THE AMERICAN SOCIETY OF
Breast Surgeons

September 14, 2026

Mehmet Oz, MD, MBA
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1848-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted electronically via www.regulations.gov

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 Society of Breast Surgeons (ASBrS), we would like to thank you for the opportunity to comment on the calendar year (CY) 2027 Medicare Physician Fee Schedule proposed rule. ASBrS is the primary leadership organization for surgeons who treat patients with breast cancer and benign breast diseases. By providing education, accelerating innovation, supporting research, and promoting advocacy, ASBrS empowers breast surgeons and the clinical care team to optimize patient outcomes. Founded in 1995, the Society now has more than 4,000 members throughout the United States and in 50 countries around the world. Active membership is open to surgeons with a special interest in breast disease.

Payment & Other Provisions of the PFS Proposed Rule

CY 2027 MPFS Conversion Factor & Reimbursements

The Centers for Medicare and Medicaid Services (CMS) has proposed a CY 2027 Medicare Physician Fee Schedule (MPFS) conversion factor of $32.8409, a 1.68% decrease over CY 2026. While CMS has also proposed a $33.1693, or a 1.19% decrease, for qualifying Advanced Alternative Payment Model (APM) participants, there are remarkably few APM participation opportunities for surgeons and so we expect that most of our members will provide services under the $32.8409 (-1.68%) conversion factor.

While the CY 2026 conversion factor increased, the CY 2027 proposed decrease returns to the pattern of decline of the conversion factor under the MPFS and emphasizes the lack of stability in the Medicare program. Except for CY 2025, the MPFS conversion factor has decreased every year since CY 2020. This pressure is compounded by CMS decision last year to implement a so-called "efficiency adjustment"

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and all procedures performed by breast surgeons despite ASBrS providing detailed information to the Agency about how CMS' assumption that surgery always gets more faster and more "efficient" over time is simply not true for breast procedures. CY 2027's conversion factor continues to be affected by the significant changes in the values of the office and outpatient evaluation and management (E/M) code set implemented in CY 2021. Since then, if finalized for CY 2027 as proposed, the conversion factor will have decreased by 9.0 percent. This has created an unstable environment for reimbursements for services provided to Medicare patients, including for surgeons who care for patients with breast cancer. Worse, these numbers do not take into account the 2% sequestration that applies to Medicare payments since 2012 due to the *Budget Control Act of 2011* (and subsequent Congressional extensions of that sequestration).

ASBrS understands that avoiding the consequences of many of these provisions requires Congressional action. Therefore, ***ASBrS asks that CMS work with Congress to enact legislation that would avoid these cuts to payments for services provided to Medicare beneficiaries by creating an annual inflationary update for services provided under the Medicare Physician Fee Schedule***. While the Agency and Congress have instituted methodologies for nearly every other Medicare payment system that include annual update mechanisms that generate positive payment updates and take into account medical inflation, the Agency and Congress have allowed the payment system that reimburses the direct provision of care to Medicare beneficiaries by their physicians to become a fixed pie leaving physicians in an adversarial competition for resources and, worse yet, to be used as a funding mechanism by reducing Medicare physician payments to pay for spending in other parts of the federal budget. This must stop. It is critical that CMS and Congress work together to ensure stability in the Medicare program for beneficiaries and the health care system overall.

ASBrS requests that CMS begin to consider steps that can be taken to create longer term stability in the Medicare Physician Fee Schedule. Now, several years after the passage of the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA), the numerous alternative payment models (APMs) that were a primary goal of the legislation have not materialized, particularly for surgeons and specialists. Without available APMs in which to participate, physicians are left to participate in the Merit-Based Incentive Payment System (MIPS), which has few relevant measures for many specialties, including ours, and has not met its goals of serving as an adequate payment update system that provides incentives to measurably improve quality. As we discuss in more detail below, CMS trying to achieve this by relying on the problematic MIPS Value Pathways (MVP) mechanism is, quite simply, insufficient.

Physicians are under the constant threat of reimbursement cuts while the cost of providing care and complexity of patients increases. As stated in the most recent Medicare Trustees Report,

> *If the health sector cannot transition to more efficient care delivery and if the provider reimbursement rates paid by commercial insurers continue to be based on the same negotiated process, then the availability, particularly with respect to physician services, and quality of health care received by Medicare beneficiaries will, under current law, fall over time compared to that received by those with private health insurance.*[1]

We are also concerned that allowing this to continue will exacerbate health care disparities and inequities. Population-based breast cancer mortality rates are higher among African American women and

[1] 2026 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, p. 3, https://www.cms.gov/oact/tr/2026, (June 9, 2026).

population-based incidence rates of triple-negative breast cancer are two-fold higher among African American women.[2] As shared by Susan G. Komen, breast cancer is the leading cause of cancer death in Black women and Black women are about 34% more likely to die of breast cancer than white women and have a lower 5-year relative breast cancer survival rate compared to white women.[3] Ensuring that the U.S. health care system is providing services to patients and creating better access to screening, diagnosis, and treatment for patients is all dependent on a properly financed system. We hope that CMS will consider this as it devises future policies and work with Congress where it believes it needs additional authorities.

Medicare's ability to secure medically necessary access to care for every Medicare beneficiary is paramount. The financial pressures through both statute and from actions taken by CMS will continue to make it more difficult to ensure that Medicare beneficiaries have the access to care that they deserve. This is not just the opinion of ASBrS members, but of the Medicare Trustees:

> *Over time, unless providers could alter their use of inputs to reduce their cost per service correspondingly, Medicare's payments for health services would fall increasingly below providers' costs. Providers could not sustain continuing negative margins and would have to withdraw from serving Medicare beneficiaries or (if total facility margins remained positive) shift substantial portions of Medicare costs to their non-Medicare, non-Medicaid payers.*[4]

While ASBrS acknowledges that some of the corrective action needed to address the Trustees' concerns are in the domain of Congress, ASBrS asks that CMS consider our comments below on its CY 2027 proposals in this context.

Updates to Practice Expense (PE) Methodology – Site of Service Payment Differential

Citing concerns about the evolution of practice structures and employment trends by the health systems where facility-based services are delivered, in CY 2026 CMS finalized a policy to shift PE RVUs from services that are delivered in the hospital or ASC to services that are delivered in the non-facility or office setting. Specifically, CMS cut PE RVUs that are derivative of work RVUs by 50%.

While CMS cited concerns that Medicare is overpaying for indirect/overhead expenses when a physician is employed by the hospital where they perform the service, the methodology for the PE realignment cut payment for essentially all procedures performed in the hospital or ASC setting (regardless of employment status) and increased payments for essentially any service that is provided in the office setting (regardless of employment status) by using the "facility" place-of-service as a proxy for employment and/or a lack of office-based practice behind the physician delivering services in the facility setting.

In this year's rule, CMS acknowledged criticism of its policy from last year's rulemaking cycle. While CMS did not propose any changes to the policy, CMS requested input about what was finalized in CY 2026, including requests for information on how to more narrowly tailor the policy. ***ASBrS continues to oppose CMS CY 2026 policy which reduced facility indirect PE RVUs due to the fact that the policy is***

[2] The American Society of Breast Surgeons (ASBrS), Position Statement on Screening Mammography, https://www.breastsurgeons.org/docs/statements/Position-Statement-on-Screening-Mammography.pdf.
[3] https://www.komen.org/breast-cancer/facts-statistics/breast-cancer-statistics/ (accessed August 28, 2026).
[4] 2026 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, p. 198, https://www.cms.gov/oact/tr/2026, (June 9, 2026).

overbroad, fails to achieve CMS' stated goals, lacks a quantitative rationale for the reduction amount, and undermines that accuracy and integrity of the Medicare Physician Fee Schedule.

CMS made a false proxy between service delivery in the facility setting and hospital employment status and/or lack of office-based practice

ASBrS recognizes that the practice of medicine is constantly changing and delivery models evolve over time. However, to execute a cut in reimbursement to all services delivered in the facility setting because CMS believes the percentage of hospital-employed physicians has increased or because physicians who furnish services in the facility setting offer no office-based services is an irrational connection. CMS has severely cut practice expense reimbursements to breast surgeons in independent practice, who continue to struggle to maintain those practices as Medicare continues to generally cut physician payments. Likewise, because of CMS' practice expense budget neutrality policy, CMS significantly increased practice expense reimbursements to physicians who are employed by hospitals and health systems but that offer office-based services. The policy quite simply continues to be irrational in its application.

ASBrS again urges CMS to review its assumptions and proposals in light of states that maintain laws and/or regulations against the Corporate Practice of Medicine. In California, Colorado, and North Dakota, to name only a few, where direct physician employment by hospitals is constrained by Corporate Practice of Medicine restrictions, CMS still cut reimbursements to all services delivered in the facility setting even though it is patently obvious that CMS' facility/employment proxy cannot be true in most situations. ***Because of this incongruity, in the CY 2027 final rule, ASBrS urges CMS to restore the indirect facility PE work-derived RVUs that it reduced by 50% in CY 2026.***

CMS makes general financial assumptions about hospital-employed physicians that are not generally applicable

Inherent in CMS' rationale for its policy to reduce indirect facility PE RVUs is an assumption that the incremental indirect costs that a hospital or health system incurs when it employs a physician are fundamentally less than the indirect costs of an independent practice but provides no basis or data for this argument. At its core, this discussion is one of the relative indirect costs that are associated with the delivery of care by physicians. Indirect costs like coding, billing, scheduling exist for each and every professional service delivered by a physician. Even if a hospital employs a physician, the billing entity for those physicians continue to carry all of those incremental indirect costs. The hospital still incurs administrative costs on a per case basis for billing and coding. CMS also fails to recognize that the administrative overhead for insurance authorization on a per case basis continues to increase. This is no longer just applicable to commercial insurance. CMS has reduced the practice expense for these functions that are incremental to each professional service that is delivered regardless of the billing entity, while at the same time creating additional burdensome prior authorization of its own under the WISeR Model[5] as well as the burden and cost of complying with CMS' MIPS reporting requirements. We are concerned that CMS fails to appreciate the true nature of indirect costs that are associated with billing and quality reporting requirements because none of these costs just evaporates when a physician becomes employed by a facility.

In addition, CMS needs look at our members who have dedicated their careers to treating patients with breast cancer to know that CMS' assumption that if a service is delivered in the facility setting, then there is no office-based practice behind those procedures is objectively false. Breast surgeons provide significant time and care to patients in our offices. To cut payments for breast surgery under the

[5] https://www.cms.gov/priorities/innovation/innovation-models/wiser.

assumption that there is no office-based care associated with the procedures is unacceptable for our members.

For these reasons, ***ASBrS urges CMS to take the following actions:***

- ***ASBrS urges CMS to rescind its policy that reduced work-derived facility PE RVUs by 50%***
- ***ASBrS urges CMS to collect reliable, researched data to identify whether there are actual differential indirect costs incurred by the delivery of a service by a physician who is hospital-employed and those incurred by the delivery of a service by physician who is in independent practice and quantify them based on reliable, verifiable data***
- If CMS pursues a new policy in the future, ***ASBrS urges that CMS apply the policy more directly to the providers it believes have lower indirect costs by either:***
    - ***Developing a data-driven PE adjustment factor that would be applied similarly to GPCI adjustments (rather than distorting the entire PE allocation of the PFS as it does under the current proposal) for employed physicians (which could be triggered by appending an "employed" modifier to a code on a claim); or***
    - ***The development of a new PE column in the fee schedule that would be data-driven and calibrated to reflect the PE of employed physicians (who could by identified by appending a modifier to reflect the employment status of the physician).***

Updates to Practice Expense (PE) Methodology – IPCI & PE Stabilization Factor

Elimination of the Indirect Practice Cost Index (IPCI)

For several years now, CMS has utilized the 2007 PE/HR survey data to "allocate indirect costs to each code and to re-scale the resulting PE RVUs for each code at the end of the established methodology to ensure that the overall allocation of PE RVUs for each specialty across the PFS approximates those expected based on the index derived from the PE/HR survey data." In this year's rule, CMS expresses concern that this approach "privileges the historic survey data over incorporation of more recent data" and favors "the aggregate specialty-level survey data over the code level inputs and allocators. In order to de-emphasize these factors in the PE methodology, CMS proposes to eliminate steps 12 through 17 of the current PE methodology prior to calculation of the final PE RVUs, which would eliminate the indirect practice cost index (IPCI) from the calculation of PE RVUs.

ASBrS appreciates CMS' concern about the use of data that may appear to be outdated. However, we are concerned that walking away from that data does not necessarily yield more accurate PE values for the services. This is compounded by the lack of detail and transparency in the long term PE calculation effects for each service if this were to be implemented. Therefore, ***ASBrS recommends that CMS delay implementation of the elimination of the IPCI until it can better articulate how its removal results in a more accurate reflection of relative practice expense between MPFS services and until it produces a file that shows the changes in PE RVUs by year throughout the transition to ensure that stakeholders can review more transparent data to be able to comment on whether the new methodology truly produces more accurate PE RVU distribution.***

Introduction of the PE Stabilization Factor

CMS makes that observation that the IPCI proposed for elimination coincidentally provided some protection from large fluctuations in the distribution of PE RVUs because of the IPCI's reliance static PE/HR data. To provide more steadiness in the distribution of PE RVUs each year without the stabilizing effect of the IPCI, CMS proposes a "PE stabilization factor" by comparing the calculation of total PE RVUs for a service in a given calendar year to the results from the prior year, and the PE RVUs for the

service in the given calendar year "will be subject to a cap and will not increase or decrease by more than 5 percent each year." However, CMS proposes exceptions to the PE stabilization factor for:

- New and revised codes
- Formerly contractor priced codes that transition to nationally priced
- Revalued codes

Regarding the exceptions, CMS also seeks comment on how it might apply the stabilization factor to new and revised codes/formerly contractor priced codes. ***If CMS finalizes its proposal to eliminate the IPCI, ASBrS supports the implementation of a PE stabilization factor of +/-5%.*** However, explicit in this policy is CMS' agreement that a change of 5% (up or down) can cause a significant disruption in payments under the fee schedule. Therefore, ***ASBrS urges that CMS remove the exceptions from the PE stabilization factor to ensure that MPFS policies support stability for Medicare patients and the physicians that serve them rather than act as a huge blind spot that practices must brace for as the MPFS continues to serve up wild swings in reimbursement from year to year.***

Improving the Accuracy of Global Surgery Valuation

Data Collection on Resources Used in Furnishing Global Services

After the passage of the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA), CMS embarked on a data collection effort by requiring the reporting no-pay code CPT 99024 when a post-operative visit was furnished in the context of a 10- or 90-day global surgical service.[6] This has been required only for physicians in Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon, and Rhode Island and only after they have delivered one of the services on the list, which CMS appears to have been last updated in 2025.[7]

In this year's proposed rule, CMS proposes to end the CPT 99024 data collection requirement. ***ASBrS supports CMS' proposal to rescind the CPT 99024 reporting requirement as the effort has delivered no valuable information for purposes of providing a relative valuation of MPFS services, partially due to the fact that few practice are aware of the requirement, confusion about the frequency with which the code should be reported, and because, as a no-pay code, some billing systems reject its submission. For those practices that are aware of it, ASBrS also believes that CMS has placed an undue administrative burden on physicians in Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon, and Rhode Island since 2017.***

Comment Request on 10- and 90-Day Global "Imputed RVU" Public Use File

CMS stated that it is "posting a public use file with this proposed rule to display the imputed RVUs associated with both the 10- and 90-day post-operative visits based on a purely arithmetic approach to understand the valuation of the services based on the data that was analyzed. This public use file shows the current work RVUs, the number of post-operative visits that are reported to CMS using no-pay HCPCS code 99024, and the work RVUs remaining if all postoperative visits are removed."[8] ***ASBrS is concerned that CMS would post a file suggesting the devaluation of breast surgery based on the CPT 99024 data collection requirement discussed above about which the U.S. Department of Health and Human Services Office of Inspector General (HHS OIG) stated,***

[6] https://www.cms.gov/medicare/payment/fee-schedules/physician/global-surgery-data-collection
[7] https://www.cms.gov/files/zip/global-reporting-list-2025.zip
[8] https://www.cms.gov/files/zip/cy-2027-pfs-proposed-rule-global-surgical-services-visit-summary.zip

> *For 45 of 105 sampled global surgeries, a total of 98 postoperative visits were not accurately reported to CMS. Based on our sample results, we estimated that for 47,421 of the 110,650 global surgeries in our sampling frame, there was a difference of 103,273 postoperative visits between the number of visits reported and the number of visits provided. This occurred because practitioners were unfamiliar with CMS's data collection requirements, or their billing systems were not designed to always submit CPT code 99024 on claims to CMS.* (citations omitted).[9]

The finding that after medical record reviews that CMS' CPT 99024 data collection effort severely undercounted the actual number of post-operative visits performed led the HHS OIG to explicitly state in the report, "Postoperative visit data CMS gathered for 45 of 105 sampled global surgeries were ***inaccurate and cannot assist in improving global surgery valuation as Congress intended***" (Emphasis added).

CMS nonetheless chose to post a file suggesting based CPT 99024 reporting that breast surgeons only deliver a single post-operative visit to a patient after receiving a partial mastectomy (CPT 19301), and based on this, it could impute a potential reduction of work RVUs of over 21%. Likewise for CPT 19303 (Mast simple complete) and CPT 19307 (Mast mod rad) with two "observed" post-op visits each where CMS imputes a potential wRVU reduction of over 11% for CPT 19303 and a reduction of between 13% and 15% for CPT 19307. CMS and the CPT 99024 reporting fail to somehow recognize the amount of physician work that has resulted due the evolution of mastectomy from the inpatient setting to the outpatient setting. Due to the healthcare shock of the Covid-19 pandemic, outpatient mastectomy rates increased from reported 11% in 2019 to stabilizing around 80% post pandemic.[10] This shift has proven safe and cost effective, but shifts the workload of care from the hospital to the clinic staff. These patients require closer early oversight, and transitioning to home recovery can result in a higher frequency of early, scheduled post-op check-ins or minor unplanned clinic visits for reassurance, pain adjustments, or minor fluid collections. At face value, it simply does not make sense that there are these few "observed" post-op visits after mastectomy.

Given the HHS OIG findings on the inaccuracy of the CPT 99024 data, we are extremely concerned as to why CMS would publicly post a file with data of this little value. ***ASBrS opposes the use of any CPT 99024 "data" for any ratesetting efforts because of the findings of the HHS OIG.***

We would also note that, ***ASBrS continues to believe that CMS has distorted the integrity of the relativity of the MPFS by (a) failing to provide commensurate increases to the global surgical packages based on the 2021 re-valuation of the office and outpatient E/M codes sets; and (b) by now implementing an unscientific, unsupportable "efficiency adjustment" to work RVUs.*** ASBrS and our members have always supported the accuracy of valuation of services in the PFS and will continue to do so. ***But CMS' own actions to apply across-the-board devaluations to global surgical packages in CY 2021 and in CY 2026 with the introduction of the so-called "efficiency adjustment" (scheduled to return in 2029) have rendered CMS' time and work files to be an inaccurate data source for determining global surgical values***.

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[9] https://oig.hhs.gov/documents/audit/10428/A-05-20-00021.pdf.

[10] (Zeelst, L. & Derksen, R. & Wijers, C. & Hegeman, Judith & Berry, R. & Wilt, J. & Strobbe, Luc. (2022). The Quest for Outpatient Mastectomy in COVID-19 Era: Barriers and Facilitators. The Breast Journal. 2022. 1-6. 10.1155/2022/1863519.)

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Modifier ~25 Payment Reduction

CMS reviewed Modifier ~25, which is appended to E/M codes to signify that the E/M code is "significant and separately identifiable from the procedure" that is billed on the same day as the E/M. CMS expresses concern about "overlap and duplication of payment between the E/M service already paid for during the global surgical package, and any additional E/M services billed for through the use of Modifier ~25 as significant and separately identifiable." Citing previously established CMS policies intended to reduce payments where it believes there is duplication of payment when several services are performed close in time, CMS proposes that, when a separately identifiable office and outpatient E/M is furnished by the same physician (or physician in same group practice) on the same day as a 0-, 10-, or 90-day global procedure, CMS will pay 100% for the most expensive service billed and reduce payment by 50% for all other services. ***ASBrS opposes CMS' proposal to reduce payments when a service is delivered on the same day as a significant and separately identifiable E/M as well as the percentage amount of the proposed CMS decrease due to the fact that CMS fails to provide data to support its proposal and ignores steps already taken to identify and remove duplication.***

In proposing a 50% reduction to everything but the most expensive service when a significant, separately identifiable E/M is billed on the same day as 0-, 10-, and 90-day global, CMS provides no reasonable justification for either the policy or the percentage reduction. CMS' actual rationale cites "**likely** overlap and duplication of payment. This is not the data driven rationale that CMS demands of other services throughout MPFS valuations nor does it provide a legitimate rationale for a 50% reduction in reimbursement for a service. This level of reduction becomes even more unjustifiable when CMS applies it to the reimbursement of a 10- and 90-day global where a 50% reduction would no doubt cut into the reimbursement of the post-operative care that are provided on a separate day from the delivery of the E/M to which Modifier ~25 is applied so it is *impossible* that there is same day duplication for a portion of the work valued in the 10- and 90-day global codes. For this reasons, ***ASBrS urges CMS to withdraw its Modifier ~25 proposal in full.***

Billing Mechanism for Inherent Complexity: Modifier MOD1

After several years of activity, CMS is revisiting its billing policy for office and outpatient E/M "inherent complexity" add-on code G2211 (*Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (Add-on code, list separately in addition to home or residence or office/outpatient evaluation and management service, new or established.)*). CMS proposes to convert G2211 from an office and outpatient E/M add on code to an office and outpatient E/M *modifier* (placeholder MOD1) described as "*Visit complexity inherent to new or established office/outpatient or home or residence evaluation and management service, associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition.*" ***ASBrS supports CMS' proposal to convert G2211 to a modifier because we agree with the CMS argument that the flat payment amount for G2211 does not reflect the variation in work across the different office and outpatient E/M visit levels***. ASBrS is however concerned with CMS' approach to valuing the payment adjustment. CMS proposes to value use of the modifier at +16% because it believes that this would result in a budget neutral shift of dollars in moving the identification of the service from a HCPCS add-on code to modifier. This rationale in no way contemplates the actual resources required to deliver the work described by MOD1. ***ASBrS requests that CMS hold itself to the standard it espouses for other services in the MPFS and develop a MOD1 payment adjustment amount that is based on actual time and resource consumption data.***

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Valuation of Specific Codes: Fine Needle Aspiration (CPT 10005 & CPT 10006)

In CY 2025, both of the follow codes were nominated as Potentially Misvalued Codes:

- **CPT 10005** (*Fine needle aspiration biopsy, including ultrasound guidance; first lesion*)
- **CPT 10006** (*Fine needle aspiration biopsy, including ultrasound guidance; each additional lesion*)

CMS did not add the codes to the Potentially Misvalued Codes list for CY 2026 but noted that the AMA RUC intended to review the codes, which subsequently occurred in early 2026.

In this year's rule, CMS proposes to accept the RUC work RVU recommendations for each code (CPT 10005: 1.35 work RVUs; CPT 10006: 1.00 work RVU). CMS made a modification to the direct PE input with a more specific equipment item described as a "Fine Needle Aspiration portable ultrasound" (ER130). ***ASBrS supports the CMS proposed CY 2027 values and direct PE inputs for CPT 10005 and CPT 10006.***

CPT Request for Information

CMS seeks comment from stakeholders on the role and utilization of CPT as the national coding standard for submitting claims for reimbursement for physician services. While ASBrS always believes in continuous process improvement and increased transparency, ***ASBrS is supportive of the continued use of CPT as the national coding standard for physician services and believes selecting a different coding system would create unprecedented administrative disruption at a time when physician practices are under constant pressure from decreasing Medicare payment rates, increasing inflationary costs of delivering care, and rapidly moving technological developments that require resources and capacity to integrate into clinical practice.***

We also believe it is important for CMS to distinguish the role of CPT in providing a national nomenclature standard to describe furnished physician services from the role of the RUC in providing only recommendations on valuation of physician services that CMS retains the sole authority to adopt, reject, modify, or ignore. We believe the RUC has provided a valuable, informed role in providing this recommendations which is evidenced by the frequency with which CMS agrees with or only slightly modifies their recommendations. Regardless, the roles of CPT and RUC must be distinguished because maintenance of CPT as the national physician coding standard does not provide any obstacle to improving the valuation of services under the MPFS via RUC recommendations or otherwise.

Finally, HHS and CMS have criticized the amount of funding that is expended on operation and maintenance of CPT. ASBrS is supportive of efforts to reduce costs associated with the health care system- from prevention to efficient diagnostics to the delivery of treatments to the claims processing system. However, many of the costs that are involved with the development and maintenance of CPT are of no cost to the federal government or the Medicare Trust Fund. We are concerned that an effort to replace CPT with a government run nomenclature development system will only replace the current costs in the overall health care system, add to those costs given the change required to develop the new system, and transfer the costs currently carried by CPT and supporting stakeholders to the federal government and taxpayer funds.

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Quality Payment Program (QPP)

Sunsetting Traditional MIPS and Transitioning to MVPs

CMS proposes to end traditional Merit-based Incentive Payment System (MIPS) reporting after the 2028 performance period**.** Starting with the CY 2029 performance period, MIPS Value Pathways (MVPs) would become the required reporting option for clinicians not participating in an Alternative Payment Model (APM). ***The ASBrS opposes this proposal and urges CMS to maintain flexible reporting options for MIPS eligible clinicians, particularly those in specialties with few relevant measures.*** With the recent retirement of measure #264: *Sentinel Lymph Node Biopsy for Invasive Breast Cancer*, breast surgeons no longer have any breast surgery-specific measures in the program-- neither in traditional MIPS or in MVPs. The Surgical Care MVP proposed for 2027 still includes the *Lumpectomy, Partial Mastectomy, Simple Mastectomy* cost measure, but includes no breast surgery-specific quality measures, which means that breast surgeons would have to select from the general surgery, advancing health/wellness, or experience of care measures in the MVP.

While the reporting options for breast surgeons are limited regardless of participation pathway, transitioning to mandatory MVPs will further exacerbate this issue since participants may only select measures from their selected MVP and not the broader MIPS measure inventory. ***We request that CMS consider delaying mandatory MVP reporting until all specialties have an adequate set of relevant and meaningful measures in the program.***

ASBrS also urges CMS to partner with interested stakeholders to invest in the development of breast surgery measures to fill existing measure gaps, similar to the ongoing work it is doing through the Gordon and Betty Moore Foundation's Diagnostic Excellence Initiative to develop a set of clinical quality and cost measures related to breast cancer screening and diagnosis.

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ASBrS appreciates the opportunity to provide comments on the CY 2027 MPFS proposed rule. If you have questions or if ASBrS can ever be of assistance, particularly on any breast cancer and patient education efforts, please do not hesitate to reach out to Sharon Grutman, Director of Advocacy, Communications, and Quality Initiatives, at sgrutman@breastsurgeons.org.

Sincerely,

Eric Manahan, MD, MBA, FASBrS

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