AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY®

Protect Medicare Patients' Access

Urge CMS to Withdraw the Proposed Payment Reduction for Same-Day Care (Modifier 25)

Medicare patients' access to ENT care is at risk. Under the proposed 2027 Medicare Physician Fee Schedule, the Centers for Medicare & Medicaid Services (CMS) would reduce payment when a physician provides a medically necessary, separately identifiable office or outpatient visit on the same day as a procedure with a 0-, 10-, or 90-day global period. Even when both services are distinct, fully documented, and clinically appropriate, Medicare would no longer fully reimburse each service. **CMS projects a 10% cut to Medicare payments for otolaryngologists—ear, nose, and throat (ENT) specialists—under this proposal.**

Specifically, the proposal would:

- **Delay needed care.** The policy could force patients to return for separate appointments. This would increase wait times, transportation challenges, and out-of-pocket costs, particularly for patients in rural areas who often travel significant distances to see specialists.
- **Threaten access to specialty care.** Many practices will be forced to reduce staff, limit appointments for Medicare beneficiaries, eliminate patient services, or consider selling their practices.
- **Arbitrarily and automatically undervalue care.** CMS would pay the highest-valued service in full and reduce payment for each additional service by 50%. The proposal does not target fraud or inappropriate billing; it imposes an across-the-board reduction.
- **Revive a previously rejected policy.** CMS proposed a similar approach in 2019 but withdrew it after patients and physicians warned that it would reduce access, unnecessarily increase visits, and harm practices.

CMS retains the authority to revise or withdraw these policies before issuing the final rule, making congressional engagement during the public comment period through September 14 especially important.

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OUR ASK

AAO-HNS urges Members of Congress to call on CMS to **withdraw the proposed Modifier 25 payment reduction** before the 2027 Medicare Physician Fee Schedule is finalized.

CMS should preserve payment for medically necessary, separately identifiable procedures and services. This will help ensure Medicare patients have access to timely, same-day care.

Our goal is not simply to preserve the status quo. We urge CMS to work collaboratively with physicians to develop evidence-based payment policies that reflect clinical reality, preserve patient access, ensure appropriate stewardship of Medicare resources, and maintain Medicare's long-term fiscal sustainability.

WHAT IS MODIFIER 25?

Modifier 25 is appended to an evaluation and management (E/M) code when a physician performs a **significant, separately identifiable** E/M service on the same day as a procedure. This may include assessing the patient's symptoms, reviewing medical history, evaluating clinical risks, or determining whether the procedure is appropriate. Modifier 25 identifies the physician's work and helps ensure appropriate reimbursement. This service is integral to the visit, not duplicative or less valuable.

How ENTs Use Modifier 25—and Why Full Payment Matters

New symptoms during a visit. A patient with throat pain also reports one-sided hearing loss and a neck mass. The ENT assesses for head and neck cancer and separately scopes the throat and voice box. The cancer evaluation is distinct, significant work, and early diagnosis can be lifesaving.

Acute problem at a routine follow-up. A patient with chronic sinus disease arrives with sudden, heavy nosebleeds. The ENT evaluates the cause—including medications, blood pressure, and risk factors—then controls the bleeding. The diagnostic work is distinct and necessary before treatment.

In each case, the physician provides two distinct services and should be fully paid for both. Arbitrarily cutting the second service's payment in half forces physicians to do the same work for less—often at a loss—or to adopt scheduling models that separate care.

HOW WOULD THIS HURT MEDICARE PATIENTS?

Reduce patient access. Private practices cannot absorb a 10% cut in Medicare reimbursement without tradeoffs, including reducing staff and services, delaying technology investments, or limiting Medicare appointments. This will leave patients with longer waits, fewer choices, and reduced access to care.

Delay needed care and increase patient burden. By encouraging physicians to split evaluation and treatment across multiple visits, the proposal would delay care while increasing travel, transportation challenges, time away from work, and out-of-pocket costs—particularly for seniors, caregivers, and patients in rural communities who often travel long distances to see specialists.

Accelerate physician consolidation. Independent physician practices are ill-equipped to absorb these reductions. As more practices are acquired by hospitals, health systems, corporations, or insurers, Medicare beneficiaries will lose local access and increasingly receive care in higher-cost settings. Once independent practices close or are acquired, those care options rarely return.

WHY IS THIS POLICY FLAWED?

Current policy appropriately reimburses physician work. The code valuation process already accounts for physician work, practice expense, and other costs while preventing payment overlap between a procedure and a separate E/M service. Modifier 25 does not give physicians an extra or duplicate payment; it identifies distinct physician work.

The proposed 50% reduction lacks evidence. CMS says it continues "to believe" efficiencies exist and that Medicare is "likely duplicating" payments, but it provides no empirical analysis demonstrating that physician work or practice expense is duplicated by 50%.

The proposal compounds years of declining Medicare payments. This policy would further strain physician practices and threaten patient access to specialty care.

FOR MORE INFORMATION

For case studies and other details, contact our advocacy team at **GovtAffairs@ENTnet.org**

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