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American Association of Oral and Maxillofacial Surgeons

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The Honorable John Thune
Majority Leader
US Senate
Room S-230, The Capitol
Washington, DC 20510

The Honorable Chuck Schumer
Minority Leader
US Senate
Room S-221, The Capitol
Washington, DC 20510

The Honorable Mike Johnson
Speaker
US House
Room H-232, The Capitol
Washington, DC 20515

The Honorable Hakeem Jeffries
Minority Leader
US House
Room H-204, The Capitol
Washington, DC 20515

Dear Leader Thune, Leader Schumer, Speaker Johnson, and Leader Jeffries,

The American Association of Oral and Maxillofacial Surgeons (AAOMS), representing more than 9,000 oral and maxillofacial surgeons (OMSs) across the United States, writes to urge Congressional action to reverse portions of the recently finalized rule published by the Centers for Medicare & Medicaid Services (CMS) on October 31st (90 Fed. Reg. 32352 et seq.) that impose an efficiency adjustment to work relative value units (RVUs) and revise the methodology for allocating indirect practice expense (PE) costs for facility-based services. Both policies will have negative consequences for stable physician reimbursement, payment adequacy, and patient access to care.

Our organization shares with Congress and the Administration the goals of ensuring high-quality care and supporting independent physician practice. We appreciate CMS's efforts to improve the accuracy and transparency of service valuation under the Medicare Physician Fee Schedule (PFS). However, we are increasingly concerned that as CMS relies less on long-standing, evidence-based valuation resources – such as the AMA Relative Value Update Committee (RUC) and specialty-specific survey data – its proposed and finalized payment policies risk becoming arbitrary and insufficiently granular to reflect the realities of clinical practice. The finalized

efficiency adjustment and indirect PE methodology change are the result of reduced collaboration with the AMA and specialty societies to develop accurate and responsive policy.

The efficiency adjustment applies a blanket 2.5% reduction to 8,961 codes, comprising approximately 91% of physician services according to the AMA, while disproportionately affecting procedural and diagnostic specialties such as oral and maxillofacial surgery. CMS 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. Further, the policy assumes that services will continue to become efficient indefinitely, which we believe to be flawed. 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.

We have similar concerns regarding the finalized indirect PE methodology, particularly for the treatment of facility-based services. The finalized reduction in indirect PE RVUs for services provided in the facility setting 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.

The vast majority of OMS practices remain overwhelmingly independent and office-based. The nature of oral and maxillofacial care often requires surgeons to maintain two distinct and parallel fixed-cost centers: the private, office-based practice where consultations, evaluations, postoperative care, and in-office procedures occur, and the facility setting where more complex surgeries requiring general anesthesia or specialized equipment must be performed. 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.

The agency broadly assumes that most physicians are employed by facilities that are separately reimbursed for indirect PE under other payment systems. The practice environment of OMSs disproves this assumption and presents substantial cause for reevaluation of the finalized indirect PE adjustment. Additionally, this policy ignores that many OMS procedures must be performed in a facility setting for patient safety, particularly for older adults and individuals with complex medical conditions. CMS itself does not price many OMS procedures in the non-facility setting for this reason. Penalizing surgeons for performing medically necessary procedures in the safest and most appropriate setting is at odds with the goal of supporting private practice and ensuring high-quality care.

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 Congress to use all legislative tools at its disposal to halt the implementation of these policies and support the development of more nuanced and evidence-based valuation methodologies.

If you have any further questions, please feel free to contact Patricia Serpico, Director of Health Policy, Quality & Reimbursement at the American Association of Oral and Maxillofacial Surgeons (pserpico@aaoms.org, 847-233-4394).

Sincerely,

Robert S. Clark, DMD
AAOMS President