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ACS Health Policy Alert

Hot Topics in the 2027 Physician Fee Schedule

Modifier 25 & Overlapping Services, Part 2

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In the first part of this series, we described one of the controversial policies in CMS's 2027 proposed rule for the Medicare physician fee schedule (PFS). The proposal would effectively expand the existing multiple-procedure payment reduction policy—which has historically applied only when multiple procedures are performed on the same day – to a second group of potentially overlapping services: when procedures are performed the same day as an outpatient evaluation & management (E/M) visit. We showed that this policy would affect a broad range of office-based procedures, many of which are performed millions of times each year. Although dermatology would be particularly affected, the proposal would impact a host of medical and surgical specialties.

In this second article, we take a step back to explore the PFS more broadly and identify a third category of overlapping physician services that was left out of the CMS proposed rule, but is arguably far more financially influential. Using the 2024 Medicare 5% carrier file, we explored how often E/M visits are combined with another service on the same claim. We analyzed codes 99202-5 and 99212-5, which describe new and established office visits, respectively. These codes describe nearly 220 million encounters in fee-for-service Medicare. In 63% of cases, these codes are billed alone, but in 37% of cases – approximately 80 million encounters – they are billed alongside at least one additional service. We first characterize these additional services based on their global period (Table 1). The current proposed CMS policy (the subject of part 1) would only apply to services with a 000, 010, or 090 day global periods. We ignore ZZZ claims, as these are "add-on" codes that are specifically valued assuming they are being performed in addition to another code. What stands out from the table is that the largest spending in terms of overlapping services in the Medicare PFS is on services with XXX global periods – that is, services without a global period. If the same 50% reduction were applied to this category, over $1 billion would be saved in fee-for-service Medicare each year.

Table 1: Allowed charges for additional services on the same claim as a new (99202-5) or established (99212-5) office visit, by global period.

Global Period	Allowed Charges	Comments
0	$1,687,356,300	These are the focus of the current CMS proposed policy
10	$968,581,400	
90	$133,868,480	
XXX	$2,384,556,440	Services without a global period—e.g., additional E/M codes, diagnostics

We explore this further by evaluating individual codes. Table 2 shows the most common services billed alongside an office visit. One code has an outsized impact – the Medicare annual wellness visit (AWV, G0439).

Table 2: Most common "XXX" services on the same claim as a new or established office visit

CPT	Description	Frequency	Allowed Charges
G0439	Annual wellness visit	4,962,060	$630,164,980
93000	EKG	7,658,660	$109,898,320
92134	Optho imaging, retina	2,526,900	$97,937,400
92083	Visual field examination	1,192,340	$72,640,460
99497	Advanced care planning	697,340	$56,293,340
96372	Injection	2,776,900	$41,826,360
92250	Fundus photography	1,135,900	$40,839,040
92133	Optho imaging, optic nerve	1,188,320	$40,541,400
73630	Foot Xray	1,065,360	$35,746,380
73564	Knee Xray (4 view)	762,360	$35,024,360
73562	Knee Xray	723,420	$28,441,740
73030	Shoulder Xray	856,380	$27,901,320
G2212	Prolonged services	517,540	$27,136,120
73502	Hip Xray	618,680	$26,455,800
G0444	Depression screening	1,435,380	$25,930,040
95251	Glucose monitoring analysis	747,720	$24,615,640
92136	Optho biometry	531,020	$20,266,680
71046	Chest Xray	655,180	$18,049,848
G0442	Alcohol screening	545,880	$9,987,138
93010	EKG, report only	754,180	$5,836,430

Diagnostic procedures (e.g., radiographs, electrocardiograms) are only included when they are on the same claim as the office visit. If additional claims are generated, for example, if the imaging study is reviewed by a radiologist, that will generate a separate claim and not be included in these estimates.

The AWV was introduced by CMS as 2 G-codes (G0438 and G0439) in 2011 to implement preventive care provisions of the Affordable Care Act. These services describe initial and subsequent AWVs that include a personalized prevention plan. Although the codes have never been formally surveyed by the AMA Relative Value Scale Update Committee (RUC), their work RVUs were updated in 2021 to maintain parity with comparable office visit valuations.

AWVs are performed almost exclusively by family physicians, internists, and advanced practice providers. In a follow-up analysis, we used the same data source and identified all claims containing an AWV code. There were just under 11 million such claims in 2024. We then examined the frequency and types of additional services billed on the same claim.

Annual wellness visits were billed alone only 37 percent of the time (Table 3). In the remaining 63 percent of claims, at least one additional service was reported, and multiple additional services were common. The most common additional services were a level 3 or 4 office visit, advanced care planning, and screening for alcohol misuse and depression.

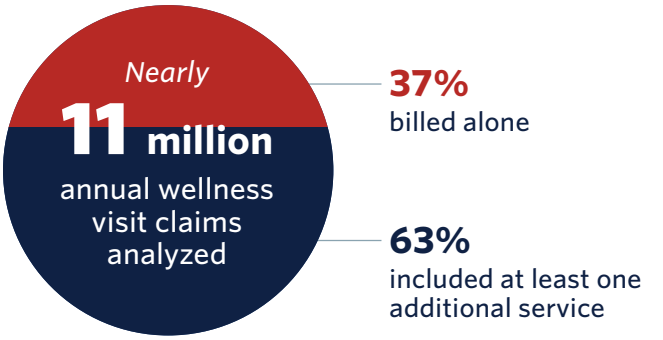

Table 3: Annual Wellness Visit (G0438/G0439) Claims with Additional Services

	Claims	Proportion
Billed alone	4,046,500	37%
Billed with 1 other code	4,521,580	41%
Billed with 2 other codes	1,474,040	13%
Billed with 3 other codes	599,580	5%
Billed with 4 other codes	226,860	2%
Billed with 5 other codes	87,020	1%
Billed with 6 other codes	26,520	0.2%
Billed with 7 other codes	8,400	0.1%
Billed with 8+ other codes	5,520	0.1%

Another way to conceptualize the extent of overlapping physician work is to sum the work RVUs for all services billed on a claim. Across claims with an AWV, the mean (SD) total work RVUs per claim was 3.07 (SD = 1.13), while the median (IQR) was 3.22 (1.92–3.84). Total work reached 4.38 RVUs at the 90th percentile and 6.15 RVUs at the 99th percentile, with a small number of claims exceeding 10 work RVUs.

In this part, we have shown that overlapping services are common in the PFS and are not limited to procedures with a defined global period. In fact, the most consequential overlap is when E/M visits are combined with services without global periods – that is, diagnostic services and, most consequentially, other E/M codes. In particular, AWVs are now an outsized source of spending in the Medicare PFS and almost always combined with other services. For some providers, the concomitant billing of other E/M codes can lead to encounter valuations greater than some surgical procedures that include 90 days of postoperative care. This observation is not, by itself, an argument that CMS should reduce payment for overlapping services. Rather, it highlights an inconsistency in the agency's current proposal. If the rationale for reducing payment is that physician work becomes more efficient when services overlap, then the same principle should apply to overlapping E/M services, where concurrent billing is both common and substantial.

Taken together, this two-part series examined CMS's proposal to reduce payment for procedures performed on the same day as an E/M visit. In part 1 we describe the services and providers most impacted and we summarize important logistical and conceptual questions and some of the potential unintended consequences. In part 2 we demonstrate that this policy leaves unaddressed a much larger category of overlapping physician work. Any policy intended to improve valuation accuracy should apply consistent principles across the PFS. Failing to evaluate the full spectrum of services that overlap with E/M visits while targeting procedural care risks creating the impression that the proposal reflects policy preferences rather than a consistent application of evidence.