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VIA Electronic Submission to www.regulations.gov

The Honorable Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program [CMS-1848-P]

Dear Administrator Oz:

On behalf of the American Urogynecologic Society (AUGS), I am pleased to submit comments in response to the proposed rule for the Calendar Year (CY) 2027 Medicare Physician Fee Schedule (CMS-1848-P). AUGS is a national medical society whose mission is to promote the highest quality of care in urogynecology and pelvic reconstructive surgery through excellence in education, research, and advocacy. Our comments address the following CMS proposals:

1. CY 2027 Conversion Factor Update
2. Modifier -25
3. Misvalued Services

1. CY 2027 Conversion Factor Update

CMS proposes a CY 2027 Medicare Physician Fee Schedule (PFS) conversion factor (CF) of **$33.1693 for clinicians who are QPs in APMs and $32.8409 for other clinicians. This represents an overall decrease of 1.19% and 1.68%, respectively, compared to the CY 2026 CFs.** This update reflects: (1) The Statutory Update in the Medicare Access and CHIP Reauthorization Act (MACRA): 0.25% for non-QPs and 0.75% for QPs (2) A 0.53% positive budget neutrality adjustment (3) The expiration of a 2.5% one-year payment increase from the One Big Beautiful Bill Act (OBBBA) that boosted the CY 2026 CFs. This temporary increase provided in the OBBBA expires at the end of CY 2026, and CMS is required to remove that amount from the CY 2027 CFs.

This volatility points to deeper structural problems in how the PFS rate-setting methodology works, including budget neutrality rules that haven't kept pace with current practice, and the lack of an annual inflation-based update like the market basket adjustments hospitals and other facility-based providers already receive. Repeated

year-over-year reductions put the financial sustainability of urogynecology practices at risk and threaten patients' ability to access timely care.

The accumulated effect of these ongoing cuts raises particular concern for patient access. Many practices are already struggling to sustain their participation in Medicare, and continued reimbursement erosion risks pushing some providers to leave the program entirely, further limiting access, especially in rural and underserved communities.

This year's proposed CF update also underscores inequities in the Quality Payment Program (QPP). Because the statutory CF update factor provides higher increases for clinicians who qualify as Advanced APM participants, specialties with more limited measure sets, such as urogynecology, are effectively excluded from accessing that higher update amount. This lack of robust and relevant measures creates a structural inequity that compounds the erosion of the CF. Independent practices, which are often lower-cost settings for Medicare, are disproportionately threatened by continued CF erosion, jeopardizing both access and cost containment goals.

While we recognize that CMS is constrained by statutory limits, the agency nonetheless plays a critical role in providing technical support to Congress on needed reforms. **AUGS therefore strongly urges CMS to work proactively with Congress to implement permanent, meaningful positive updates to the CF, modernize budget neutrality policy, and establish a stable, predictable payment system that reflects the real cost of delivering care in today's environment.**

2. Modifier -25

As in past years, CMS continues to scrutinize how it pays for the "global surgical package", a billing structure where Medicare makes one flat payment covering a surgical procedure along with all related pre- and post-operative visits. Modifier -25 is used to denote when an E/M visit is significant and separately identifiable from a same-day procedure. Because global surgical packages already account for the resource costs of routine visits, a stand-alone E/M code can only be billed alongside a procedure when this modifier is used. It is CMS's belief that billing a same-day E/M visit alongside a procedure with a global period likely duplicates payment, since global surgical packages already account for some of that E/M work.

CMS proposes to reduce payment when a separately identifiable office/outpatient evaluation and management (E/M) visit is furnished by the same physician (or a physician in the same practice) on the same day as the procedure included in a 0, 10, or 90-day global. The most expensive service (either surgical or E/M visit) would be paid at 100% and all other surgical procedure(s) or E/M visit(s) furnished on the same day would be paid at 50%. This would affect any physician who sees a patient for an office visit and then performs a same-day procedure.

Under current rules, a physician generally cannot bill separately for an office visit and a procedure performed the same day, unless that visit involved real, distinct medical decision-making beyond just leading into the procedure. Importantly, the visit doesn't need a different diagnosis than the procedure to count as separate; it just needs to reflect genuine, standalone clinical work. For example, a clinician performs and interprets a urodynamics study for an established patient with stress incontinence. The clinician then synthesizes the urodynamic findings with the patient's prior history, examination, urinalysis, and postvoid residual to formulate a treatment plan. After discussing the risks, benefits, and alternatives, the patient chooses urethral bulking and elects to proceed with bulking at a subsequent visit. Because the clinician documents distinct decision making and management beyond what is inherent to the urodynamic study, the correct billing would be: 51729 (urodynamics study), 51741-51 (uroflow), 51784-51 (EMG), +51797 (abdominal pressure), and 99213-25 or 99214-25 (level based on MDM). Cutting payment for the medical decision making by 50% in this situation

significantly underpays for the actual work involved in both services, and penalizes exactly the kind of efficient, coordinated care that benefits the patient by combining two visits into one.

In another example, a new patient presents with postmenopausal bleeding. The clinician conducts a comprehensive history and physical along with a pelvic ultrasonography demonstrating a 10 mm endometrial lining. Based on these findings, the patient is counselled and consents to an endometrial biopsy performed on the same day. Because the visit involved a full diagnostic evaluation that independently justified the decision for the biopsy, modifier 25 is appropriate to use. If the encounter had been solely for the purpose of performing the biopsy, an E/M service would not be billed. In many cases, the E/M appropriately leads to a same-day procedure, when clinically indicated.

The 50% is meant to match the longstanding Medicare multiple procedure payment reduction policy, which reduces payment by 50% for the second and subsequent surgical procedures furnished on the same day to the same patient, largely based on the efficiencies in PE and pre- and post-surgical physician work. The existing MPPR policy recognizes the efficiencies gained when two or more procedures are performed during the same encounter (e.g., there is overlap in the physician work for the procedures). However, the proposed modifier 25 reimbursement reduction policy is unlike the MPPR because CMS and the RUC already carefully account for how often a given procedure tends to be performed alongside an office visit when it's known or expected that both will happen the same day, the redundant time and resources (particularly in the preservice and postservice periods) are already stripped out of the valuation.

Layering this E/M payment cut on top of an already flawed, one-size-fits-all payment system will harm physician practices.

While this proposal's overall impact on a specialty may look modest at the macro level, it would be highly disruptive for many individual practices. Because urogynecologists care for menopausal and postmenopausal women who often present with multiple, multi-symptom complaints, they tend to bill a disproportionately high number of high-level E/M visits.

Additionally, preserving modifier 25 is especially important in rural communities where patients may have to travel significant distances to access care. Allowing medically necessary E/M services to be provided on the same day as a procedure improves efficiency, reduces unnecessary return visits, and helps clinicians serve more patients without compromising appropriate reimbursement

AUGS therefore strongly urges CMS not to finalize this proposal. Instead, AUGS recommends that CMS work collaboratively with specialty societies to better understand the clinical circumstances warranting same-day E/M and procedural billing before pursuing any changes to current payment policy.

3. Misvalued Services

CMS received a request from a nominator regarding CPT code 51715 (Endoscopic injection of implant material into the submucosal tissues of the urethra and/or bladder neck) as potentially misvalued. The nominator stated that CPT code 51715 currently does not include a supply for the implant material necessary to properly perform CPT code 51715 in the office setting, which is a clinically desired place of service for this treatment. The nominator submitted invoices and requested that CMS create a supply code for a urethral bulking agent sold in 2 mL vials, with a non-facility quantity of 1 priced at an average of $1,175 and incorporate this new supply into CPT code 51715 to appropriately value the service in the non-facility setting.

After consideration, CMS is proposing to create a new supply code (SD396) priced at $1,175 and add one unit to CPT code 51715 in the non-facility setting to reflect current clinical practice.

AUGS thanks CMS for considering this update and supports the proposal to create an appropriate supply code, which will help ensure proper reimbursement for this treatment in the office setting and preserve patient access to a clinically preferred site of care.

Thank you for the opportunity to provide comment for your consideration. If AUGS can provide CMS with additional information regarding these matters, please contact me at 301-273-0570, ext. 116 or email Stacey@augs.org.

Sincerely,

Stacey Barnes
AUGS CEO