

First National Guild of Medical Providers for the Lower Extremity

Local 45

Office and Professional Employees International Union, AFL-CIO

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September 2, 2026

**Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1848-P CMS-2026-2377
P.O. Box 8013
Baltimore, MD 21244-8013**

Subject: CMS-2026-2377 CMS-1848-P Opposition to Proposed Revisions to Modifier 25 Payment and Documentation Policies

To Whom It May Concern:

I am writing on behalf of The First National Guild of Medical Professionals for the Lower Extremity, OPEIU AFL-CIO. We count, as our members, over three thousand Podiatric Physicians in seven states. I am submitting these formal comments in order to express strong opposition to the proposed changes regarding the use and reimbursement of Modifier 25. CMS-1848-P

While we support the Centers for Medicare & Medicaid Services' (CMS) ongoing efforts to ensure billing integrity and manage program expenditures, the proposed modifications, specifically the heightened documentation requirements and the proposed 50% payment reduction, will severely impact patient care, increase administrative burdens, and exacerbate provider burnout.

We urge CMS to reject these proposed changes based on the following critical concerns:

1. Compromising Patient-Centered Care and Efficiency

Modifier 25 allows a physician to provide a significant, separately identifiable Evaluation and Management (E/M) service and a minor procedure or preventive service during the exact same patient encounter. This capability is the cornerstone of efficient, patient-centered care.

Forcing a patient—particularly elderly, low-income, or mobility-challenged Medicare beneficiaries—to schedule a separate appointment for a minor, necessary procedure that could safely be performed on the same day creates unnecessary barriers to care. It increases transportation costs, delays essential treatment, and diminishes the patient experience.

2. Flawed Economic Assumptions Regarding Dilution of Care

The proposed payment reductions assume a duplication of practice expenses when an E/M service and a procedure occur together. However, this assumption is fundamentally flawed. Additionally, there is no expressed rationale for a 50% reduction in reimbursement. A physician performing a separately identifiable E/M service must still conduct a distinct clinical evaluation, review medical history, and engage in complex medical decision-making entirely separate from the pre- and post-operative work associated with the minor procedure. Reducing payment fails to recognize the independent resource inputs and clinical expertise required for both services.

3. Exacerbating Administrative Burden and Burnout

The proposed policy will inevitably lead to overly rigid documentation scrutiny and an increase in automated, unjustified claim denials. Navigating complex appeals processes takes valuable time away from direct patient care. At a time when the healthcare system faces unprecedented levels of provider burnout and workforce shortages, CMS should look for ways to streamline administrative workflows rather than adding punitive barriers to standard coding mechanisms.

4. Shifting Costs and Increasing Total Program Expenditures

Rather than saving money, restricting the use of Modifier 25 will likely increase overall Medicare expenditures. When care is fragmented into multiple visits, CMS will be responsible for multiple E/M facility fees or independent visit codes, alongside the associated administrative costs of processing double the volume of claims.

Conclusion

The existing guidelines for Modifier 25 are already stringent and require clear documentation of a "significant, separately identifiable" service. Increased education and targeted auditing of outliers represent a far more balanced and effective approach to compliance than a sweeping policy change that penalizes compliant providers and vulnerable patients.

We strongly urge CMS to withdraw the proposed changes to Modifier 25 and maintain the current reimbursement structure to protect patient access to timely, comprehensive, same-day medical care.

I am including a additional material explaining our opposition in greater depth.

Thank you for your time, consideration, and dedication to the health of our communities.

Sincerely,

**John A. Mattiacci, DPM
President , The First National Guild
Office and Professional Employees International Union AFL-CIO**

Background. In the CY 2027 MPFS proposed rule, CMS included a proposal targeting services reported on the same day as an evaluation and management (E/M) visit reported with Modifier 25. Specifically, CMS proposed to reduce payment when a separately identifiable office and outpatient E/M visit is furnished by the same physician (or a physician in the same group practice) on the same day as a 0-, 10-, and 90-day global procedure; while, the most expensive service would be paid at 100 percent, all other surgical procedure(s) or E/M visit(s) would be paid at 50 percent. Concerns. APMA has significant concerns with this Modifier 25 proposal. To begin, the proposal is intended to target overlap when procedures are furnished on the same day as a separately identifiable E/M visit. CMS does not provide any clear evidence or empirical support for imposing the proposed payment reductions, particularly given previous work by the RUC to remove duplication when procedures are furnished together with a E/M more than fifty percent of the time. The Modifier 25 proposal upends existing payment policy and has major implications for physician payment, thereby requiring thoughtful consideration of relevant evidence and a detailed justification to support the change. However, CMS failed to demonstrate the existence of any overlap in its discussion of the proposal. Furthermore, CMS did not provide any data to support an arbitrary across-the-board reduction of 50 percent to lower-cost services, which we believe would be particularly egregious in cases where the RUC and CMS have already finalized changes in valuation to account for duplication. Troublingly, the proposal would result in payment rates that do not cover the costs of delivering care. Indeed, our analysis shows that a 50 percent reduction in the payment of a several procedures commonly performed by podiatrists would result in payment for the procedure that does not even cover the direct practice expense costs, much less the physician work or indirect

practice costs involved in furnishing the services (see Appendix A for examples). When a policy results in physicians being unable to recoup the direct practice expense costs to perform a procedure, it is clear that the policy is flawed. Notably, APMA devotes significant resources to educating physicians regarding the appropriate use of Modifier 25, including documentation requirements and examples of both compliant and noncompliant

Without clear evidence or empirical support, CMS asserts in the 2027 Medicare Physician Fee Schedule Proposed Rule that there is overlap when two services are performed on the same day and therefore physicians should receive a payment reduction when reporting the 25 Modifier. Specifically, the agency proposes an arbitrary 50% cut to unrelated services reported on the same day. CMS does not identify where specifically duplication occurs or how it came to 50 percent as a justifiable reduction amount. CMS also fails to recognize that the American Medical Association's (AMA's) Relative Value Scale Update Committee (RUC) already considers and removes duplication for many codes where it identifies overlap when two unrelated services are performed. For example, in podiatry, payment was revalued and reduced for CPT code 11755 (biopsy of nail unit) in 2019 and CPT code 29540 (strapping, ankle and/or foot) in 2011. CMS still proposes to apply its reductions to codes that have already been subject to reduced payment by the RUC. CMS's 50 percent payment reduction will be catastrophic for podiatrists and their patients. — Podiatrists' payments will not cover the cost of delivering care. — Podiatrists' ability to provide comprehensive, patient-centered care during a single visit will be reduced. — Patients may be forced to take multiple trips to their physician for care that could have been provided in a single visit, incurring additional travel and cost-sharing expenses. — Solo, small, and rural independent podiatry practices will face increased pressure to close or consolidate given additional financial strain. — Access to podiatry services for patients will decrease.