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On behalf of the undersigned organizations representing a broad coalition of rheumatologists and rheumatology patients, we write to express our serious concern regarding the Centers for Medicare & Medicaid Services' (CMS) proposal in the Calendar Year (CY) 2027 Medicare Physician Fee Schedule (MPFS) to reduce payment when medically necessary, separately identifiable evaluation and management (E/M) services are furnished on the same day as procedures with 0-, 10-, or 90-day global periods. This policy will imperil patient access to rheumatic disease care and place an undue financial burden on already struggling independent rheumatology practices.

The cognitive work performed during these patient encounters extends far beyond deciding whether to perform an injection or other procedure. For a rheumatologist, a typical visit includes assessment of disease activity, review of laboratory studies for medication efficacy and toxicity, evaluation of imaging, medication reconciliation, discussion of treatment risks and benefits, adjustment of immunosuppressive or biologic therapy, coordination of ongoing care, and shared decision-making regarding long-term disease management. The procedure itself generally represents only a small portion of the total physician work performed during the visit.

Instead of allowing patients to receive comprehensive care during a single encounter, rheumatologists may be forced to schedule procedures on a separate day to preserve the financial viability of providing these services. This would increase inconvenience for Medicare beneficiaries, delay treatment, increase transportation and caregiver burdens, and likely increase overall Medicare spending through additional office visits and associated administrative costs, all without improving quality of care.

For many seniors with chronic conditions, particularly those living in rural communities, each additional visit means more time away from work or family caregivers, greater transportation challenges, and further barriers to accessing timely specialty care. Data demonstrates that rheumatic disease patients in rural areas are already less likely than urban counterparts to report office visits[1] and, as a result, are more likely to face delayed diagnoses.[2] Moreover, a service ratio of approximately one rheumatologist per 200,000

[1] Margaretten, M. E., Jinoos Yazdany, & Mandal, J. (2024). Rheum at the Table for Everyone: A Call to Expand Rheumatology Knowledge for Primary Care Providers. Arthritis & Rheumatology, 76(7), 993–995. https://doi.org/10.1002/art.42800
[2] Lennep, D. S., Crout, T., & Majithia, V. (2020). Rural health issues in rheumatology: A review. *Current Opinion in Rheumatology*, *32*(2), 119–125. https://doi.org/10.1097/BOR.0000000000000694

patients[3] means that patients are already experiencing wait times of weeks or months to see their physician. Asking chronically ill, medically complex patients to travel to two appointments will only lessen the likelihood that they will seek the care they need promptly.

We appreciate CMS's duty to ensure Medicare payments accurately reflect the resources required to provide care and to safeguard taxpayer dollars. However, a policy with this broad an impact should be supported by substantial empirical evidence demonstrating that current payment dramatically overstates physician work or practice expense. The CPT/RUC valuation process already reviews services that are frequently billed together and accounts for potential duplication in physician work, practice expense, and professional liability. When a separate E/M visit is reported with modifier -25, the work represented by that service is in fact distinct from the pre-service, intra-service, and post-service work. The current valuation process does separate and reduce any payments and discounts that apply to these services, making the proposal unnecessary for the goal of efficiency while posing a threat to patient access. We encourage CMS to continue working with physicians, specialty societies, MedPAC, and other stakeholders to evaluate this issue and develop evidence-based payment policies that reflect clinical practice while ensuring appropriate stewardship of Medicare resources.

Aimed Alliance
Alaska Rheumatology Alliance
Alliance for Patient Access
Arthritis Consultants, P.A.
Arthritis Foundation
Association of Women in Rheumatology
Center for Rheumatology, Immunology, and Arthritis
Coalition of State Rheumatology Organizations
Florida Society of Rheumatology
Infusion Access Foundation
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Nebraska Rheumatology Society
North Carolina Rheumatology Society
Ohio Association of Rheumatology
Rheumatology Alliance of Louisiana
Rheumatology Association of Minnesota and the Dakotas
Spondylitis Association of America
Tennessee Rheumatology Society
Virginia Rheumatology Society
West Virginia State Rheumatology Society

[3] Desilet, L. W., Pedro, S., Katz, P., & Michaud, K. (2023). Urban and rural patterns of health care utilization among people with rheumatoid arthritis and osteoarthritis in a large patient registry. *Arthritis Care &Amp; Research*. https://doi.org/10.1002/acr.25192