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The Honorable Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1834-P
P.O. Box 8010
Baltimore, MD 21244-8010.

Submitted online via www.regulatons.gov

RE: File Code CMS-1832-P Calendar Year (CY) 2026 Medicare Physician Fee Schedule (PFS) Proposed Rule

Dear Administrator Dr. Oz:

The American Association of Oral and Maxillofacial Surgeons (AAOMS) representing more than 9,000 oral and maxillofacial surgeons (OMSs) across the United States, appreciates the opportunity to comment on the proposed CY 2026 Medicare Physician Fee Schedule.

We commend CMS for proposing an increase to the Conversion Factor for both Qualifying Participants (QPs) and non-QPs. The inclusion of the 2.5% increase from the One Big Beautiful Bill Act (OBBBA) reflects a meaningful step toward stabilizing physician reimbursement and addressing longstanding concerns about payment adequacy. As signatories to the coalition letter supporting this provision, we are pleased to see CMS recognize and implement this statutory adjustment.

Quality Payment Program, Advanced Payment Models, and MVPs

While we fully support the overall increase in the Conversion Factor, we remain deeply concerned about the challenges providers face in qualifying for Advanced Alternative Payment Models (APMs) under the Quality Payment Program (QPP). The QPP continues to evolve with shifting benchmarks and reporting requirements that are often unclear and administratively burdensome. Our members continue to express significant concerns regarding the administrative complexity and burden associated with complying with QPP requirements, particularly within the Merit-based Incentive Payment System (MIPS) and APMs.

We also have concerns with the MIPS Value Pathways (MVPs) in which CMS plans to roll out with the 2028 performance year. The current MVP framework may not adequately reflect the scope of services provided by oral and maxillofacial surgeons (OMSs). Specifically, the requirement that clinicians or groups select an MVP aligned with their clinical scope and report on defined quality, cost, and improvement activity measures presents several challenges for the OMS specialty. For instance, the

measures included in existing MVPs do not correspond to the procedures and patients typically managed by our specialty. As a result, participation could yield artificially low performance scores due to irrelevant or inapplicable metrics, undermining the intent of value-based care. The requirement to form subgroups for MVP participation adds significant complexity, particularly for small and solo OMS practices. The infrastructure needed to support subgroup formation and reporting may be cost-prohibitive and operationally burdensome.

Although the goals of MIPS, APMs, and MVPs are well-intentioned, the reality for many practices is that the programs remain overly complicated, resource-intensive, and difficult to navigate.

Many practices lack the certified technology, technology with FHIR capabilities; and/or financial resources to continuously upgrade EHR systems to meet these demands. Staff shortages across the healthcare industry have only exacerbated these challenges. In many cases, practices do not have the personnel to manage MIPS/APM participation tasks such as data collection, performance tracking, and reporting. In smaller or rural practices, these responsibilities often fall to clinical staff who are already stretched thin—diverting time and attention away from direct patient care. Even understanding the nuances of MIPS scoring, category weighting, and measure selection requires expertise that many practices cannot afford to maintain in-house. These challenges—combined with the threat of financial penalties—discourage participation, despite clinicians' commitment to value-based care, ultimately undermining the intent of the program.

We urge CMS to consider eliminating or at a minimum, significantly streamlining MIPS, APM, and MVP requirements. We recommend expanding technical support and educational resources and offer greater flexibility for practices facing staffing and infrastructure constraints. Simplifying the program and reducing the reporting burden would go a long way in helping providers meaningfully engage with QPP and focus on what matters most—caring for their patients.

Efficiency Adjustment

We appreciate CMS's efforts to improve the accuracy and transparency of service valuation under the Medicare Physician Fee Schedule (PFS). However, we strongly oppose the proposed -2.5% efficiency adjustment to work RVUs and intra-service times for non-time-based services and urge CMS to reconsider this approach.

The proposed adjustment is arbitrary and lacks sufficient granularity. Applying a blanket 2.5% reduction across 8,961 codes—as estimated by the AMA—would result in a 1% overall payment cut, disproportionately affecting procedural and diagnostic specialties such as oral and maxillofacial surgery. The proposal assumes uniform efficiency gains across all non-time-based services, disregarding clinical complexity, patient acuity, and increasing documentation burdens. It also overlooks the fact that many codes have recently been valued and validated by the RUC and CMS. Efficiency gains are not evenly distributed and should not be treated as such.

CMS critiques the AMA RUC process for limited annual code review, yet it simultaneously proposes a sweeping adjustment every three years without individualized reassessment. This could introduce volatility and administrative burden for practices, especially small and independent practices. Despite its limitations, RUC survey data reflects real-world physician experience and clinical judgment. Discarding this input in favor of purely empirical data risks marginalizing the expertise of practicing clinicians in valuation decisions. Lower reimbursement may exacerbate financial strain on small, rural, and independent practices, accelerating consolidation and reducing patient access to care.

While CMS proposes using time-motion studies, EHR data, and administrative datasets, these sources may not be standardized, scalable, or representative across all specialties and practice settings. The Urban Institute pilot study cited by CMS, observed only sixty services, many of which were limited to E&M, imaging, and select procedures. Notably, oral and maxillofacial surgery procedures were not included, nor were procedures similarly performed by ENT and/or plastic surgery. Furthermore, the study's observations were conducted in three large health system sites located in New England, the Middle Atlantic, and the Pacific regions. These multispecialty group practices embedded within larger health systems do not reflect the workflows of rural, solo, or independent practices. The study focused heavily on intra-service time, while critics argue that pre-service and post-service activities were inadequately captured or standardized.

Adjusting payment based on limited and non-representative data could shift resources away from procedural specialties, leading to reduced access and compromised care delivery.

We urge CMS to refrain from implementing blanket efficiency adjustment without robust, representative, and specialty-specific data. We encourage CMS to collaborate with specialty societies to refine time valuation methodologies; preserve the role of physician input in service valuation; and ensure that any future adjustments are transparent, equitable, and reflective of the diverse realities of medical practice.

E/M Visit Complexity Add-On Code (HCPCS code G2211)

We appreciate CMS's continued efforts to refine the Medicare Physician Fee Schedule and recognize the importance of appropriately valuing Evaluation and Management (E/M) services. However, we are concerned about the agency's handling of HCPCS code G2211.

We oppose CMS's decision not to revise its 2026 payment rates to correct the prior overestimation of G2211 utilization. This oversight disregards repeated guidance from the AMA and other stakeholders who have demonstrated that the inflated projections contributed to significant payment reductions in 2024 due to budget neutrality constraints. Failing to adjust this error risks perpetuating distortions in the budget impact and undermines the integrity of the fee schedule. Budget neutrality should be based on accurate and current data. Continuing to rely on flawed assumptions penalizes physicians and destabilizes reimbursement across the board. **We urge CMS to revisit and revise the utilization assumptions for G2211 to reflect actual billing patterns**.

Practice Expense Methodology Overhaul

We appreciate CMS's commitment to modernizing the practice expense (PE) methodology within the Medicare Physician Fee Schedule (MPFS). However, we have significant concerns about the direction and assumptions underlying the proposed changes, particularly regarding the treatment of facility-based services and the rejection of physician-reported data.

We are disappointed that CMS has chosen not to incorporate the AMA's PPI survey data into its PE methodology. While CMS cites concerns about low response rates, this decision overlooks the value of physician-reported data and risks replacing it with less representative or unvalidated sources. The low response rate may itself reflect broader systemic issues, including staffing issues, documentation burdens, and growing dissatisfaction with Medicare reimbursement trends. The AMA's survey offers critical insights into real-world practice costs, including indirect expenses that are not easily captured through administrative datasets.

We also strongly oppose CMS's proposed reduction in indirect PE relative value units (RVUs) for services provided in the facility setting. The proposed adjustment is arbitrary and lacks a clear, evidence-based rationale. By reducing the portion of facility PE RVUs allocated based on work RVUs to half the amount used for non-facility PE RVUs, CMS introduces a highly technical mechanism that fails to reflect the actual costs associated with providing care in facility environments.

Indirect expenses in these settings—such as administrative support, compliance infrastructure, and coordination of care—remain substantial and unavoidable. The assumption that all physicians practicing in facilities no longer maintain separate offices ignores the prevalence of hybrid practice models as well as the fact that physician payments for their services rendered in the facility setting already reflect the reduced practice expense RVU. Private practices performing services in facilities still incur significant administrative and clinical support costs—including scheduling, coding, billing, and post-operative care. For surgical global codes, bundled post-op visits are often conducted in physician offices, meaning that facility-based procedures still generate non-facility overhead.

Penalizing facility-based providers through this reduction risks undermining the financial viability of care delivery in hospitals and other critical settings. Moreover, this change could discourage providers from practicing in facility environments, ultimately threatening patient access to essential services.

While we appreciate CMS' proposal to increase payments to non-facility-based providers by 4%, the proposed 7% reduction in facility-based payments to physicians could destabilize practices that rely on hospital settings for surgical procedures, particularly those serving high-acuity or underserved populations. Such a shift may further incentivize consolidation, as smaller or independent practices struggle to absorb the financial impact. Frequent recalibrations and site-of-service differentials introduce unpredictability in reimbursement, complicating budgeting, staffing, and long-term planning.

We urge CMS to reconsider its rejection of the AMA's PPI survey and withdraw the proposed reduction in facility-based PE RVUs until a more nuanced and evidence-based methodology is developed. We encourage CMS to work collaboratively with the RUC and specialities to develop a more equitable and transparent approach to calculating indirect PE RVUs.

Global Surgical Payment Accuracy

We appreciate CMS's ongoing efforts to improve transparency and accuracy in the valuation of global surgical packages. We acknowledge CMS's direction to allow surgeons to use modifier -54 when they perform only the surgical portion of a global procedure, even without a formal transfer of care. This flexibility may be appropriate in limited scenarios—such as when a patient travels for surgery and receives follow-up care from a different provider in their home state.

However, we urge CMS to reconsider the introduction of a new G-code for post-operative visits since CPT code 99024 already exists. Adding a separate code for Medicare claims risks creating confusion among providers, especially when commercial payers continue to expect CPT coding. This dual coding system could lead to billing errors, administrative burden, and inconsistent data collection. Additionally, practice management systems often do not allow entry of codes with a zero-dollar charge, further complicating compliance with reporting requirements.

We understand CMS's interest in using claims-based reporting to refine the allocation of payment shares among pre-operative, operative, and post-operative components. However, we remain concerned about the reliability of the underlying data and methodology. The RAND analyses of CPT code 99024 reporting has been widely criticized, including in the AMA's detailed response to the 2022 MPFS proposed rule.

Claims data may not accurately reflect the number or complexity of post-operative visits, especially when providers are not incentivized or equipped to report zero-dollar services.

If CMS intends to use this data to reassess global surgical values, we strongly urge the agency to continue to rely on the physician-led AMA Relative Value Update Committee (RUC) for valuation recommendations.

We recommend that CMS limit the use of modifier -54 to cases where post-operative care is clearly rendered by a different provider; avoid introducing new G-codes that duplicate existing CPT codes and create unnecessary complexity; maintain alignment with RUC recommendations and avoid relying solely on claims-based data for valuation decisions; and engage with specialty societies and practice management experts to ensure that any reporting requirements are feasible and meaningful.

Inextricably Linked Dental Services

We appreciate CMS's acknowledgment of public feedback on the role of dental care in managing chronic conditions like diabetes and autoimmune diseases. The intent to consider this input in future rulemaking (CY 2026) is a meaningful step toward integrating oral-systemic health into broader clinical policy.

Diabetes significantly affects oral health. 11.6% of the U.S. population and 26% of Medicare FFS enrollees affected by diabetes. According to the *American Diabetes Association's Standards of Care in Diabetes—2024*, patients with diabetes are at increased risk for periodontal disease, which can worsen glycemic control.[1] A consensus report by Sanz et al. emphasizes that managing periodontal disease improves diabetes' outcomes and calls for collaboration between medical and dental professionals.[2] While dental issues often emerge gradually, they can become critical in advanced disease stages, especially when compounded by immunosuppressive therapies.

Research into autoimmune conditions like Sjogren's disease highlights the complex relationship between oral and systemic health. Immunosuppressive treatments—used for cancer, transplants, and autoimmune diseases—can cause oral complications such as mucositis, xerostomia, infections, and periodontal disease. These issues impact quality of life, nutrition, and treatment efficacy.

Studies in *Frontiers in Physiology* show that periodontal disease promotes systemic inflammation through inflammatory mediators and microbial translocation. Patients with periodontitis often exhibit elevated systemic markers like C-reactive protein and white blood cells.[3]

Given CMS's existing coverage for dental services tied to cancer and transplant-related immunosuppression, consideration of extending coverage to other conditions involving similar therapies is understandable. However, expanding coverage for dental services linked to diabetes and autoimmune disorders must be approached cautiously. Broad inclusion could strain Part B resources and disincentivize care for more critical services under budget neutrality constraints.

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[1] *Standards of Care in Diabetes—2024*. ADA Professional Site

[2] Sanz M, Ceriello A, Buysschaert M, et al. *Scientific evidence on the links between periodontal diseases and diabetes: consensus report and guidelines.* J Clin Periodontol. 2018;45(2):138–149. doi:10.1111/jcpe.12808

[3] Martínez-García M, Hernández-Lemus E. *Periodontal Inflammation and Systemic Diseases: An Overview*. Front Physiol. 2021;12:709438. doi:10.3389/fphys.2021.70943

Maxillofacial Prosthetic Services (21076-21088)

We recognize that CMS has received a recommendation from the Maxillofacial Foundation; the American Academy of Maxillofacial Prosthetics (AAMP); and the American College of Prosthodontists (ACP) and several specialists to update the practice expense values for maxillofacial prosthetic services (CPT 21076-21088). While we understand the groups' rationale for nominating these codes for the revaluation of practice expense values, at this time AAOMS is offering comments only with regards to CPT 21085 since this procedure is commonly performed by oral and maxillofacial surgeons in conjunction with orthognathic procedures. We support the submitters' practice expense recommendations for CPT 21085 and urge CMS to consider updating the practice expense inputs since the submission was in alignment with the RUC's traditional practice expense format.

Skin Substitutes

We appreciate CMS's efforts to improve value and sustainability within the Medicare program and recognize the intent behind the proposed changes to payment methodology for skin substitute products. These products play a critical role in managing complex wounds, including diabetic foot ulcers and venous leg ulcers.

However, treating them as incident-to supplies risks undervaluing their clinical importance and could discourage appropriate use. While CMS suggests that access will not be compromised, a reduction in reimbursement of up to 90% may lead to product shortages, reduced provider participation, and delays in care—particularly in underserved or rural communities. **We urge CMS to reconsider this approach and ensure that payment policies reflect the therapeutic importance and variances in the costs of these products.**

Telehealth Services Under the PFS

We appreciate CMS's continued commitment to expanding and refining telehealth services under Medicare, particularly in light of the evolving needs of patients and providers. The proposed simplification of the process for adding services to the Medicare Telehealth Services List is a welcome change. Replacing the previous five-step review with a streamlined three-step process and eliminating the distinction between "provisional" and "permanent" status will reduce administrative burden and provide greater clarity for providers. Permanently adding approved services unless later removed ensures stability and predictability in telehealth coverage, which is essential for long-term planning and investment in virtual care infrastructure.

We also support the proposal to remove frequency limitations for subsequent inpatient visits, nursing facility visits, and critical care consultations. These changes reflect the reality of modern care delivery and will allow clinicians to use their judgment in determining the appropriate cadence of telehealth interactions based on patient needs rather than arbitrary limits.

We commend CMS for proposing to adopt a permanent definition of direct supervision that includes real-time audio-video telecommunications. This change is especially important for rural and underserved areas, where access to supervising practitioners may be limited. Allowing virtual supervision for incident-to services, diagnostic tests, and rehabilitation services will improve access and efficiency without compromising quality.

However, we urge CMS to consider extending this flexibility to services with a 000 global surgery indicator. While concerns about patient safety are valid, many of these services are minor and could be safely supervised virtually. We recommend CMS conduct further analysis and stakeholder engagement before excluding these services categorically.

We are concerned about the proposal to revert to pre-PHE policies requiring physical presence of teaching physicians in metropolitan statistical areas. The pandemic demonstrated that virtual supervision can be effective, safe, and educationally sound. Reinstating the physical presence requirement may hinder innovation and reduce flexibility in academic medical centers. We urge CMS to maintain this option across all geographic areas to support consistent training standards and access to care.

Additionally, we are concerned that CMS is not proposing to add the CPT® codes for telemedicine E/M services to the Medicare Telehealth Services List. Requiring providers to continue reporting audio-only and audio-video E/M visits using in-person CPT codes with modifiers creates confusion and increases the risk of billing errors. We recommend that CMS reconsider this decision and formally recognize telemedicine-specific E/M codes to streamline documentation and ensure accurate reimbursement.

In summary, while we support many aspects of CMS's telehealth proposals—particularly the streamlined service review process and removal of visit frequency limits—we urge the agency to reconsider its stance on virtual supervision in metropolitan areas and the exclusion of telemedicine-specific E/M codes. These changes are critical to ensuring equitable access, reducing administrative complexity, and supporting the continued growth of high-quality telehealth services.

Thank you for considering these comments. We look forward to continued collaboration with CMS to strengthen the outpatient care system and ensure that payment policies support both quality and sustainability. Please contact Patricia Serpico, AAOMS Director of Health Policy, Quality, and Reimbursement with any questions at 800-822-6637, ext. 4394, or pserpico@aaoms.org.

Sincerely,

J. David Morrison, DMD
AAOMS President