ENDOCRINE SOCIETY
Hormone Science to Health

September 11, 2026

Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies: CMS-1848-P

Submitted via Regulations.gov.

Dear Administrator Oz,

On behalf of the Endocrine Society, thank you for the opportunity to submit these comments on the Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies proposed rule.

Founded in 1916, the Endocrine Society represents approximately 18,000 physicians and scientists engaged in the treatment and research of endocrine disorders, such as diabetes, hypertension, obesity, osteoporosis, endocrine cancers (i.e., thyroid, adrenal, ovarian, pancreatic, pituitary) and thyroid disease.

Our membership includes over 11,000 clinicians and many of the patients our members treat are Medicare beneficiaries. Access to endocrinologists and the care they provide is challenging for Medicare beneficiaries and other patients, particularly in rural and underserved areas, because of the ongoing and significant shortage of adult endocrinologists.[1] Wait times to see an endocrinologist can be many months long, delaying access to medically necessary care. Resolving this shortage is complicated by the fact that endocrinologists, despite their significant role caring for some of the most common health conditions impacting our population, e.g. diabetes and obesity, remain among the lowest compensated medical subspecialists and often work outside of clinic time due to the complexity of diagnosis and

[1]Romeo GR, Hirsch IB, Lash RW, Gabbay RA. Trends in the Endocrinology Fellowship Recruitment: Reasons for Concern and Possible Interventions. J Clin Endocrinol Metab. 2020 Jun 1;105(6):1701–6. doi: 10.1210/clinem/dgaa134. PMID: 32188983; PMCID: PMC7150610

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treatment of endocrine conditions. Recent data show **endocrinologists have the third lowest salary among physicians, below those of primary care groups including internal medicine and family medicine**.[2] Endocrinologists have not seen significant increases in Medicare payments in decades. Consequently, the payment policies proposed for the CY 2027 Medicare Physician Fee Schedule (MPFS) are significant to our members. We are extremely concerned that some of the agency's proposals will have detrimental effects on providers, the Medicare beneficiaries they treat, and will further threaten the pipeline of new trainees in the field.

With this background, we provide comments on the following topics discussed in the proposed rule.

- CY 2027 Conversion Factor
- Fine Needle Aspiration Services
- Revision of G2211 with Modifier MOD1
- Shared Medical Appointments
- Proposed Changes to Payments Using Modifier -25
- Reconsidering Relative Primary Care Payment in the Medicare Physician Fee Schedule

Conversion Factor for CY 2027

2027 marks the second year that there are two separate conversion factors: one for practitioners working in a qualifying advanced alternative payment model (APM) and the other for those not participating in a qualifying APM. The conversion factor for the former will be $33.17, a ***decrease*** of 1.19%, and the conversion factor for the latter will be $32.84, a ***decrease*** of 1.68%. The decreases reflect the expiration of the 2.5% adjustment to the 2026 conversion factor included in the One Big Beautiful Bill Act.

While congressional intervention is necessary to update the conversion factor, the proposed policies in this rule would unfortunately continue to exacerbate the continued downward pressure on physician reimbursement which has a direct impact on endocrinologists. The rule proposes to change the payment for same day services performed in the office setting and would also change the physician payment formula which includes the proposed removal of the indirect practice expense index. As you are aware, physician payment has been stagnant for nearly thirty years, with the current conversion factor set only a few dollars higher than it was 30 years ago. The MPFS conversion factor has not kept pace with inflation and continues

[2]McKenna, Jon. Comparing Your Pay Against Your Peers': Medscape Physician Compensation Report 2025. Medscape. Published: 2025 July 8. Retrieved from: https://www.medscape.com/slideshow/2025-compensation-overview-6018103#

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to be the only Medicare payment system that does not receive an annual update. The lack of annual updates coupled with payment policies that further reduce reimbursement creates an unsustainable situation for physician practices and threatens patient access to medically necessary services.

The administration has focused its attention on battling chronic diseases, including endocrine diseases and disorders like osteoporosis, obesity, and diabetes, through its Make America Healthy Again (MAHA) initiative. Access to endocrinologists and the care they provide are critical to the success of the Administration's goals to end the chronic disease epidemic. We request that you reconsider proposed policies that cut reimbursement, and we encourage the agency to work with Congress to develop solutions that provide certainty and stability to the MPFS. The Endocrine Society intends to continue its congressional advocacy to support a sustainable reimbursement system for MPFS services that includes regular positive updates to the conversion factor.

Valuation of Specific Services: Fine Needle Aspiration (CPT Codes 10005 and 10006)
The Centers for Medicare & Medicaid Services (CMS) proposes a new practice expense equipment item, ER130 ("Fine Needle Aspiration portable ultrasound"), with a proposed price of $83,750. The new equipment item will replace the existing portable ultrasound equipment (EQ250) in the practice expense inputs for CPT codes 10005 and 10006, while retaining the same equipment times recommended by the AMA Relative Value Scale Update Committee (RUC), 37 minutes for CPT 10005 and 17 minutes for CPT 10006. CMS accepted all other RUC recommended practice expense inputs associated with providing FNA services. CMS also proposes a RUC recommended work RVU of 1.35 for CPT code 10005 and 1.00 for 10006.

We thank the agency for this update to the practice expense inputs for fine needle aspiration services and for acceptance of the RUC recommended work RVUs. Members of our society participated in a multi-specialty society RUC survey to revalue these services, and this is an example of the process working as intended. The Endocrine Society and its partners were able to use the clinical expertise of their members to develop work values and practice expense inputs that reflect the actual value of the provision of FNA procedures. Prior to the resurvey, the FNA procedures were undervalued, and many beneficiaries were at risk of losing access to this service given the undervaluation. The collaborative effort between the medical specialty societies, the AMA RUC, and CMS ensures that Medicare beneficiaries have access to the care they need.

Revision of G2211 with Modifier MOD1

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The agency proposes to delete code G2211 (*Visit complexity inherent to evaluation and management associated with medical care services)* and replace it with a new modifier, MOD1. The modifier will have the exact same descriptor as G2211, and per the agency should be reported and billed in the same way as the G-code, except the new modifier is placed on the same claim-line as the CPT® code for the evaluation E/M service. Instead of a flat payment rate of approximately $17.00, CMS proposes to pay 16% of the total payment of the base E/M service. The revised payment rate for the services associated with new modifier will be higher for the higher-level E/M services than the flat payment rate, however the associated RVUs including a work RVU of .33 will no longer be applicable.

The Endocrine Society does not support this proposal, and we ask that the agency maintain G2211 to report services associated with complex, longitudinal care. The care provided by endocrinologists highlights the need for this service. Currently, the specialty of endocrinology comprises 3.3% of the total volume of G2211 provided to Medicare beneficiaries in 2024. In fact, Type 2 diabetes mellitus is the second most common diagnosis associated with this service, behind essential (primary) hypertension. The complex, longitudinal care associated with chronic disease management is key to maintaining the health of Medicare beneficiaries and is essential to the long-term viability of the Medicare program. Endocrinologists manage complex conditions, with varying degrees of comorbidities, and more appropriate payment for this care is provided by code G2211. The care our members provide keep patients out of the hospital, the emergency room, and other sites of care by appropriately managing endocrine specific diseases and decreasing health care cost.

We believe that a change to a modifier, replacing G2211, is premature and without merit. There is only one year of data associated with code G2211, and so utilization patterns, diagnoses, and specialty type have not yet been fully recognized. Typically, three years of data collection are needed to determine if a service and associated code is working as it should. The agency states that changing to a modifier will reduce administrative burden, and we disagree. Physicians have adapted to the documentation requirements, and the billing parameters of G2211. Understanding that this will not change, we see no reason to delete the code and move to a modifier. In fact, switching to a modifier will likely increase the administrative burden. Reeducation efforts will have to be undertaken, and physicians will again need to adjust their workflows. Additionally, practice administrators, payers, and other stakeholders will need to adjust how claims are filled out and make other administrative adjustments.

While we appreciate the increased payment rate that CMS proposed, our members would rather maintain code G2211 and the associated RVUs. The loss of associated work RVUs is problematic for many of our members. Many endocrinologists are employed by hospital

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systems, academic medical centers, and other entities. Under certain employment arrangements, physician compensation and bonuses are tied to meeting a work RVU target. Changing to a modifier to report the services associated with code G2211 eliminates the 0.33 work RVUs, and the physician will not accrue the work RVU when providing this service. Many endocrinologists report that their work RVU targets increase each year and losing the work RVU associated with G2211 will have detrimental effects. Additionally, work RVU targets are generally set by the Association of American Medical Colleges, and those targets are used by hospital systems to determine compensation and bonuses. The targets often reflect a three year running average. Therefore, any changes, including downward trends in the work RVU targets caused by the loss of the work RVUs associated with G2211 will not be reflected for at least three years. Changing G2211 to a modifier will have unintended consequences. Physicians will need to work more just to achieve the same wRVU targets, which is unsustainable, and threatens the future pipeline of endocrinology and other cognitive specialties. Given these factors, the Endocrine Society requests that CMS not finalize its proposal to replace G2211 with a modifier and instead maintain the payment rate and associated RVUs for G2211.

Shared Medical Appointments

CMS proposes to establish a new HCPCS code, GSMAS, beginning in CY 2027 to recognize and separately pay for Shared Medical Appointments (SMAs) under the MPFS. CMS states that shared medical appointments have become an increasingly common model for delivering care to patients with chronic conditions, but there is not a HCPCS or CPT code to describe these services. The proposed code is intended to report services furnished by a physician or other qualified health care professional in a group setting while still providing individualized E/M services to each patient.

The Endocrine Society generally supports the establishment of GSMAS to report services associated with SMAs. The specialty of endocrinology already uses care models like SMAs, and the associated team-based care is paramount to successful patient outcomes, particularly as it pertains to care for Medicare beneficiaries with diabetes.

We appreciate the agency's efforts to craft HCPCS codes to report additional types of SMAs; however, we recommend, that before proceeding with implementation of these services the agency provide clear documentation and reporting guidelines that may include the following:

- Group component
    - Date, duration of sessions, participants (number), educational content, group discussion topics, medical-decision making performed during the group portion, associated team members present, and interventions.
- Individual E/M service component

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- Reason for encounter, patient-specific assessment, data reviewed, medical-decision making, treatment changes, individualized plan, and follow-up.

Understanding the items and documentation elements that CMS will be looking for within the charts of each patient will be key to successful implementation and improve adoption of these types of services. Additionally, as noted above, we appreciate the agency's efforts to support group care; however, the practicalities of working these types of sessions into the physician's practice and workflow remain unclear. We recommend that the agency publish subregulatory guidance to ensure that physicians and other providers understand documentation requirements to support reporting these services.

Proposed Changes to Payments Using Modifier -25

CMS proposes to reduce payment when a separately identifiable office/outpatient evaluation and management (E/M) visit, as indicated by modifier -25, 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/procedure/E/M would be paid at 100% and all other procedure(s) furnished on the same day would be paid at 50%.

The Endocrine Society respectfully requests that the agency not implement this payment policy. This policy has no data to support it and essentially rests on CMS's belief "*that there are efficiencies when the same physician (or a physician in the same group practice) provides an E/M service for the same patient in conjunction with a procedure with a global period*." Additionally, the perceived duplication of resources that CMS believes exists is addressed through the very valuation processes on which CMS relies, including using the AMA RUC's Relativity Assessment Workgroup (RAW). One of the screening criteria relevant to this CMS proposal is codes reported together 75% of the time. This screen is meant to capture duplication of resources.

The RAW workgroup meets three times annually to address CPT and HCPCS codes that CMS deems to be overvalued. During this process**, codes nominated as potentially misvalued by CMS** are reviewed and studied by medical specialty societies who must then submit action plans to address the potential misvaluation. The action plans, which include action options such as resurvey, refer to the CPT Panel, or rereview in three years, are then adjudicated by the RAW. Medical specialty societies must then invest time and resources to follow through on the action plans to meet CMS requirements that any misvalued codes must be addressed.

We also note that RUC's survey and valuation methodology is specifically designed to exclude the physician work and practice expense overlap associated with separately identifiable E/M services reported with modifier -25. This process has been used for decades,

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and CMS has implicitly accepted this methodology by historically accepting more than 90% of the RUC recommended work, practice expense, and malpractice RVUs for inclusion in the MPFS. Yet, CMS now believes, quite arbitrarily and without empirical evidence, that the process does not work, and that any overlap in practice expense has not been considered during the RUC review process.

We believe that if the agency were to conduct a thorough analysis of the direct practice expense inputs associated with E/M services and same day procedures that this analysis would show that there is little if any overlap between practice inputs for E/M services and procedures. We argue that if there is practice expense overlap, it is very minimal, and certainly not 50%. We request CMS to demonstrate, at the code level, that the assumed amount of resource overlap exists for the services to which the policy would apply. Payment adjustments should be based on evidence of actual resource efficiencies rather than the assumption that services furnished on the same day necessarily require substantially fewer resources. CMS should not apply a uniform reduction based solely on the timing of when services are performed. The resources used are not necessarily duplicative simply because two or three or more services are performed at the same patient encounter.

A cut of this magnitude will have far-reaching consequences, particularly for the small, independent practices CMS has stated it wants to sustain and strengthen, making this proposal fundamentally inconsistent with that commitment. Small, independent practices bear the full costs of clinical staff, supplies, equipment, and other infrastructure. There are many instances when for both patient convenience and timely patient care, that procedures and E/M services are performed on the same day. For many patients, particularly in rural and underserved areas, the endocrinologist schedules a single visit to the clinic or office that includes several types of services, including E/M for follow up of a patient with diabetes who may also need a fine needle aspiration of a thyroid nodule. Scheduling appointments in this way eliminates the burden of return trips to the office. It also eases the burden for patients who must take time off from work and deal with the increased costs to see a physician. These burdens are particularly important for Medicare beneficiaries who may have limited mobility, rely on family members or public transportation, or travel substantial distances to obtain specialty care. Finally, it is unreasonable to expect a physician to send a patient home without performing a procedure that is clinically necessary. When services that are medically necessary and furnished during the same encounter, the encounter then reflects appropriate, patient-centered care and should not be presumed to involve duplicative resources.

Reconsidering Relative Primary Care Payment in the Medicare Physician Fee Schedule
CMS requests stakeholder feedback on how Medicare should modernize the payment and valuation of primary care services under the MPFS. The agency states that primary care is

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central to HHS's "Make America Healthy Again" (MAHA) priorities and emphasizes that current payment policies should better support preventive, high-value care while reducing long-term health care costs associated with chronic disease.

According to CMS, the current valuation of primary care services was established when care was primarily delivered through traditional office-based visits. The agency notes that advances in digital health technologies and artificial intelligence (AI) are changing how beneficiaries access medical information and how primary care clinicians deliver care. As a result, CMS is evaluating whether existing fee-for-service payment policies, including office/outpatient evaluation and management (E/M) visits, annual wellness visits, and care management services, continue to appropriately reflect the time, intensity, and value of primary care services.

Like primary care physicians, endocrinologists bill outpatient E/M services for the care they provide. The Endocrine Society has long advocated for improved payment for E/M services. The Resource-based Relative Value Scale (RBRVS) was created to determine relative values for medical procedures but has failed to appropriately value E/M services since its inception. In fact, we note that the primary developer of the RBRVS, Dr. William Hsiao stated that the development of the E/M portion of the MPFS was not adequately supported, and that more refinement was needed when the RBRVS was first launched.[3] This statement from Dr. Hsiao still holds true today despite recent efforts to redefine and revalue E/M services.

For many patients with endocrine specific diseases, the endocrinologist provides care that goes far beyond treatment and management for a single disease. For example, diabetes is a complex, chronic condition that requires continuous assessment and management across multiple body systems. Endocrinologists not only manage glycemic control, but also must consider and assess cardiovascular conditions, consider overall kidney health, manage medication, cancer screening and prevention, provide nutrition guidance, and help prevent diabetes-related complications. As a result, endocrinologists frequently assume responsibility for many of the functions traditionally associated with primary care, particularly for patients with complex or difficult-to-control diabetes. Patients with the most complex and difficult-to-manage diabetes are treated by endocrinologists. As a result, endocrinologists routinely care for this complex patient population whose clinical needs are not adequately captured by E/M codes. The current payment system fails to account for this reality, effectively requiring endocrinologists to do more work and manage greater clinical complexity without payment that reflects the care they provide. In some cases, patients may rely on their endocrinologist as their principal physician for ongoing management of their overall health because of the

[3] Hsiao, WC, Braun, P, Dunn DL et al. Med Care 1992;30 (11) Supplement: NS1-NS12.

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frequency and breadth of care required to manage their diabetes. Therefore, an endocrinologist must often manage multiple chronic conditions that are intricately linked with diabetes, such as hypertension, obesity, and other metabolic diseases. This longitudinal, comprehensive care requires physicians to understand the patient's overall health status and treatment goals rather than focusing solely on a single procedure, test, or organ system.

CMS also requests comment on the establishment of separate categories to help further refine office visit E/M services based on the purpose of the encounter. CMS has outlined three categories to describe the purpose of an E/M encounter:

- **Longitudinal care visits**, which involve an ongoing patient-clinician relationship and include care delivered during and between visits, such as chronic disease management, preventive care, and care coordination.
- **Acute care visits**, which focus on evaluating and treating a specific, short-term medical issue.
- **Consultative visits**, which are performed in response to a referral to address a specific clinical question and provide recommendations back to another practitioner.

A longitudinal care visit category may be particularly useful in describing the care provided by endocrinologists, where the physician-patient relationship often lasts many years. Endocrinologists care for patients with conditions such as diabetes, thyroid disorders, osteoporosis, and obesity. These chronic conditions frequently require repeated visits and continual modification of treatment based many factors including disease progression, comorbidity changes or progression, and changes in patient circumstances like living arrangements and access to transportation. The physician work involved in these visits is not limited to addressing a single complaint or condition at a particular point in time but instead reflects the physician's knowledge of the patient that has been accumulated over time which translates to a longitudinal relationship.

CMS should therefore consider a longitudinal care category that is broad enough to recognize specialty care that is relationship-based and involves ongoing medical management. For endocrinologists, a longitudinal care visit could help distinguish the ongoing management of a patient with a chronic endocrine condition from an episodic or acute care visit. This is particularly important for patients whose conditions require regular monitoring and medication adjustments. Recognizing this type of care would also acknowledge the role that endocrinologists have in providing longitudinal specialty care which often prevents complications, reduces unnecessary acute care, and improves a patient's long-term outcome.

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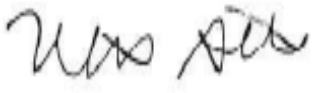
We described above the care often provided by endocrinologists to illustrate that improving "primary care" reimbursement should not be the sole focus of the agency, and instead the focus should be on improving reimbursement for E/M services for the primary care physicians and the specialists they rely upon. These services should be valued appropriately and accurately to reflect the true cognitive effort, time, and intensity of care delivered to Medicare beneficiaries.

Thank you again for the opportunity to provide comments on this proposed rule. We are committed to working with you on the development of these proposed policies. Should you have any questions or require additional information, please direct your correspondence to Rob Goldsmith, Director of Advocacy and Policy, at rgoldsmith@endocrine.org.

Sincerely,



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