriate coding should be addressed through existing documentation, auditing, and program-integrity mechanisms. The proposed policy instead broadly reduces payment even when both services are medically necessary, appropriately documented, and correctly reported.

APMA strongly urges CMS not to finalize the proposed Modifier 25 payment reduction and to maintain current payment for appropriately reported same-day services. If CMS believes resource duplication may exist, the agency should first undertake a transparent, data-driven analysis of specific services before considering any future policy changes. That analysis should also evaluate the potential effects of any proposed policy on independent physician practices, beneficiary access to care, patient outcomes, and Medicare spending. Finally, CMS should work collaboratively with the physician community, including podiatrists and other affected specialties, to address any demonstrated overlap through established code-specific valuation processes rather than through a uniform payment reduction.

III. Determination of Practice Expense (PE) RVUs

PE Methodology Changes

CMS proposes to update its overall methodology for assigning practice expense (PE) relative value units (RVUs) to individual codes, including to:

- To allocate indirect PE consistently across services using both work RVU and clinical labor RVUs for all services except for 10- and 90-day global services,
- To remove the indirect practice cost index (IPCI) from the PE methodology altogether, with a 2-year phase in, and
- To establish and apply a "PE stabilization factor" to limit changes in total PE RVUs to 5 percent each year, with certain exceptions for new, revised, and revalued codes and codes formerly subject to contractor pricing.

APMA is concerned that CMS has proposed these changes without providing clear justification, supporting data, or code or specialty level impacts – including impacts after the IPCI policy is fully phased in. For example, CMS does not provide any rationale for excluding 10- and 90-day global services from the first proposal. We are particularly perplexed about that decision given that global services are already undervalued relative to other fee schedule services, as CMS did not apply updated

evaluation and management (E/M) valuations and practice expense inputs to the follow-up E/M services bundled into the 10- and 90-day global codes. The proposed exclusion of 10- and 90-day global services from the proposal would further distort relativity between global services and all other fee schedule services.

Without analyses and clear impact data, it is difficult to understand how each of the individual proposals impacts podiatry or the services our members furnish, particularly given the intertwined nature of the proposals, particularly for the IPCI proposal. However, we are concerned that a previous RAND analysis found that removal of specialty-specific inputs from the PE methodology would result in a 9 percent reduction in PE RVUs and a 5 percent reduction in allowed charges for podiatry services.[5]

CMS also does not provide information or impacts for reasonable alternatives that could be implemented in lieu of the proposals that could help assess whether CMS' policy goals could be achieved in a more targeted and less disruptive manner.

Given the above, ***APMA disagrees that CMS should move forward with these proposals until stakeholders have adequate information to assess the impacts and provide informed feedback.*** As one exception, ***APMA believes it is important to increase stability in RVU allocations from year-to-year, such that we would support the implementation of a PE stabilization factor. However, we recommend that – to the extent practicable – CMS apply the PE stabilization factor uniformly to all codes, in order to maximize stability and minimize confusion in how the stabilization factor is applied.***

PE Site-of-Service Payment Differentials

CMS revisits its site-of-service differential payment policy that it finalized for PE allocation for CY 2026, under which the agency allocated half the amount of indirect PE RVUs per work RVU for services furnished in the facility setting (as opposed to the non-facility setting). In particular, CMS acknowledges input received citing unintended consequences for patients who are similarly situated in the nursing facility setting, but who are treated differently when they are in a skilled nursing facility (SNF) stay under Medicare part A versus when they are in a non-skilled stay. Under the Part A scenario, the SNF is designated a "facility," so physician services furnished to those patients are paid at the facility rate, while services provided to patients not in a skilled stay are paid at the higher, non-facility rate. To address this disparity, CMS proposes to increase the facility PE RVUs to match the non-facility PE RVUs for initial nursing facility visits, subsequent nursing facility visits, and nursing facility discharge management visits (CPT codes 99304-10 and 99315-16).

Furthermore, in light of additional ongoing concerns regarding the site-of-service differential, CMS also seeks comment on how to consider valuation and payment methodologies to better reflect relative resources involved in furnishing services across settings and across business structures.

[5] Burgette LF, Liu JL, Miller BM, et al. Research report: Practice expense methodology and data collection research and analysis. RAND Corporation: 2018. https://www.rand.org/pubs/research_reports/RR2166.html.

APMA supports CMS' proposal to increase facility PE RVUs to match non-facility PE RVUs for nursing facility visits and recommends that CMS finalize the policy as proposed. APMA member podiatrists provide a high volume of services to Medicare beneficiaries in nursing facilities, including medically necessary evaluation and management (E/M) visits. The physician work, direct and indirect practice expense costs, and professional liability costs are the same for the physician practice, regardless of whether the patient is in a skilled or non-skilled stay. The site-of-service differential payment policy CMS finalized last year reduced payment for patients in skilled stays by 35 percent, a payment reduction that was not reflective of the relative resources involved in furnishing care. CMS' proposal to equalize payment would rectify the flawed policy in place for 2026 and support more appropriate payment going forward.

Separately, in response to CMS' request for comment, ***APMA repeats our belief that the finalized site-of-service differential payment policy does not accurately reflect the resource costs incurred by practices in facility settings and recommends that CMS rescind the policy effective starting CY 2027.*** APMA supports Medicare payments for the same service routinely and safely provided in multiple outpatient settings that are based on sufficient and accurate data regarding the actual costs of providing the service in each setting. However, the policy inappropriately disadvantages private practice physicians, who do not benefit from any payments CMS makes to facilities under facility payment systems. When private practice physicians perform services or procedures in facility settings, their practices still incur indirect costs – for example associated with scheduling, coding and billing, and patient follow-up of the visit. They are also still responsible for broader overhead costs that support every patient encounter, including for office space, utilities, office equipment, hardware, and software. An across-the-board policy that treats employed and independent practices the same fails to account for these added resources that independent physicians bear.

IV. Global Surgical Packages

APMA applauds and supports CMS' proposal to pause data collection related to the submission of CPT 99024 for the stated purpose of tracking the delivery of post-operative visits. The vast majority of podiatric physicians perform procedures with 10-day and 90-day global packages. However, a large percentage of podiatric physicians report that they do not report CPT 99024 when these post-operative visits are furnished. There are multiple reasons for this. One reason is that the current CMS reporting requirement applies to practitioners in groups of 10 or more in one of only nine listed states, which represents a very small percentage of podiatric physicians. A significant number of podiatric physicians continue to practice in groups of fewer than 10 practitioners. In circumstances where reporting CPT 99024 is not required, CMS only "encourages" reporting. Accordingly, the reporting patterns of podiatric physicians are not fully captured under the current reporting requirements.

Furthermore, this dataset cannot reasonably be used to forecast overall trends, given the limited, inconsistent, and intermittent participation of eligible physicians, as well as the difficulty CMS has identified in matching procedures to the reporting of CPT 99024.

CMS states that it is concerned that the data collection requirement could be causing unnecessary burden for providers. APMA agrees that this requirement is burdensome for some providers. This burden provides an additional reason to support CMS' proposal to pause data collection related to the submission of CPT 99024 for the stated purpose of tracking the delivery of post-operative visits.

CMS also seeks comment on whether it would be more appropriate to require all providers to report CPT 99024 rather than only those providers in the states selected for the effort. ***APMA strongly recommends against requiring all providers to report CPT 99024.*** Such a requirement would impose an additional burden on practitioners already subject to significant regulatory requirements that contribute to physician burnout while offering little benefit in return given the already identified weaknesses with using CPT 99024 reporting as an indication of actual practice patterns.

Relatedly, CMS seeks comment on potential revaluation strategies to consider for global services in future rulemaking. APMA is an active participant in the Relative Value Scale Update Committee (RUC). Based on this participation, APMA recognizes it as a thorough, rigorous, and deliberative process. This experience informs APMA's view that the current valuations of global surgical packages appropriately reflect the E/M services typically furnished during the global period. APMA therefore urges CMS to respect the rigorous, evidence-based RUC process used to incorporate the value of post-operative visits into the valuation of global procedures.

CMS representatives also participate in RUC meetings and are therefore familiar with the RUC's consideration of Office of Inspector General (OIG) reports identifying underreporting of post-operative visits. The RUC has considered these findings when revaluing codes to more accurately reflect the post-operative services typically furnished. These established processes already provide appropriate safeguards to support accurate valuation.

With respect to recent rulemaking intended to improve the accuracy of global surgical package valuations, APMA reminds CMS that the RUC process is largely based on what is *typical* in clinical practice. The vast majority of podiatric physicians perform procedures with 10-day and 90-day global periods, and their experience demonstrates that the great majority of post-operative care is furnished by the same practitioner, or the same group practice, that performed the surgical procedure. Scenarios in which "the surgical procedure and follow-up care are provided by different practitioners in different group practices" are not typical in the delivery of podiatric care. Accordingly, CMS should not base the valuation of global surgical packages on these atypical scenarios.

CMS seeks comment on the public use file it has posted "to display the imputed RVUs associated with both the 10- and 90-day post-operative visits based on a purely arithmetic approach to understand the valuation of the services based on the data that was analyzed."

CMS states that the file includes:

- Current work RVUs;
- The number of post-operative visits reported to CMS using no-pay CPT 99024; and

- The work RVUs remaining if all post-operative visits are removed.

APMA reminds CMS that surgical global RVUs are not assigned using a building-block methodology. Specifically, the work RVUs of each included post-operative visit were not simply added to the global service to reach an RVU total. Therefore, adjusting the work RVUs in any manner based on the number of post-operative visits included in the valuation or on CPT 99024 submission data would not be appropriate. We also reiterate our concerns above with reliance on follow-up visits reported using CPT 99024. For all these reasons, removing imputed E/M work associated with what CMS seems to be suggesting is a new typical number of post-op visits from the work RVUs of a global surgical service does not reliably measure the appropriate work of the remaining surgical service.

As CMS continues to evaluate the valuation of global surgical packages, APMA reiterates its longstanding concern regarding CMS's failure to incorporate into global surgical services the revised values for office/outpatient and other E/M services that became effective January 1, 2021, and thereafter. ***APMA again urges CMS to correct this longstanding valuation inconsistency by incorporating the updated E/M values into the corresponding 10- and 90-day global surgical packages.*** Until it does, CMS is embarking on attempts to improve the accuracy of 10- and 90-day global surgical codes using an infrastructure that has already distorted the relativity of the PFS due to valuing standalone E/M visits differently than E/M visits bundled into the global surgical packages.

Considering reductions to global surgical package values based, in part, on incomplete CPT 99024 reporting while continuing to exclude the increased values assigned to post-operative E/M services would further distort relativity within the MPFS and undermine accurate comparisons among physician services. ***Before considering any downward revaluation of global surgical packages, CMS should first correct this longstanding undervaluation.*** Further, APMA requests that CMS refrain from *any* revaluation of global periods based on collected CPT 99024 data given the OIG's recognition that the resulting data was not reflective of the care actually furnished and therefore was inappropriate for use in revaluing global surgical codes as Congress intended.[6]

V. Valuation of Specific Codes Including Potentially Misvalued Services Under the MPFS

CPT 36465, 36470, 36471, 36473, and 36474 (Treatment of Incompetent Veins)
APMA is an active participant in the Relative Value Scale Update Committee (RUC) process and regularly engages in RUC meetings, deliberations, communications, and related activities in collaboration with other medical specialty societies.

[6] See, HHS OIG, *CMS Should Improve Its Methodology for Collecting Medicare Postoperative Visit Data on Global Surgeries, https://oig.hhs.gov/documents/audit/10428/A-05-20-00021.pdf, (June 2025).*

Podiatric physicians provide care for patients with incompetent veins, and APMA participated in the RUC activities that led to the RUC recommendations. ***APMA appreciates CMS proposing to accept the RUC recommendations for CPT codes 36465, 36470, 36471, 36473 and 36474. APMA also appreciates CMS' proposal to accept the RUC-recommended direct PE inputs for all six of these services without refinement.***

Real-time Fluorescence Wound Imaging (CPT Code 976XX)
At the September 2025 AMA CPT Editorial Panel Meeting, a new CPT code was created to report the performance of real-time fluorescence wound imaging. Podiatrists often perform this service, which helps determine the presence and identification of bacteria in a wound bed. This helps target the treatment of limb-threatening, chronic lower extremity wounds and supports the care podiatrists provide to prevent amputations. With the creation of this new Category I CPT code, the Category III codes that were being used to represent this service (CPT 0598T and 0599T) were deleted. This new Category I CPT code was reviewed at the January 2026 RUC HCPAC Review Board meeting.

APMA representatives participated in the thorough process that resulted in the RUC recommendation to institute contractor pricing for CPT 976XX for 2027. The RUC supports a Resource-Based Relative Value Scale (RBRVS) grounded in accurate, current data that reflect the resources actually incurred to furnish services, including differences across settings and practice arrangements. The RUC process led to the determination that the utilization data associated with this service were too low to support a robust survey. Therefore, the RUC did not make specific work or direct PE input recommendations.

APMA does not support CMS' proposal of a work RVU of 0.8, which is based on a recommendation from an industry representative. APMA agrees with the RUC's recommendation to implement contractor pricing for CPT 976XX in 2027 and to plan for RUC re-evaluation of utilization in three years to determine whether a survey should occur.

Skin Cell Suspension Autograft (CPT 15X19, 15X20, 15X21, and 15X22)
In September 2025, the AMA CPT Editorial Panel created four new codes to report skin cell suspension autograft (SCSA):

- CPT 15X19 - Skin cell suspension autograft (SCSA), trunk, arms, and/or legs; first 100 sq cm or less, or 1% of body area of infants and children)
- CPT 15X20 - Skin cell suspension autograft (SCSA), trunk, arms, and/or legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)
- CPT 15X21 - Skin cell suspension autograft (SCSA), face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children)
- CPT 15X22 - Skin cell suspension autograft (SCSA), face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure).

These four new codes were surveyed for the January 2026 RUC meeting. ***APMA appreciates and supports CMS' proposal to accept the RUC-recommended work RVUs of 10.97 for CPT code 15X19, 0.59 for CPT code 15X20, 11.28 for CPT code 15X21, and 0.98 for CPT code 15X22 as well as the RUC-recommended direct PE inputs for CPT codes 15X19, 15X20, 15X21, and 15X22 without refinement.***

Ultrasonic Wound Assessment (CPT 97610)
CPT 97610 (*Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day*) has been nominated as potentially misvalued. CMS states that this nomination is based on a link identified online and relates to the price of supply code SA119 (kit, low frequency ultrasound wound therapy (MIST)) as a direct PE input, as well as the suggestion that this cost creates a site-of-service payment disparity, resulting in CMS reimbursing significantly more for the non-facility practice expense than under the hospital outpatient prospective payment system (OPPS).

SA119 is assigned a $320 direct PE input. As CMS notes in the preamble at 91 FR 43935, the suggestion that this code may be misvalued appears to stem from a hyperlink to a PowerPoint presentation available on the UltraMIST® system manufacturer's website. The presentation states:

> *"Consumable costs = ~$100/procedure (list price)"*

The slide does not specify which consumable costs this statement is intended to reference. It does not state that the amount represents all consumable costs, nor does it state that the amount represents the costs associated with SA119. Based on publicly available information regarding the cost of the system's single-use, disposable applicators and other items included in the direct PE for this service, it appears that the $100 cost referenced on the slide in question pertains to the disposable applicators rather than to costs associated with SA119.

CMS proposes to change the cost of supply code SA119 to $100 in the direct PE database based on this PowerPoint slide identified online, which appears to be unrelated to SA119, and requests comment on this proposal.

CMS also suggests that the physician time associated with furnishing the service represented by CPT 97610 may be inflated because the slide identified online states that the procedure takes an average of six minutes, without disclosing the source of that figure. The current intraservice time is listed as 15 minutes. CMS therefore seeks comment on whether the typical physician time required to perform this service is, in fact, 15 minutes.

The value assigned to SA119 and the intraservice time of 15 minutes are based on extensive evidence-based research and surveys of practitioners familiar with the service. The process requires disclosure of any conflicts of interest and is blinded where appropriate.

Based on this experience and understanding, APMA does not support the proposal that CPT 97610 may be misvalued. A determination that the code may be misvalued should not be based solely on an unreliable, unofficial online source. The value should instead be based on the rigorous and thorough RUC process, which includes safeguards designed to eliminate potential conflicts of interest. Furthermore, for reasons unrelated to the PowerPoint slide identified online, the Relativity Assessment Workgroup (RAW) of the RUC is already reviewing CPT 97610 at its September 2026 meeting. CPT 97610 is being addressed at that meeting because of a change in the specialty types most commonly responsible for its submission. A robust discussion based on actual data, with appropriate safeguards to eliminate bias, is planned to determine whether CPT 97610 should be revalued. ***APMA requests that CMS refrain from implementing changes to CPT code 97610 until further review and recommendations are made by the RUC.***

VI. Current Procedural Terminology (CPT) Request for Information (RFI)

CMS is seeking comment on the Current Procedural Terminology (CPT) as the national coding standard to describe physician and other healthcare professional services. The Request for Information (RFI) also questions the AMA influence on the coding system and physician payment policy.

APMA is an active participant in CPT processes and has been for many years. APMA has a representative physician Advisor to the CPT Editorial Panel and a physician Alternative Advisor to the CPT Editorial Panel, as well as legal staff, regulatory consultants, and coding consultants to support these physicians. These representatives attend and actively participate in all CPT meetings, collaborate with other society representation regarding CPT activities, and participate in CPT communications and decisions that are made outside of the meetings. APMA has also had physician representation on the CPT Assistant Editorial Panel. As active participants, we know the CPT process is thorough and painstaking.

CPT is the common language of American medicine. It gives physicians and other qualified healthcare professionals, hospitals, payers, researchers, and federal agencies a common language—grounded in a rigorous clinical process and the latest clinical evidence—to describe the care that is delivered, so that the terms used to identify a service mean the same thing wherever it is furnished and whoever is paying for it. Claims processing, quality measurement, interoperability, clinical research, and program integrity all rest on those shared descriptions, enabling all interested parties to measure whether care is working. Quality measures, registries, and value-based payment models are specified in CPT codes, so the same vocabulary that documents a service also supports evaluating outcomes and rewarding better patient care. New and emerging services, including AI-enabled services, enter that same framework through

Category III codes and the Appendix S taxonomy, which is how innovation becomes trackable and, only when the evidence supports it, payable.

As deeply integrated into the delivery and assessment of health care in this country as CPT is, moving away from CPT would result in massive disruption, fragmentation, and administrative burden that would far outweigh any presumed benefits. ***APMA therefore urges CMS to ensure that CPT remains the national coding standard to describe physician and other healthcare professional services.***

Below we provide responses that directly address the specific questions in the RFI. However, to start, APMA would offer one key clarification in regard to the language included in the preamble and excerpted below:

> *"When a new CPT® code is defined by the CPT® Advisory Committee, it is then assigned a payment value by the AMA Relative Value Scale Update Committee or RUC."*

This assertion that a new code is "assigned a payment value" by the RUC is false. The RUC does not assign, and cannot assign, a payment or value. It recommends the relative resources involved in furnishing a service: physician work and the direct practice expense inputs of clinical staff time, supplies, and equipment. Whether and how any such recommendation is translated into a payment amount is a separate determination reserved entirely to CMS, and CMS has no obligation to adopt the RUC recommendations. However, the RUC provides information to CMS based on clinical expertise, using CMS standards and policies. CMS's high rate of use of RUC recommendations reflects the operational value of timely, specialty-specific clinical input in a highly technical payment system.

1. **What, if any, evidence is there for CMS to consider regarding the harms or challenges associated with AMA's monopoly over CPT-4 licenses for healthcare entities? Please cite potential improvements to patient care diverted or delayed due to AMA's monopoly over CPT codes, including inhibited innovations and acquisition or maintenance costs of CPT licensure.**

CPT became the national standard for reporting physician services because it was, and remains, the most comprehensive, clinically precise, trusted, and rigorously maintained system of its kind. CPT functions as a national standard because the healthcare system benefits from a single, clinically authoritative, continuously maintained nomenclature for physician and other qualified healthcare professional services. AMA stewardship serves a public-interest function by convening the clinical, payer, hospital, industry, and governmental expertise needed to maintain that standard in a way that is nationally uniform, operationally reliable, and responsive to changes in medical practice. More than 200 CPT

Advisors drawn from over 100 national medical specialty societies and other healthcare organizations participate in the process, and the Editorial Panel includes representatives from medicine, other qualified healthcare professionals, payers, hospitals, industry, and federal agencies. Any stakeholder may submit an application for a code change, provide comments, and observe Panel proceedings subject to applicable process rules. In this way, the code set is maintained through broad clinical and operational participation rather than unilateral decision-making. We strongly believe that practicing clinicians should lead the discussion on how medicine is practiced, focusing on the well-being of the patient first. At APMA, we are thankful for the AMA's careful and responsible stewardship of the CPT code set.

While CMS has asked commenters to identify harms, we believe that any potential harms that may accrue based on the reliance on CPT pale in comparison to the harms that would be imposed if CMS were to replace CPT as the national standard. Introducing a competing code set would add substantial complexity, impose significant burden, and require significant, ongoing investment in new technical infrastructure, governance, and system changes across EHRs, payer systems, APIs, quality programs, patient applications, and longitudinal datasets to preserve consistent clinical meaning. Given lack of any compelling evidence regarding the benefits of a transition away from CPT, we believe that such unnecessary and ill-advised disruption should be averted.

2. **What, if any, evidence is there that the generation of CPT-4 codes follows a process of identification of medical necessity? What opportunities or examples from other populations, sites of care, or international health systems could instruct a process of identification of medical necessity in the CPT-4 code development process?**

CPT is a nomenclature. It provides standardized descriptions of the services and procedures that physicians and other qualified healthcare professionals perform. CPT does not determine whether that service is medically necessary for a particular patient, and it has never been designed or intended to make that determination. This separation is an attribute, not a flaw. It preserves the distinction between accurate clinical description on the one hand and patient-specific coverage determinations on the other.

Medical necessity is a coverage determination. It is made by payers, including Medicare, in the context of an individual patient and a specific clinical circumstance. Medicare makes these determinations through national and local coverage determinations and related policy. The existence of a CPT code does not establish coverage, does not establish medical necessity, and does not obligate any payer to pay for the service. CMS has stated this directly in its own guidance, noting that the existence of a code does not determine coverage.

A code must describe a service accurately, whether or not a given payer covers it, and whether or not it is appropriate for a given patient. That separation preserves judgment where it belongs. The physician or

other qualified healthcare professional at the bedside recommends what a patient needs, and each payer, including Medicare, decides independently what it will cover. Had those determinations been embedded in the code set, both would be constrained by a decision made elsewhere, by people who have never seen the patient and who are not accountable for the coverage policy. Preserving the separation is what allows the same code set to serve Medicare, Medicaid, and commercial payers, each of which sets its own coverage policy.

3. **A combination of CPT-4 and HCPCS codes were formally adopted by HHS as the legal standard for national coding for physician and other services as part of implementing HIPAA (45 CFR 162.1002 (a) (5)). If CMS were to revisit this standard in future rulemaking, which if any alternatives exist to CPT-4 for CMS to consider as part of the national coding standard for physician services? Would CMS need to specify a separate legal standard, or could CMS allow private competition to supplement the existing CPT-4 coding standard?**

The question presumes a set of alternatives, and it is worth clarifying at the outset about what those systems are and how they relate to CPT. Importantly, each code set (SNOMED CT, LOINC, ICD-10/PCS), while being applied to a clinical encounter, describes something different within that very same encounter **and is not** interchangeable with one another. ICD-10-CM records the patient's diagnosis. SNOMED CT captures clinical findings and observations in the medical record. CPT describes the service the physician or other qualified healthcare professional performed. LOINC identifies the laboratory tests ordered and the results returned. These are layers of a coordinated stack, built to work together. CPT occupies a specific position in the stack as the layer that connects clinical documentation to payment. Replacing CPT would not substitute one code set for another. It would require rebuilding every linkage between these systems at once, across every payer, electronic health record, clearinghouse, and billing system in the country. Other standards are important, but they serve different functions and are best understood as complementary rather than interchangeable. With that context, we are not aware of an existing code set that could replace CPT as the national coding standard for physician services.

With respect to private competition or supplementary coding, the principal value of a national standard is uniformity: one clinically grounded interpretation across Medicare, Medicaid, commercial payers, EHRs, physician practices, coders, researchers, and developers. If CMS were to move away from CPT as the national coding standard, a separate legal standard would be necessary; private competition should not be introduced in a way that creates an environment of competing code sets for the same physician and other healthcare services. Multiple competing code sets for the same physician services would increase administrative burden, create mapping inconsistencies, and undermine comparability across payers, clinicians, vendors, and government programs. Importantly, CMS already has tools to

address program-specific coding needs without fragmenting the standard. HCPCS Level II and Medicare-specific G-codes already provide a mechanism, fully under CMS control, to identify services outside the CPT process when the Agency determines that such coding is needed.

It should be noted that any change of the uniform standard would carry a measurable cost and timeline. The most recent comparable effort was the industry's transition from ICD-9 to ICD-10, and it is instructive on both counts. While cost estimates varied, work commissioned in 2014 by the AMA placed implementation costs for a typical small practice between $56,639 and $226,105, and for a large practice between roughly $2 million and $8 million. Contemporaneous industry analysis estimated that the entire healthcare industry, including facilities and clinicians, would spend approximately $14 billion over a two- to three-year period; in actuality, more than six years elapsed between the final rule and implementation, and the final extension required an act of Congress.

Replacing CPT would be a significantly larger undertaking than ICD-10. ICD-10 replaced diagnosis coding and inpatient hospital procedure coding. Replacing CPT would replace reporting for professional services, payment schedules, payer contracts, and relative values. Every physician payment schedule in the country is built on CPT codes, payer contracts reference them, the resource-based relative value scale is constructed around them, and quality measures are specified in them, so the cost and burden associated with replacing CPT would be multiplied.

4. **What objective alternatives exist, or could be developed, to maintain a more objective process to the current AMA CPT and RUC committee processes? How would these alternatives support or inhibit innovation?**

The CPT and RUC processes are structured, criteria-based, clinically grounded, and increasingly transparent. To establish a CPT code, the Panel uses a set of published criteria that are applied to every application and are available on the AMA website. These criteria are always clinically-focused, and they are designed to be comprehensive. They establish that a service is real, well-defined and clinically effective before it receives a permanent code. The CPT process is also open, with any stakeholder able to submit a code change application. Each application is reviewed by staff, evaluated by the CPT Advisory Committee, opened to public comment, and decided by the Editorial Panel in a meeting that anyone may attend. The same criteria and the same process apply to every applicant.

Likewise, the RUC process is a rigorous objective process, relying on CMS defined criteria and standards, clinical expertise of hundreds of physicians and healthcare professionals, and a multi-disciplinary review. The RUC is transparent with its minutes, recommendations to CMS, and voting reports available on the AMA website.

As a result, the current processes maintain a level of rigor that we believe is unmatched among potential alternative code sets. The current processes also support innovation, including through the use of Category III codes and Appendix S taxonomy, to enable coding to keep pace with changes in medical practice.

5. **What are the benefits and drawbacks of paying for physician procedural services on the basis of the underlying Classification of Diseases, 10th Revision (ICD-10) procedure code, as an alternative to CPT-4 code? How could the International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) services be group or bundled into payment categories, similar to Medicare Severity Diagnosis Related Groups (MS-DRGs), or Outpatient Prospective Payment System (OPPS) Ambulatory Payment Classifications (APCs)? What other alternatives exist for bundling or group procedural services?**

APMA disagrees with relying on ICD-10-PCS to serve as the national coding standard for physician and other healthcare professional services. Based on CMS's own guidance, ICD-10-PCS cannot serve as the basis for paying physician services as it is used only for the reporting of inpatient procedures by hospitals.

Every ICD-10-PCS code is a seven-character string in which each position describes an attribute of an inpatient procedure: the body system, the root operation, the body part, the approach, the device, and a qualifier. That grammar describes something done to a patient in a facility. It has no place to record the evaluation and management work that constitutes a large share of physician services, which involves history, examination, and medical decision-making rather than a procedure performed on a body part. It also has no place for the many professional services, including care management, counseling, care coordination, and behavioral health services, that have no inpatient procedural equivalent. These are categories of care that CMS has been actively working to recognize and pay for, and a shift to ICD-10-PCS would stand in the way of the Agency's long-term effort to support these initiatives.

Furthermore, ICD-10-PCS also has no mechanism for provisional coding of emerging services. There is no equivalent to the Category III pathway, so a new service would have no way to be identified and tracked while its evidence base develops.

VII. Healthcare Common Procedure Coding System (HCPCS) code G2211 Change to MOD1

CMS proposes to revise its approach for accounting for inherent complexity associated with the delivery of longitudinal care, based on its updated belief that associated resources are an inherent part of the E/M visit that would be more accurately valued as a modifier to the base E/M code, rather than as a separate code. APMA does not agree with this change. As APMA members have had more opportunity to use G2211, we have come to agree with CMS' opinion expressed in the CY 2024 MPFS Final Rule (88 FR

78818, 78970) that the extra work, time, risk, and effort involved with evaluating and managing a patient's single, serious or complex condition on a longitudinal basis is not an inherent part of the base E/M service.

Podiatric physicians have appropriate opportunities to submit G2211 and appreciate the ability to use this code when applicable. Podiatrists often provide longitudinal care that is ongoing care related to a patient's single, serious condition or a complex condition. There are multiple examples of complex conditions that podiatrists manage over extended periods of time, in many cases covering a decade or more of management. Just some examples include Charcot neuroarthropathy, gait dysfunction, debilitating neuropathy, and chronic degenerative joint disease. APMA therefore appreciates the following CMS comment from CY 2024 MPFS Final Rule, which clarified podiatrists' ability to bill G2211:

> *"We also note unequivocally that this code is not restricted to medical professionals based on particular specialties. Instead, it should be used by medical professionals, regardless of specialty."*[7]

Furthermore, the CY 2024 MPFS provided an example of when a specialist may use G2211. The example provided describes a specialist providing ongoing care for a single, complex condition and points out that this specialist is not the focal point for all services. In this example, the specialist must carefully weigh their response to a patient's history during the visit, considering "the intonation in their voice" and "their choice of words" to engender trust and optimize the patient's outcome.[8] Podiatrists practice this exact technique every day in caring for complex conditions such as Charcot neuroarthropathy, osteomyelitis, and long-standing ulcers that pose the threat of lower limb amputation.

CMS proposes to replace HCPCS code G2211 with a modifier, MOD1, that would be billed under the same circumstances that HCPCS code G2211 is currently billed. Under the proposal, CMS would increase payment for the associated base E/M code by 16 percent when the modifier is reported. CMS also proposes that the code descriptor for HCPCS code G2211 would be revised for MOD1, with some technical changes. The proposed Modifier MOD1 description is:

> *Visit complexity inherent to new or established office/outpatient or home or residence evaluation and management service, associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition.*

APMA does not support the proposal to replace HCPCS code G2211 with modifier MOD1 and, when MOD1 is reported, to increase payment for the associated base E/M code by 16 percent. We question CMS' assumption that the resources required to engage in longitudinal care as required by G2211 varies

[7] 88 Fed. Reg. 78974 (Nov. 16, 2023).
[8] *Id.*

based on the level of the associated base E/M code and therefore recommend that CMS maintain the current policy and valuation for G2211 as an add-on code.

VIII. National Payment for Non-Sheet Form Skin Substitutes

APMA agrees with CMS' assessment that, in general, the resource costs per square centimeter for non-sheet form skin substitutes are comparable to the resource costs associated with sheet form products. APMA also agrees with CMS' approach of allowing the reported square centimeters for non-sheet form skin substitutes to reflect the wound surface area treated, rather than the physical dimensions of the product itself.

APMA's support for consistent payment treatment between sheet and non-sheet form skin substitutes should not be interpreted as an endorsement of the underlying payment methodology or payment rates applicable to sheet-form skin substitutes. APMA believes continued evaluation of the CY 2026 skin substitute payment policy is warranted, particularly with respect to its potential implications for physician practices, patient access, and the availability of clinically appropriate products. APMA encourages CMS to continue evaluating the adequacy and impact of that payment methodology and to consider appropriate refinements based on experience under the CY 2026 policy and available data.

Accordingly, APMA supports CMS' proposal to establish national payment rates for non-sheet form skin substitutes that are consistent with the payment rates applicable to sheet form skin substitutes for CY 2027.

IX. Remote Physiologic Monitoring (RPM) and Remote Therapeutic Monitoring (RTM) Services

CMS states that it believes that a lack of data regarding the typical device used in the provision of RPM and RTM services has led to possible overpayment. Therefore, CMS proposes to decrease the PE RVUs for several of these services using crosswalks to other services. CMS also proposes to eliminate all direct practice costs for the treatment management codes. ***APMA opposes these proposals to decrease the PE RVUs for several of these services using crosswalks to other services and eliminating all direct practice costs for the treatment management codes.***

CMS also contemplates bundling the RPM and RTM services by creating four new HCPCS G-codes for 2027 to describe remote monitoring services, which CMS would recognize in lieu of the existing RPM and RTM CPT codes. Under the revised coding, CMS would apply similar crosswalks for PE RVUs as proposed for corresponding CPT codes, which would again lead to significant payment reductions. ***APMA opposes creation of four new HCPCS G-codes to replace the existing RPM and RTM CPT codes, as well as CMS' contemplated corresponding valuation.***

Where CMS has identified gaps in the underlying resource data, the appropriate response is to obtain and evaluate better data rather than assume lower resource costs in the absence of such evidence. This

can be accomplished through the robust, blinded survey process that the RUC employs, which goes to great lengths to eliminate any bias. As CMS is making this proposal due to a lack of current data on the typical devices and other resources being used in the provision of RPM and RTM services, we suggest it would be far better to collect the needed data than to reduce payments for the services without any data to serve as a foundation for revised RVUs. The RUC was already scheduled to begin re-examining the RPM and RTM services, which coincides nicely with CMS's concern regarding the direct practice expense inputs on the typical devices used and typical clinical staff workflow/time for these services. ***APMA urges CMS to refrain from implementing changes to the RPM and RTM direct practice expenses or creating G codes until the specialty societies and the RUC have the opportunity to review these services.***

Proposals Related to the CY 2027 Medicare Shared Savings (MSSP) and Quality Payment Programs (QPP)

X. Transforming MIPS: MIPS Value Pathway (MVP) Strategy

Beginning with the CY 2029 performance period, CMS proposes that all MIPS eligible clinicians, with the exception of clinicians reporting through the APM Performance Pathway (APP), would report through a MIPS Value Pathway (MVP). ***APMA strongly opposes CMS' proposal to mandate MVPs in 2029, since it would further limit participation options for our specialty, which already suffers from a limited set of relevant and viable measures.*** To date, MVPs have been used by a very small portion of MIPS eligible clinicians, and we do not believe that CMS has sufficient data on the relevancy and feasibility of MVPs or its impact on patient care. We instead urge CMS to preserve choice in the program. Participants should maintain the flexibility to choose a reporting strategy that is most meaningful to their patient population, while also the most viable for their practice. ***If CMS opts to move forward with this proposal despite our strong opposition, we strongly urge it to provide additional accommodations for small practices, which face unique challenges in terms of resources and feasible participation pathways. Accommodations could include more time to transition to MVPs and/or other scoring and reporting adjustments that account for the lack of adequate infrastructure and other compliance barriers.***

While APMA appreciates that the MVP framework aims to support more streamlined, less burdensome, and more relevant participation options for physicians, it unfortunately carries over policies from traditional MIPS that make the program challenging for podiatrists, including a very limited inventory of podiatry-relevant quality measures and restrictive scoring policies that limit podiatrists' success in the program regardless of high performance. As illustrated in the table below, the Podiatry MVP, as proposed for 2027, includes very few podiatry-specific quality measures, and almost all measures in the MVP are subject to the 7-point topped-out scoring cap or lack a benchmark.[9] APMA is extremely concerned that our members are being set up for failure each year, irrespective of their efforts to provide high-quality patient care.

[9] Based on the most recently available 2026 benchmarks.

2027 Proposed Podiatry MVP

Measure	Collection Type	Topped Out	Subject to 7-Pt Topped Out Scoring Cap	Benchmark with Less Than 10 Deciles
#126: Diabetic Foot Care- Peripheral Neuropathy	CQM	Y	Y *Not subject to cap in 2027 if CMS finalizes core measure policy as proposed.*	Y *99% = 6th decile
#127: Diabetic Foot Care- Ulcer Prevention- Footwear Evaluation	CQM	Y	Y *Not subject to cap in 2027 if CMS finalizes topped out scoring policy as proposed.*	Y *99% = 5th decile
#155: Falls Plan of Care	CQM	Y	Y *Not subject to cap in 2027 if CMS finalizes core measure policy as proposed.*	Y *99% = 2nd decile
#226: Tobacco Screening/Cessation	CQM	Y	Y	Y

				*99% = 5th decile
	Claims	Y	Y	Y *99% = 3rd decile
	eCQM	N	N	N
#317: Screening for High Blood Pressure and Follow-Up Documented	CQM	Y	N	Y *99% = 6th decile
	Claims	Y	Y	Y *99% = 5th decile
	eCQM	N	N	N
#358: Patient-Centered Surgical Risk Assessment and Communication	CQM	Y	Y **Not subject to cap in 2027 if CMS finalizes core measure policy as proposed.*	Y *99% = 3rd decile
#374: Closing the Referral Loop: Receipt of Specialist Report	CQM	Y	Y	Y *99% = 4th decile
	eCQM	N	N	N
USWR32: Adequate Compression at each visit for patients with venous leg ulcers appropriate to arterial supply	QCDR	--	--	Lacks historical benchmark (and not eligible for 7 or 5 point new measure floor)
USWR33: Diabetic Foot Ulcer Healing or Closure	QCDR	--	--	Lacks historical benchmark (and not eligible for 7 or 5 point new measure floor)

USWR34: Venous Leg Ulcer Healing or Closure	QCDR	--	--	Lacks historical benchmark (and not eligible for 7 or 5 point new measure floor)
USWR35: Adequate Off-Loading of Diabetic Foor Ulcers Performed at Each Visit	QCDR	--	--	Lacks historical benchmark (and not eligible for 7 or 5 point new measure floor)
MEX5: Hammer Toe Outcome	QCDR	N	N	N
REGCLR1: Heel Pain Treatment Outcomes	QCDR	N	N	N
REGCLR3: Bunions Outcome	QCDR	N	N	N

**The data in this table are based on 2026 MIPS benchmarks.*

Adding to these difficulties is the fact that more than 60% of podiatrists meet the definition of small practice.[10] In performance year 2024/payment year 2026, nearly 20% of podiatrists, almost all of whom were in small practices, received the maximum MIPS penalty, compared to a national average of 1.4%. In fact, for that same year, podiatry was the specialty with the largest number of clinicians who did not report MIPS measures and did not receive an exemption from doing so.

Since the inception of MIPS, APMA has tried to actively engage with both CMS and its members to make the program more meaningful and less burdensome for podiatrists. For example, APMA invested resources in the development and validation of podiatry-focused quality measures (#126 and #127) and was one of the first specialties to offer members a qualified clinical data registry (QCDR) for purposes of more focused MIPS participation. In 2020, APMA made the difficult decision to end its QCDR after it proved to be too expensive an endeavor for our small specialty and for our members, who were already sinking under the financial strain of federal reimbursements that do not keep up with the actual cost of delivering care. Nevertheless, APMA continues to provide numerous webinars, educational resources, and other communications to its members to help them navigate ever-evolving MIPS requirements each year and to identify as meaningful a participation pathway as possible given ongoing constraints. Additionally, our clinical expert leaders continue to engage in CMS measure development activities, taking time out of their practice to serve as clinical experts on CMS panels, such as those focusing on the development of episode-based cost measures. Despite all of these efforts, our members are still some of the least engaged MIPS-eligible clinicians, suggesting that it is simply too challenging

[10] Based on data from the 2024 QPP Public Use File.

and cost-prohibitive for small practice podiatrists to participate in MIPS and that additional accommodations must be made to account for their circumstances and ensure these already vulnerable practices are protected from maximum penalties.

Overall, APMA does not believe CMS should sunset traditional MIPS and force participants into MVPs until it has 1) developed a mechanism to support the ongoing development and adoption of new quality measures—particularly for specialties with limited measure choice; 2) further refined existing scoring policies—particularly those intended to support small practices and specialties with limited measure options; and 3) adopted additional policies and technical support to assist small practices so that they have a fair chance to succeed in MIPS.

Proposed Changes to the Podiatry MVP for 2027

For 2027, CMS proposes to remove the following two Qualified Clinical Data Registry (QCDR) measures from the Podiatry MVP:

- REGCLR5: Offloading with Remote Monitoring
- REGCLR8: Monitor and Improve Treatment Outcomes in Chronic Wound Healing

The APMA opposes the removal of measures REGCLR5 and REGCLR6 and urges CMS to preserve these two QCDR measures, which measure important aspects of podiatry care. CMS proposes to remove these measures due to low adoption rates, which has resulted in the inability of CMS to calculate a benchmark. APMA believes that by continuing to offer these measures through the Podiatry MVP, clinicians would have a greater incentive to report them, especially as they are faced with more limited and focused measure choices through MVPs, which could result in the volume of data needed to establish a benchmark. The ongoing inclusion of these two measures would also provide podiatrists with a more expansive choice of measures that might more accurately reflect their specific patient population. It also would allow participants reporting through the Registry Clearinghouse QCDR to have a full set of four QCDR measures to report through this MVP. ***We request that CMS maintain these two measures in the Podiatry MVP for at least a couple more years in order to assess whether increasing movement into MVPs over time impacts the reporting rates of historically un-benchmarked measures.***

APMA also reiterates its recommendation from last year that CMS include the following measure in the Podiatry MVP:

- ***318: Falls: Screening for Future Fall Risk (eCQM)***

This measure is currently in the MIPS Podiatry Specialty Set, which means that CMS has already identified it as relevant to our specialty. Podiatrists help prevent falls by treating foot pain, improving balance, and providing stabilizing devices like custom orthotics or braces, and screening for future fall risk is a critical component of ensuring comprehensive fall prevention care. We also believe that MVPs should align with well-established specialty sets to minimize confusion in an already overly complex program.

RFI on MVP Scoring
As CMS works toward full MVP implementation in 2029, the agency is exploring new MVP scoring methodologies and policies to ensure fair comparisons within and across different MVPs. CMS seeks feedback on potential policies, as well as the appropriate timing and strategies for implementing new scoring methodologies.

APMA appreciates that CMS is evaluating new and better ways to score clinicians participating in MVPs, but urges CMS to also re-evaluate its scoring methodologies in traditional MIPS since this will remain the primary participation pathway for most clinicians over at least the next two years. As part of this process, ***APMA urges CMS to expand the application of the revised benchmarking methodologies that CMS recently adopted for MIPS cost measures and administrative claims-based quality measures.*** This revised methodology anchors median performance to a point value derived from the MIPS performance threshold and then assigns score ranges based on standard deviations above and below the median score. Under the current decile-based approach used to score MIPS quality measures, if most clinicians' scores differ only slightly from each other, then a small difference in a clinician's score could lead to a large penalty. However, under the revised methodology, clinicians with average performance do not receive disproportionately low scores and are not penalized for falling near the statistical center of the distribution. The 2024 performance year was the first year that CMS applied this new methodology to cost measures, and data from the 2024 QPP Public Use File demonstrates the positive effect it has had on cost scores across the board.

APMA urges CMS to expand this revised methodology to all MIPS quality measures, so long as CMS remains transparent about how benchmark ranges and standard deviations are set each year and solicits formal comments before changing the thresholds. The revised benchmarking methodology is an improvement over the existing methodology. Adopting this more equitable and consistent methodological approach across the program would result in fairer performance assessments and less confusion and complexity, both of which could encourage more physicians to report condition-specific measures.

As CMS considers other approaches to ensure fairness within and across MVPs, we advise against attempting to compare performance between clinicians reporting the same MVP, which CMS has suggested in the past and seems to be contemplating again in this year's rule. Since most specialties have subspecialties or specific areas of focus, and each MVP participant may choose an individualized set of four measures to report, comparing one MVP participant to another would not result in accurate or meaningful information. Clinicians should only be compared to other clinicians who reported the same measures.

CMS also asks whether it should consider whether MVP scoring policies should provide more meaningful rewards for high-performing clinicians via larger positive payment adjustments. Given the predicament of our specialty and its inordinately large proportion of small practice clinicians, we cannot support this policy, which would mean larger penalties for low performers due to the budget neutral nature of the program. ***Instead, we urge CMS to invest resources in technical support and other***

program policies that encourage small practices to engage in MIPS and assist them with program compliance.

XI. MIPS Performance Category Measures and Activities

Beginning with the CY 2027 performance period, CMS proposes to remove the current quality measure data submission requirement of one outcome (or one high priority measure if an outcome measure is not available) for traditional MIPS and MVP reporting. As an alternative, CMS proposes a new requirement to report at least one MIPS core measure as one of the four required measures in MVPs and one of the six required measures in traditional MIPS. For 2027, CMS proposes to designate 78 measures within the MIPS measure inventory as "core," including a minimum of three core measures within each MVP that CMS believes are most reflective of the care central to the clinical specialty or medical condition represented by the MVP.

Selection of the MIPS core measures would be based on the following factors:

- Whether the measure is an outcome-based measure;
- Measure collection type availability and the clinician's ability to meet reporting requirements to the extent practicable. CMS is not proposing to designate any QCDR measures as core to ensure core measures are broadly available and accessible for all clinicians;
- Measure adoption and current and historic performance rates for each measure; and
- Whether the measure is most reflective of the care that is central to the clinical focus of the selected MVP, represents best practices essential to the MVP's specialty or medical condition, or addresses important areas for improving care.

CMS also proposes that if a MIPS eligible clinician does not have an available and applicable MIPS core measure, they could attest during the data submission period to avoid a penalty and choose another measure to report. Additionally, CMS proposes that clinicians that meet the definition of small practice would be exempt from the proposed MIPS core measure requirement and would not need to submit an attestation. Finally, CMS proposes that topped out core measures would not be subject to the 7-point scoring cap and instead eligible for up to 10 performance achievement points under CMS' newly adopted "defined topped out measure benchmark."

APMA supports CMS' proposal to retire the one outcome or high priority measure reporting requirement. Any policy that restricts physician flexibility to select which measures they report will be especially challenging for our members in the context of MVPs, which already offer a more limited set of measures to choose from.

At the same time, we support reporting practices that result in more meaningful data and recognize CMS' concern that current reporting practices may not produce sufficient comparative performance data on standardized measures to move the needle on quality and support patient choice of care. ***While the core measure proposal is not ideal and would still force clinicians to report on specific measures that might not reflect their scope of care, APMA views it as an improvement over the current***

outcome/high priority measure requirement. Our support for this alternative reporting requirement hinges on CMS finalizing the accompanying proposals to exempt small practices from the core measure requirement, to allow non-exempt clinicians to attest if a core measure is not available/applicable, and to exempt core measures from the 7-point topped out scoring cap. The topped out scoring cap exemption is especially critical for our specialty since most measures in the Podiatry MVP are either subject to the 7-point cap or lack a benchmark and are not eligible for the new measure scoring floors, which puts podiatrists at a significant disadvantage and limits their success in the program regardless of performance.

APMA strongly supports CMS' proposal to designate the following three measures as core, which would result in the removal of the 7-point cap and allow podiatrists to earn up to 10 points on each measure using the flat "topped out measure benchmark":

- ***126: Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation***
- ***155: Falls: Plan of Care***
- ***358: Patient-Centered Surgical Risk Assessment and Communication***

While CMS proposes to select a minimum of three core measures per MVP, it reserves the right to designate more than three in certain situations. In light of the relatively high number of small practice clinicians in our specialty, the limited set of viable measures available to podiatrists, and the clinical reasons described below, ***we request that CMS broaden the list of core measures applicable to the Podiatry MVP to also include the following measures:***

- ***226: Tobacco Use: Screening and Cessation Intervention***
- ***317: Screening for High Blood Pressure and Follow-Up Documented***

Measure 226 is proposed as a core measure in the Hypertension MVP and the Gastroenterology MVP and is equally vital to podiatry since nicotine narrows blood vessels and impairs circulation, which interferes with foot wound healing, worsens peripheral arterial disease (PAD), and raises the risk of amputations. Podiatrists play a key role in helping to prevent these conditions by screening for vascular risks and advising patients to quit smoking. Similarly, screening for high blood pressure often helps identify hidden systemic hypertension and assess lower-extremity vascular risks like PAD. Measure 317 is proposed as a core measure in the Diabetic Disease MVP, which demonstrates the importance of screening for high blood pressure in diabetic patients—a population commonly treated by podiatrists.

We also request that CMS clarify whether the topped out scoring cap exemption will apply to all measures identified as core regardless of whether a specific measure is listed as core within a specific MVP. For example, if CMS does not adopt our recommendation to classify measures 226 and/or 317 as core to the Podiatry MVP, will podiatrists reporting these measures through the Podiatry MVP be subject to the 7 point cap? Or would the 7-point cap not apply since these two measures are considered core in other MVPs (and presumably in traditional MIPS)? Similarly, would small practice clinicians who report a measure identified as core (within their MVP or within another MVP) still benefit from the topped out scoring cap protections even though small practices would be exempt from the core measure

requirement? ***We strongly urge CMS to apply the topped out scoring cap exemption to any and all measures identified as core, regardless of whether they are considered core within a specific MVP. It is also critical that small practice clinicians reporting these measures receive the protections from topped out measure scoring caps, even if they are technically not required to report on core measures.***

Additionally, we would appreciate if, going forward, CMS would consult with impacted specialties throughout the year leading up to rulemaking to determine which measures should be classified as core and ensure that registries and EHR vendors are ready to support core measures. These decisions should be made in a transparent manner and with the input of specialty-specific experts.

Finally, it would also be very helpful if CMS could publish a complete list of proposed core measures during rulemaking each year. CMS notes that the proposed MIPS core measure inventory would include 78 quality measures that CMS determined were most reflective of the care central to a clinical specialty or medical condition. However, this list of measures is not available in any single place in this year's rule, nor does CMS provide any rationale for why they were selected. Instead, they are designated throughout various lists, including within the MVP Inventory, within the list of newly proposed measures, and within the list of proposed specialty sets, which makes the inventory of core measures difficult to navigate.

Scoring Topped Out Measures

CMS previously finalized that beginning with the CY 2025 performance period, topped out measures frequently used by certain specialties reporting specialty measure sets that are impacted by limited measure choice, as specified in accordance with § 414.1380(b)(1)(ii)(E), are not subject to the 7-point topped out scoring cap. CMS also finalized that it will annually publish a list in the Federal Register of topped out measures determined to be impacted by limited measure choice. Measures included on the list will be scored from 1 to 10 measure achievement points according to a "defined topped out measure benchmark" calculated from performance data in the baseline period, in which a performance rate of 97 percent corresponds to 10 percent of the performance threshold for the corresponding performance year (e.g., 7.5 points for 2026). In 2026, CMS modified this approach so that each specialty measure set and MVP is reviewed by collection type to identify if the prevalence of topped out measures within such a set of measures hinders a clinician's ability to successfully participate in the MIPS quality performance category. To make such a determination, CMS will analyze the ability of clinicians reporting the specialty measure sets and MVPs to reasonably achieve 75 percent of available quality achievement points based upon the measures available to them and program requirements.

In this year's rule, CMS determined that the following podiatry-specific measure meets this criteria:

- 127: Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention - Evaluation of Footwear (CQM)

APMA is very supportive of this proposal and urges CMS to finalize the exemption of measure 127 from the topped out scoring cap.

We also reiterate our request from last year that CMS consider adding to this list the following additional measure in recognition of the face that podiatrists have very limited measure choice and to ensure they are not unfairly penalized:

- ***MIPS CQM #126 Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation***

Including measure 126 on this year's list would be especially important if CMS does not finalize the core measure requirement proposal in its entirety. In 2024, podiatrists reported measure 126 much more frequently than measure 127. Over 1,100 podiatrists reported measure 126 with an average score of 5.4 points, while only 650 podiatrists reported measure 127 with an average score of 5.6 points.

XII. Improvement Activities

CMS proposes to add multiple improvement activities to traditional MIPS in 2027, including:

- IA_CC_XX: Use of Data to Improve Practice Workflows
- IA_CC_XX: Understand and Improve Diagnostic Performance
- IA_AHW_XX: Systematic Screening and Intervention for Nutrition and other Health-Impacting, Non-Clinical Issues
- IA_AHW_XX: Advance Care Planning Conversations to Support Patient Wellness and Care Preferences
- IA_AHW_XX: Clinician Use of Artificial Intelligence (AI) to Improve Patient Care
  IA_AHW_XX: Lifestyle Approaches to Diabetes Remediation

APMA urges CMS to consider adding the following new Improvement Activities to the Podiatry MVP as soon as the 2027 performance year:

- ***IA_AHW_XX: Advance Care Planning Conversations to Support Patient Wellness and Care Preferences.*** This activity would allow MIPS-eligible clinicians to engage patients and caregivers in advance care planning and end-of-life discussions using structured communication tools. Foot health directly impacts a patient's independence and overall medical treatment plan, making the documentation of goals of care, symptom management, and patient priorities critical in the podiatric population. The management of chronic conditions, including diabetes and peripheral artery disease (PAD), also requires clear planning as to whether patients would like to pursue aggressive limb-salvage surgeries or prioritize comfort-focused palliative foot care, making the specialty an important facilitator of advance care planning discussions.
- ***IA_AHW_XX: Clinician Use of Artificial Intelligence (AI) to Improve Patient Care***. This activity would allow MIPS-eligible clinicians to implement and participate in organizational initiatives that improve patient care through the responsible and transparent use of AI in clinical and operational workflows. We believe this activity is important to include in the Podiatry MVP given the rapidly growing use of AI in numerous aspects of clinical care and the need to ensure safe and reliable use of such tools.

APMA recognizes that CMS has an established MVP Maintenance Process, which offers the public the opportunity to recommend changes to previously finalized MVPs, on a rolling basis, for CMS to consider in future rulemaking. However, this process means that when CMS proposes new and meaningful improvement activities through rulemaking, there is a full year delay until they can be considered for inclusion in relevant MVPs. ***We urge CMS to make an exception to this process and adopt newly proposed and finalized activities as part of relevant MVPs as soon as possible. We believe that by proposing these activities for traditional MIPS, CMS is providing the public with a sufficient opportunity to share feedback through rulemaking.***

XIII. Fast Healthcare Interoperability Resources®-Based Digital Quality Measurement in the Quality Payment Program and Other CMS Quality Programs

CMS reports that it is advancing quality measurement by transitioning existing quality measures and reporting processes to FHIR-based digital reporting options. CMS seeks feedback on a potential phased transition to FHIR-based digital quality reporting for applicable measures, under which CMS would introduce a 2-year transition period beginning with the CY 2028 performance period during which existing quality collection types for CQMs and eCQMs would continue to be available while FHIR-based dQM options would be introduced for select measures, including both new and existing measures. Following this transition period, FHIR-based reporting would be required for those applicable measures that were available as FHIR-based dQM collection types during the transition period, starting with the 2030 performance period.

APMA supports the eventual transition to dQMs since they rely on standardized, interoperable digital data from multiple sources, including EHRs, and will enable more comprehensive, accurate, and timely assessments of care while reducing reporting burden. At the same time, converting to dQMs—particularly FHIR-based dQMs—will require a significant investment of resources, which will be challenging for most physician practices, but especially for small practices. Physician practices do not have the same level of infrastructure or resources as hospitals and other facilities and will need more time and support to make this transition. Additionally, while the Office of the National Coordinator for Health Information Technology (ONC) claims that most electronic health records (EHRs) are on FHIR, that does not necessarily mean those EHRs are using the functionalities or that they have created optimized fields to support them.

Even where EHR vendors have the technical capability to support FHIR-based dQM reporting, the costs associated with developing, implementing, maintaining, and updating those capabilities may ultimately be passed on to physician practices through increased licensing fees, implementation costs, or other charges. For small and independent practices in particular, these additional costs could create another significant barrier to successful adoption and should be considered as CMS develops its transition timeline and support for implementation.

APMA urges CMS to ensure that this transition balances modernization goals with practical implementation considerations. In doing so, we request that CMS take into account the unique hurdles

that physicians will face in terms of implementing FHIR-based digital measures and refrain from mandating FHIR-based dQM reporting, especially among small practices, while also investing in technical support and other resources that will help small practices move in that direction.

XIV. Specialty Care in Accountable Care Models: LEAD and Diabetes-Related Lower Extremity Care

In its Request for Information on Specialty Care in the Medicare Shared Savings Program, CMS seeks input on opportunities to better integrate specialists into accountable care arrangements. ***APMA strongly supports this objective.*** As CMS considers opportunities to strengthen specialist engagement, APMA encourages CMS to use the Long-term Enhanced ACO Design (LEAD) Model and other CMS Innovation Center authorities to test approaches that more fully integrate podiatric physicians into the prevention and management of diabetes-related lower-extremity complications.

Recent research demonstrates the important role podiatric physicians play in caring for Medicare beneficiaries with diabetes. A 2026 *JAMA Network Open* study examined 707,971 diabetic lower-extremity wounds among Medicare fee-for-service beneficiaries across 306 hospital referral regions. Among the healthcare factors evaluated, higher podiatrist supply was associated with significantly fewer major amputations, while the supply of primary care physicians, endocrinologists, revascularization-performing specialists, and other relevant surgical specialists was not significantly associated with amputation rates. The authors estimated that, in areas with one podiatrist per 10,000 Medicare beneficiaries, adding one additional podiatrist would reduce the odds of amputation by 19.1 percent. They concluded that increasing access to foot and ankle care provided by podiatrists may reduce amputations among patients with diabetic lower-extremity wounds.[11]

These findings reinforce the importance of ensuring that accountable care models appropriately recognize and facilitate access to podiatric physicians. ***APMA recommends that CMS test two complementary approaches through LEAD or other Innovation Center authorities: separate payment for a Comprehensive Diabetic Lower Extremity Examination (CDLEE) and further modernization of the Medicare therapeutic shoe benefit.***

Comprehensive Diabetic Lower Extremity Examination
APMA has previously recommended that CMS adopt separate coding and payment for a CDLEE service. A CDLEE would provide beneficiaries with diabetes a comprehensive lower-extremity assessment, including vascular, neurological, dermatological, and biomechanical components. Based on the findings of the examination, the beneficiary would be placed into an appropriate risk category to guide the frequency of subsequent evaluation and management.

The recent *JAMA Network Open* findings provide additional support for testing this approach. Greater access to podiatric physicians was associated with fewer major amputations. The CDLEE would provide

[11] Ioana Popescu et al., "Geographic Variation in Amputations for Medicare Patients With Diabetic Lower-Extremity Wounds," *JAMA Network Open* 9, no. 5 (2026): e2613616, https://doi.org/10.1001/jamanetworkopen.2026.13616

a mechanism to systematically identify beneficiaries at risk for diabetes-related lower-extremity complications and connect them with appropriate preventive interventions. LEAD provides an opportunity for CMS to test whether dedicated payment for this service reduces ulcerations, hospitalizations, amputations, and associated Medicare expenditures.

Therapeutic Shoes for Persons with Diabetes

APMA also appreciates CMS' recognition through the LEAD Model that greater flexibility is needed in administering the Medicare therapeutic shoe benefit. Under current Medicare requirements, a podiatric physician may examine a beneficiary, identify and document the qualifying foot condition, determine that therapeutic shoes are medically necessary, and prescribe the shoes. However, the physician managing the beneficiary's systemic diabetes must separately document the qualifying foot condition and certify that the beneficiary needs therapeutic shoes as part of a comprehensive plan of care.

We recognize that the LEAD Model's Nurse Practitioner and Physician Assistant Services Benefit permits participating NPs and PAs to provide the required certification. However, expanding the practitioners who may complete the separate certification does not eliminate the underlying duplication that occurs across the work completed by the certifying physician or certifying NP/PA and the podiatric physician. ***APMA urges CMS to build upon the LEAD Model's flexibility by allowing a podiatric physician who examines the beneficiary, documents the qualifying foot condition, and determines that therapeutic shoes are medically necessary to attest that the beneficiary meets the requirements for the benefit and is receiving comprehensive care for diabetes, without requiring duplicative certification from another practitioner.***

The need to improve the administration of this benefit is particularly timely. In May 2026, HHS OIG announced an audit of Medicare payments for therapeutic shoes and inserts for beneficiaries with diabetes. OIG noted that Medicare paid more than $143 million for these items in CYs 2024 and 2025 and that CMS' Comprehensive Error Rate Testing program reported high improper payment rates due to insufficient documentation.[12] APMA believes that a streamlined attestation framework can reduce unnecessary administrative burden while maintaining clear documentation requirements and appropriate program integrity safeguards. Testing this approach through LEAD would allow CMS to evaluate its effects on beneficiary access, documentation compliance, utilization, and program integrity before considering broader implementation.

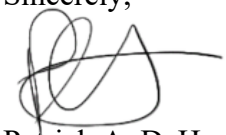
Together, these policies would allow CMS to test a more comprehensive approach to preventing diabetes-related lower-extremity complications: systematically identifying beneficiaries at risk through the CDLEE and reducing unnecessary barriers to obtaining therapeutic shoes when medically necessary. ***APMA encourages CMS to work with APMA to develop and test these approaches through LEAD and to consider additional Innovation Center opportunities focused on beneficiaries with diabetes.***

[12] U.S. Department of Health and Human Services, Office of Inspector General, "Medicare Payments to Suppliers for Therapeutic Shoes for Enrollees With Diabetes," *Work Plan*, announced May 29, 2026, https://oig.hhs.gov/reports/work-plan/browse-work-plan-projects/medicare-payments-to-suppliers-for-therapeutic-shoes-for-enrollees-with-diabetes/.

****

Thank you for the opportunity to comment on this proposed rule. We welcome the opportunity to discuss these issues further, and if you need additional information, please contact APMA's Vice President of Advocacy, Chad Appel, JD, CAE, at cappel@apma.org or (301) 581-9234.

Sincerely,



Patrick A. DeHeer, DPM
President