> **Instructions for ARS Members:** Personalize the highlighted fields (**[BRACKETED YELLOW TEXT]**) with your personal/practice details and clinical insights before submitting to **Regulations.gov Docket CMS-2026-2377** before 5:00 PM ET on **September 14, 2026**.

DATE: **[Insert Date, e.g., August 25, 2026]**

TO: Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS-1848-P / Docket CMS-2026-2377

FROM: **[Physician Name, MD/DO, FACS]**
[Title / Faculty Position / Subspecialty]
[Practice Name / Academic Medical Center]
[City, State]

SUBJECT: **Opposition to Proposed 50% Reduction to Evaluation & Management (E/M) Services Billed with Modifier 25 (CY 2027 MPFS Proposed Rule, Ref. Pages 67–68)**

Dear Administrator and CMS Rulemaking Officials,

I am writing as a practicing otolaryngologist-head and neck surgeon and member of the American Rhinologic Society (ARS) to express my rigorous opposition to the proposal within the Calendar Year (CY) 2027 Medicare Physician Fee Schedule (MPFS) Proposed Rule (Docket CMS-2026-2377) establishing an arbitrary 50% payment reduction on Evaluation and Management (E/M) codes billed with Modifier 25 on the same day as a minor surgical procedure.

I support the comprehensive technical comments submitted by the American Academy of Otolaryngology–Head and Neck Surgery Foundation (AAO-HNSF) and the American Rhinologic Society (ARS). As detailed below, this proposed rule change is legally deficient under the Administrative Procedure Act (APA), administratively unworkable, economically counterproductive, and detrimental to patient care.

1. APA Violations: Arbitrary, Capricious, and Unsupported by an Empirical Record

Under Section 706 of the Administrative Procedure Act (5 U.S.C. § 706), agency rulemaking must be grounded in substantial empirical evidence and reasoned decision-making. Agency action that relies on unquantified conjecture is arbitrary, capricious, and unlawful. On pages 67 and 68 of the proposed rule, CMS's justification relies entirely on speculative assertions rather than empirical data:

- CMS explicitly concedes its lack of data by stating that it *"continue[s] to believe that there are efficiencies"* and that same-day billing is *"likely duplicating payment."*
- Subjective bureaucratic "belief" and "likelihood" do not constitute an administrative factual record. CMS has failed to provide time-and-motion studies, clinical workflow analyses, or actuarial datasets demonstrating actual duplicative resource consumption.

2. Unlawful Rejection of Superior, Granular RUC Accounting

CMS explicitly acknowledges the exhaustive work conducted by the AMA/Specialty Society RVS Update Committee (RUC) to systematically identify and strip out overlapping work and direct practice expense inputs on a code-by-code basis. However, CMS dismisses this established, accurate accounting mechanism simply by declaring that code-level reviews are *"not a practical solution"* for the agency.

An agency cannot arbitrarily penalize physicians and dismantle accurate payment structures simply because adhering to rigorous, code-level accounting is administratively inconvenient for federal regulators.

3. Deficient Regulatory Impact Analysis (Micro-RIA: Downstream Costs)

CMS is statutorily required to conduct a rigorous Regulatory Impact Analysis (RIA) evaluating the real-world downstream economic consequences of proposed policy changes. CMS completely failed to account for the substantial cost shifts that this policy will induce from the low-cost physician office setting to high-cost hospital and emergency facilities.

> **Case Study: In-Office Acute Epistaxis vs. Emergency Department Escalation**
>
> In otolaryngology, an elderly patient presenting for a planned evaluation who suffers acute epistaxis requires immediate diagnostic evaluation (E/M) and same-day nasal endoscopy/cautery or packing (Modifier 25). CMS seeks to extract a nominal ~$13 to $40 "saving" by halving the E/M payment. However, if practices cannot absorb the uncompensated overhead of same-day intervention and are forced to direct acute patients to an Emergency Department, Medicare immediately faces facility fees, emergency E/M billing, and potential inpatient observation costs exceeding $18,500 per episode. CMS's RIA entirely ignores these catastrophic net-negative cost shifts.

4. The "Separate Day" Enforcement Scheme Penalizes Clinical Common Sense

CMS explicitly acknowledges on pages 67–68 that physicians may be forced to schedule procedures on separate calendar days. Rather than recognizing this as the natural byproduct of severe undervaluation, CMS labels this standard scheduling reality *"highly problematic"* and threatens aggressive enforcement, automated claims edits, and targeted medical audits.

This creates an unconscionable double bind: physicians are penalized if they treat patients comprehensively on the same day, and threatened with administrative audits if they reschedule care. For elderly, frail, or rural Medicare beneficiaries who travel hours for specialized rhinology care, same-day evaluation and intervention is the gold standard of compassionate, efficient medicine.

[OPTIONAL PRACTICE-SPECIFIC INSERTION: Describe how same-day flexible laryngoscopy, nasal endoscopy, biopsy, or foreign body removal saves your specific patient population travel time, lost wages, and clinical worsening.]

Conclusion and Request for Relief

Because the proposed 50% reduction to Modifier 25 E/M services violates the Administrative Procedure Act, ignores superior RUC valuation data, lacks a rational Regulatory Impact Analysis, and threatens patient access, I respectfully urge CMS to **fully withdraw this proposed policy in the CY 2027 MPFS Final Rule**.

Respectfully submitted,

[Physician Signature / Typed Name, MD/DO]
[Title / Specialty]
[Practice / Institution Name]
[Contact Email / Phone]