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ACS Health Policy Alert

Hot Topics in the 2027 Physician Fee Schedule

Modifier 25 & Overlapping Services, Part 1

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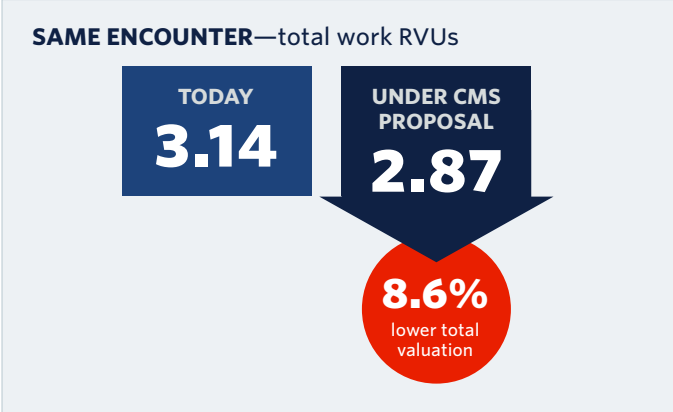
On July 14th, CMS released its proposed rule for the 2027 Medicare physician fee schedule (PFS). Among the more debated proposals is a policy to reduce payment when procedures are performed on the same day as an outpatient evaluation and management (E/M) service. This article introduces the proposal, presents data on the services and specialties most affected, and describes the central areas of controversy.

It has long been Medicare policy that when multiple procedures are performed on the same day, the additional procedures may be subject to a payment reduction. Based in part on data and analysis performing during the creation of the relative value unit (RVU) system, this reduction is generally accepted to be 50 percent of the value of the additional service. This concept is perhaps easiest to understand in the context of the operating room. If a surgeon removes a large abdominal tumor but must also perform a right colectomy because the tumor has invaded the colon, the surgeon receives credit for both the mass excision and the colectomy. However, the colectomy is not valued at its full rate because some preoperative and postoperative work overlaps, and there may be modest time savings associated with performing the procedures during the same operative session.

When a procedure is performed on the same day as a clinic visit, however, Medicare has historically paid the full value of both services as long as the clinician attests that the work associated with the E/M service is significant and separately identifiable from the procedure. The physician does this by appending modifier 25 to the E/M code.

Table 1: Example of the proposed policy on an office visit with a colorectal surgeon

	Current wRVUs	Adjustment Under CMS Proposal	Proposed wRVUs
New Patient Office Visit (99204)	2.60	None	2.60
Anoscopy	0.54	50% reduction	0.27
Total Encounter	**3.14**		**2.87**



For example (Table 1), if a patient presents to a colorectal surgeon's office for evaluation of bright red blood per rectum, the surgeon will perform a comprehensive history and physical examination and supplement the evaluation with an anoscopy—a small scope inserted through the anus to allow more detailed visual inspection. Under the current CMS proposal, the wRVUs associated with the lesser-valued service – in this case, the anoscopy - would be reduced by half, decreasing the total valuation of the encounter from 3.14 to 2.87 wRVUs (8.6% total reduction).

Using the 2024 Medicare 5% Carrier File, we found that nearly 4,400 procedures in the Medicare PFS would be eligible for this policy, although only 1,458 would be affected based on some proportion of their utilization occurring on the same day as an office-based E/M service. While many of these services are uncommon, several procedures and specialties would be substantially affected. Table 2 presents the 20 procedures most affected by the policy based on the volume of services impacted. Table 3 presents the 25 physician specialties most affected based on overall volume, along with the three most common impacted procedures within each specialty. Dermatology would experience a disproportionate impact from the proposed change, although effects would extend broadly across many office-based specialties.

The comment period for this proposal, as well as the broader PFS rule, remains open through mid-September. Our thoughts and the common themes shared by physician and specialty organizations center around the following issues:

First, the policy could incentivize providers to separate office visits and procedures onto separate days in order to capture the full value of each service. This would be inconvenient for patients and providers alike and worse, could delay care and paradoxically increase cost to patients through the extra transportation, parking, child care, time off of work etc.

Second, the actual mechanism for implementing this policy is not clear. Currently, modifier 25 is appended to the E/M service. But CMS proposal is more complicated – to pay 50% of the lower valued service on the same day as a modifier 25. Billers/coders will have to be specifically trained on this new policy creating additional administrative burden for an already taxed workforce. There is also no discussion of how to deal with nuanced situations – for example, if multiple procedures are performed or if add-on (ZZZ) codes are also billed the same day.

Third, the issue of overlapping work is already incorporated into procedural RVU valuations. When the AMA's Relative Value Scale Update Committee (RUC) generates recommendations for office-based procedures they use intentionally thin pre- and post-service packages to account for this issue. CMS is fully aware of this, suggesting this policy is not trying to account for redundant work, but is instead trying to devalue the procedure itself.

Fourth, is the concept itself. The hallmark of high-quality procedural care is not only the technical procedural elements, but in the comprehensive evaluation and counseling of the patient to make sure the procedure being recommended is the right procedure, for the right patient, for the right indication, and at the right time. This policy represents a de-valuation of either that shared decision making framework or the technical skill required to perform the procedure safely.

Finally, and perhaps most importantly, this policy addresses only one category of overlapping work within the PFS - overlap between procedures and E/M services. Current policies already account for overlapping work among procedures, and the proposed policy would extend this concept to procedures performed alongside E/M services. But there is a much larger area of the PFS that this new policy ignores – how should Medicare address overlapping work among multiple E/M service themselves? This issue will be the focus of the second portion of this series.

Table 2: Top 20 procedures by volume with concurrent office visits

CPT	Description	Work RVU	Global Period	Approximate 2024 Utilization	Proportion Billed with E&M Visit
17000	Destruction premalignant lesion	0.61	10	6,299,780	87.4%
11102	Tangential biopsy of skin	0.66	0	3,497,580	83.9%
20610	Arthrocentesis, major joint	0.79	0	4,806,620	56.2%
17110	Destruction benign lesions, up to 14 lesions	0.7	10	3,200,900	83.8%
11721	Debride nails, 6 or more	0.54	0	5,344,160	21.9%
69210	Remove impacted ear wax	0.61	0	1,502,280	67.7%
17004	Destruction benign lesions, 15 or more	1.37	10	858,720	87.8%
67028	Injection eye drug	1.44	0	3,582,260	18.8%
31231	Diagnostic nasal endoscopy	1.1	0	746,240	83.3%
20550	Injection into a single tendon/sheath	0.75	0	770,780	77.3%
20611	Arthrocentesis, major joint, with ultrasound	1.1	0	1,059,420	51.9%
11042	Debridement, subcutaneous tissue, <=20 square cm	1.01	0	2,011,240	24.6%
31575	Diagnostic laryngoscopy	0.94	0	546,140	88.9%
11056	Paring/cutting hyperkeratotic lesion, 2-4 lesions	0.5	0	1,832,440	20.9%
52000	Cystoscopy	1.53	0	830,140	37.6%
20600	Arthrocentesis, small joint	0.66	0	422,860	70.1%
11720	Debride nails, 1-5	0.32	0	1,844,580	13.5%
20605	Arthrocentesis, intermediate joint	0.68	0	347,120	71.1%
97597	Debridement, open wound, <=20 square cm	0.77	0	673,440	31.1%
11104	Punch biopsy, single lesion	0.83	0	285,460	67.3%

Data derived from the 2024 5% Medicare Carrier File and Addendum B of the Final Rule. Analysis was limited to claims with 000, 010, and 090 global period procedures. Assistant at surgery (e.g., modifier 80, AS) lines were excluded. The proportion of claims with an associated office evaluation & management code were identified (99202-5, 99211-5). Volume estimates were multiplied by 20 to generate approximate national volumes.

Table 3: Top 25 impacted specialties by volume of procedures with concurrent office visits

Specialty	Procedures without E&M	Procedures with E&M	Proportion of Procedures with E&M	Top 3 codes billed with E&M
Dermatology	4,355,740	9,004,940	67%	17000 (Destruction premalignant lesion) 11102 (Tangential biopsy of skin) 17110 (Destruction benign lesions, up to 14 lesions)
Physician Assistant	2,446,000	4,308,380	64%	17000 (Destruction premalignant lesion) 11102 (Tangential biopsy of skin) 17110 (Destruction benign lesions, up to 14 lesions)
Podiatry	11,276,720	3,617,580	24%	11721 (Debride nails, 6 or more) 11056 (Paring/cutting hyperkeratotic lesion, 2-4 lesions) 11720 (Debride nails, 1-5)
Orthopedic Surgery	2,938,200	2,183,420	43%	20610 (Arthrocentesis, major joint) 20a611 (Arthrocentesis, major joint, with ultrasound) 20550 (Injection into a single tendon/sheath)
Nurse Practitioner	2,400,560	2,117,160	47%	17000 (Destruction premalignant lesion) 11102 (Tangential biopsy of skin) 17110 (Destruction benign lesions, up to 14 lesions)
Otolaryngology	1,021,420	2,056,680	67%	69210 (Remove impacted ear wax) 31231 (Diagnostic nasal endoscopy) 31575 (Diagnostic laryngoscopy)
Ophthalmology	6,314,320	1,007,960	14%	67028 (Injection eye drug) 68761 (Close tear duct opening) 66821 (Discission of secondary membranous cataract)
Family Practice	919,900	796,920	46%	20610 (Arthrocentesis, major joint) 17000 (Destruction premalignant lesion) 69210 (Remove impacted ear wax)
Urology	2,093,620	596,720	22%	52000 (Cystoscopy) 51702 (Insert temp bladder cath) 51700 (Irrigation of bladder)
Internal Medicine	810,540	358,180	31%	20610 (Arthrocentesis, major joint) 69210 (Remove impacted ear wax uni) 17000 (Destruction premalignant lesion)
Hand Surgery	338,660	322,440	49%	20550 (Injection into a single tendon/sheath) 20600 (Arthrocentesis, major joint) 20605 (Arthrocentesis, major joint)
Physical Medicine and Rehabilitation	974,960	287,960	23%	20610 (Arthrocentesis, major joint) 20611 (Arthrocentesis, major joint, with ultrasound) 20553 (Inject trigger points, 3 or more)
Sports Medicine	226,260	257,980	53%	20610 (Arthrocentesis, major joint) 20611 (Arthrocentesis, major joint, with ultrasound) 20550 (Injection into a single tendon/sheath)
Rheumatology	71,280	221,280	76%	20610 (Arthrocentesis, major joint) 20611 (Arthrocentesis, major joint, with ultrasound) 20600 (Arthrocentesis, major joint)
Micrographic Dermatologic Surgery (MDS)	392,420	186,380	32%	17000 (Destruction premalignant lesion) 11102 (Tangential biopsy of skin) 17311 (Mohs, first stage, up to 5 blocks)
Obstetrics/ Gynecology	403,040	180,420	31%	51701 (Insert bladder catheter) 57160 (Insert pessary/other device) 58100 (Biopsy of uterus lining)
General Surgery	1,895,620	165,340	8%	11042 (Debridement, subcutaneous tissue, <=20 square cm) 46600 (Diagnostic anoscopy) 97597 (Debridement, open wound, <=20 square cm)

Pain Management	927,420	132,960	13%	20610 (Arthrocentesis, major joint) 20553 (Inject trigger points, 3 or more) 20552 (Inject trigger points, 1-2)
Neurology	326,860	118,040	27%	64615 (Chemodenervation of muscles; for migraine) 64405 (Injection, occipital nerve 64616 (Chemodeneveration; neck)
Plastic and Reconstructive Surgery	461,680	109,380	19%	20550 (Injection into a single tendon/sheath) 11042 (Debridement, subcutaneous tissue, <=20 square cm 17000 (Destruction premalignant lesion)
Optometry	538,980	105,520	16%	68761 (Close tear duct opening) 67820 (Revise eyelashes) 65778 (Cover eye w/membrane)
Osteopathic Manipulative Therapy	36,700	105,240	74%	98929 (Osteopath manj 9-10 regions) 98928 (Osteopath manj 7-8 regions) 98927 (Osteopath manj 5-6 regions)
Anesthesiology	1,906,280	104,560	5%	62323 (Injection, lumbar/sacral) 20610 (Arthrocentesis, major joint) 20553 (Inject trigger points, 3 or more)
Colorectal Surgery	208,520	89,700	30%	46600 (diagnostic anoscopy) 46221 (ligation of hemorrhoids) 45300 (proctosigmoidoscopy)
Emergency Medicine	825,940	84,580	9%	11042 (Debridement, subcutaneous tissue, <=20 square cm 20610 (Arthrocentesis, major joint) 97597 (Debridement, open wound, <=20 square cm)

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