



JIRO PRACTICE IMPACT ANALYSIS · SEPTEMBER 2026

Who Pays for CMS's Modifier 25 Proposal?

A claims-based analysis of the nearly \$1 billion payment impact across practice settings and specialties.

Private Practices Would Bear 80% of the Nearly \$1B Impact of CMS's Modifier 25

The financial impact is concentrated in six specialties.

Jiro modeled CMS's 2027 same-day payment reduction proposal against Medicare fee-for-service claims from October 2024 through September 2025. According to Jiro's analysis, CMS's proposed policy would have reallocated **\$889.0 million** in annual payments during this period. Moreover, Jiro's modeling reveals the concentrated impact of CMS's proposal. Reductions are drawn from a narrow base: 81.5 percent from private practices and solo physicians, 82.3 percent from six specialties, and within those specialties, a minority of organizations carry most of the dollars.

EXECUTIVE SUMMARY

The comment period on CMS's CY 2027 Medicare Physician Fee Schedule proposed rule closed on September 14, 2026. Among its provisions is a payment reduction affecting office and outpatient evaluation and management (E/M) visits furnished on the same day as a procedure carrying a global period, identified on the claim with Modifier 25 (the "Modifier 25 Proposal"). CMS is expected to publish the final rule on or before November 1, 2026, with any finalized policy change effective January 1, 2027.

Modifier 25 was among the most frequently addressed provisions in the record. More than 10,000 comments referenced Modifier 25, and roughly 85 percent of those contain explicit language opposing the provision or urging CMS not to finalize it. A sign-on letter led by the American Medical Association and joined by 150 other organizations, including the national societies of every specialty identified below, urged CMS not to finalize the proposal, arguing that it "would fall hardest on the independent, office-based practices CMS seeks to support".

Jiro modeled the Modifier 25 Proposal against one historical year of claims. These four findings followed:

01 · SCALE

\$889.0M

Annual Medicare FFS payment reallocated, across 23.1M affected patient-days and 67,018 billing NPIs — an average of \$38 per affected patient-day.

02 · SETTING

\$724.4M (81.5%)

Falls on private practices and solo physicians. Hospital, health-system and academic NPIs account for 17.6 percent.

03 · SPECIALTY

82.3%

From six specialties — dermatology, podiatry, orthopedic surgery, otolaryngology, ophthalmology and family medicine. Dermatology alone accounts for 44.5 percent.

04 · DISPERSION

\$214K

90th-percentile modeled reduction among higher-volume dermatology organizations. The median is about \$45,000 — outcomes vary widely inside each specialty.

PART I — WHAT CMS PROPOSED

The highest-priced service is paid in full. Every other qualifying service is halved.

Procedures carrying a global period are paid as a bundle. CMS describes the work RVUs as including "time crosswalked from E/M codes to reflect the valuation of things such as pre-operative and post-operative visits", meaning the bundle is already priced to cover the visits around the procedure.

A standalone E/M code is therefore not separately billable on the same day unless the visit was significant and separately identifiable from the procedural work, which the practitioner signals by appending Modifier 25.

CMS proposes that when a separately identifiable office or outpatient E/M visit is furnished on the same day as a 0-, 10- or 90-day global procedure by the same physician, or a physician in the same group practice, "the most expensive service (either surgical or E/M visit) would be paid at 100 percent, and all other surgical procedure(s) or E/M visit(s) would be paid at 50 percent."

The reduction concentrates in a limited set of specialties, falls predominantly on independent practices, and within those specialties lands unevenly across organizations that look similar from the outside.

Because the Physician Fee Schedule is budget neutral by statute, those dollars are redistributed across the schedule rather than removed from physician payment overall. CMS's own impact analysis describes the same shape, projecting that the proposal "would have the largest negative impact on otolaryngology, dermatology, and podiatry," while "most other specialties receive a small increase due to the redistribution of those RVUs." This report is about that distribution, particularly the private practices that may be affected by these reductions.

TIMELINE OF THE PROPOSED RULE

Jul 16, 2026

Proposed rule published, 91 Fed. Reg. 43,842

Sep 14, 2026

Comment period closes — 10,000+ Modifier 25 comments

Jan 1, 2027

Any finalized policy takes effect (final rule by Nov 1, 2026)

PART I — THE MECHANISM, IN CMS'S OWN EXAMPLE

Which service absorbs the reduction depends on the practice's service mix

CMS illustrates this mechanism with its own example: a patient receives an established-patient E/M visit at a dermatologist's office and has two skin lesions shaved in the same encounter.

Service furnished the same day	2026 total non-facility RVUs	Paid under the proposal
CPT 11301 — lesion shaving, 0.6–1.0 cm	3.48	100% → 3.48 RVUs
CPT 11300 — lesion shaving, ≤0.5 cm	2.89	50% → 1.445 RVUs
CPT 99212 — established-patient E/M visit	1.78	50% → 0.89 RVUs

Table 1. CMS's example reproduced from the proposed rule at 91 Fed. Reg. 43,908. Two of the three services furnished that day are reduced, including the visit. Which service absorbs the reduction depends on relative payment, so the effect varies with a practice's service mix.

CMS grounds the proposal in practice efficiency rather than in measured duplication, restating the position it took in 2019: "we continue to believe that there are efficiencies" in this pattern and that it is "likely duplicating payment under the current payment methodology."

The 50 percent figure is not independently derived; CMS says it aligns with its CY 2019 proposal and matches the longstanding surgical multiple procedure payment reduction. CMS has also asked whether "it would be more appropriate to match a different MPPR value, such as 25 percent," and whether the policy should extend to other E/M visits, such as inpatient visits.

THE NATIONAL RESULT

What Jiro's impact analysis model shows nationally

\$889.0M

Annual Medicare FFS payment
reallocated

23.1M

Affected patient-days
(23,113,875)

67,018

Billing NPIs represented

\$38

Average modeled reduction
per affected patient-day

Measure	Modeled result
Annual Medicare FFS payment reallocated	\$889.0M
Affected patient-days	23,113,875
Billing NPIs represented	67,018
Average modeled reduction per affected patient-day	\$38
Share of affected patient-days billed in office setting	91.7%

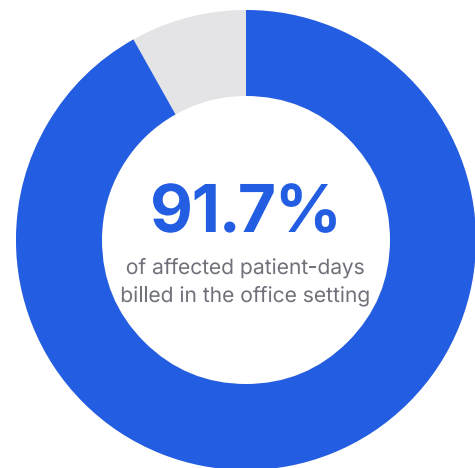


Table 2. Modeled national result. Jiro's model is deliberately conservative: it reduces the qualifying visit and one same-day procedure. Extending the reduction to additional same-day procedures, as CMS's proposal may permit, adds a further \$17.1M reduction, for an upper bound of approximately \$906M. Source: Jiro analysis of Medicare fee-for-service claims, October 2024 – September 2025.

PART II — WHERE THE REDUCTIONS COME FROM

Six specialties account for four of every five modeled dollars

Dermatology alone represents 44.5 percent of the national total. Podiatry, orthopedic surgery and otolaryngology each exceed \$80M. Ophthalmology and family medicine follow. The remaining 116 specialties in the data divide \$157.3M among them. CMS named otolaryngology, dermatology and podiatry as the specialties facing the largest negative impact; the claims put orthopedic surgery and ophthalmology in the same tier.

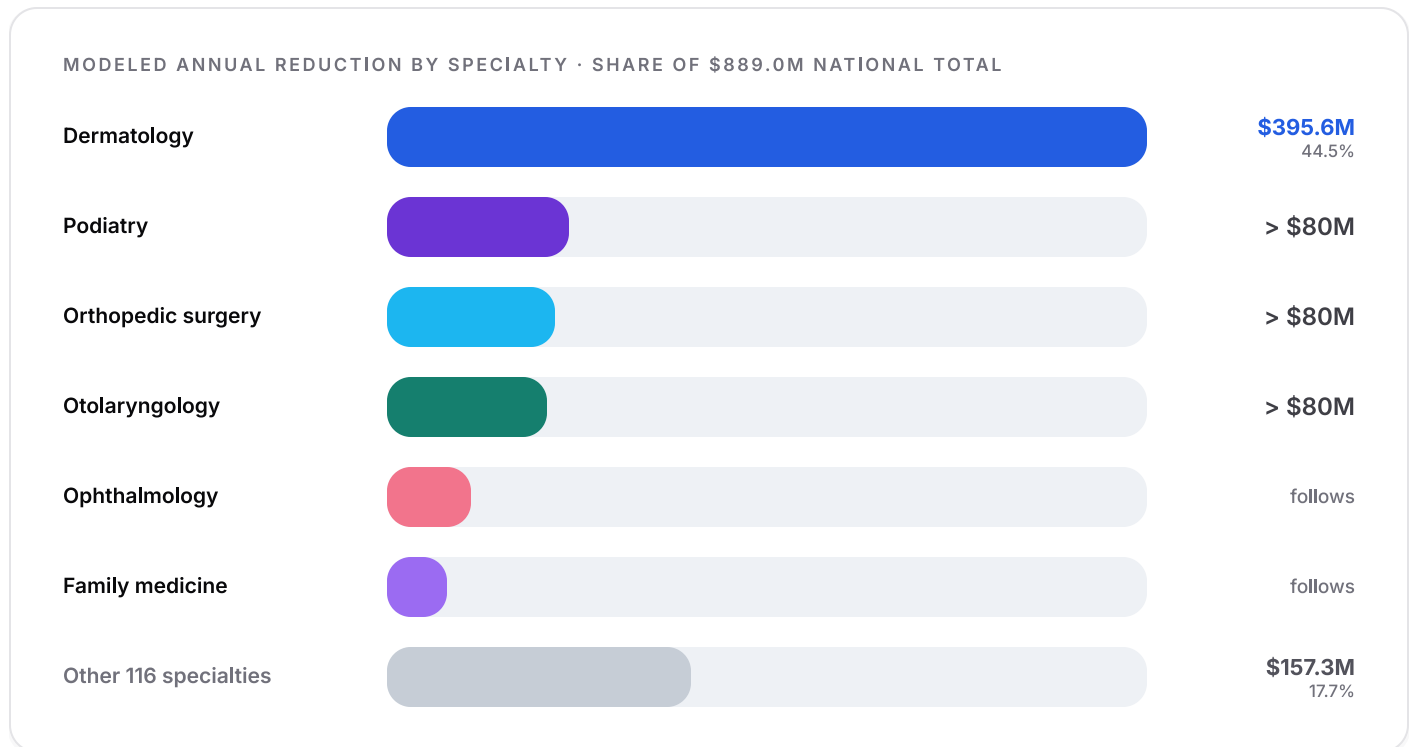


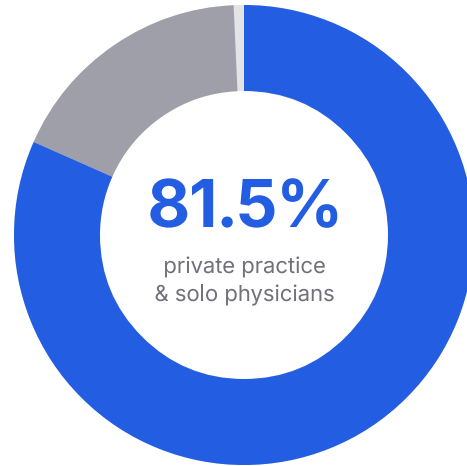
Figure 1. Modeled annual reduction by specialty, all billing NPIs and all settings. Specialty totals reflect specialty size together with the frequency and value of qualifying same-day services; they are not a percentage of each specialty's revenue. Source: Jiro analysis of Medicare fee-for-service claims, October 2024 – September 2025.

PART II — WHERE THE REDUCTIONS COME FROM

Four of every five dollars come from private practice

Private practices and solo physicians account for **\$724.4M** of the modeled total across 55,503 billing NPIs. Hospital, health-system and academic practices account for \$156.1M across 8,834. The pattern is consistent with where the affected encounters occur: 91.7 percent of affected patient-days are billed in the office setting.

- \$724.4M · 81.5%** — Private practice & solo physicians
- \$156.1M · 17.6%** — Hospital, health-system & academic
- 1.0%** — Unconfirmed or not a physician practice



The concentration is sharper still inside the most affected specialties. **Private-practice share of the modeled reduction, by specialty:**

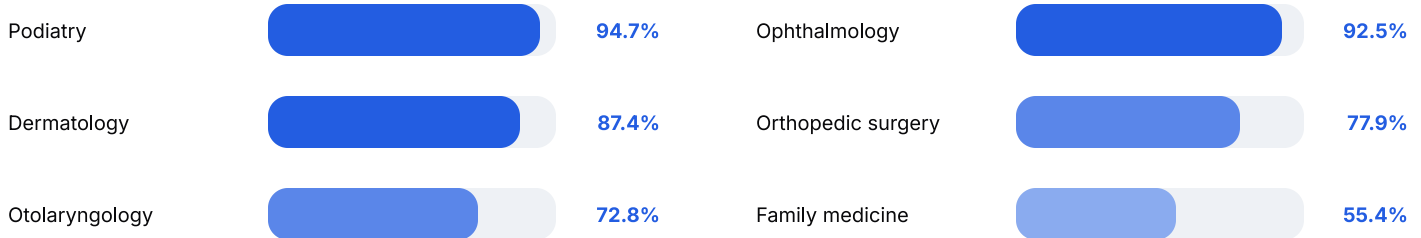


Figure 2. Modeled annual reduction by practice setting. Setting is assigned from CMS hospital enrollment, NPPES taxonomy and commercial directory signals, and reflects evidence-based site of care rather than legal ownership. The remaining 1.0 percent is unconfirmed or not a physician practice. Source: Jiro analysis of Medicare fee-for-service claims, October 2024 – September 2025.

PART III — WHY THESE REDUCTIONS LAND WHERE THEY DO

The decision to perform a procedure is the output of the evaluation, not a separate episode

The distribution is not arbitrary, and the reason is visible in the clinical patterns physicians described across the comment record for CMS's Modifier 25 Proposal. The affected specialties share a structure of care in which the decision to perform a procedure is the output of the evaluation rather than a separate episode.

Dermatology

A patient presents with several concerns. Lesions are evaluated, medications and comorbidities reviewed, and a biopsy or destruction is performed in the same visit. More than 450 comments referencing Modifier 25 raise skin-cancer detection specifically.

Otolaryngology

An ambiguous or acute symptom prompts an evaluation that indicates an immediate in-office scope. Flexible laryngoscopy is the single most-cited procedure in the record, appearing in more than 1,300 Modifier 25 comments.

Ophthalmology

The patient is examined and imaged, and that exam determines whether a same-session laser, injection or foreign-body removal is warranted. CMS has opened a separate comment solicitation on intravitreal injections, noting eye associations' position that a same-day visit "may be prompted or required by the symptom or condition for which the injection is being provided."

Orthopedic surgery

Evaluation and imaging review paired with joint aspiration, tendon-sheath injection or fracture care in the same encounter.

Podiatry

A patient with diabetic neuropathy is assessed for erythema, drainage and vascular status, then debrided during the same visit.

Exposure therefore tracks how often a specialty's ordinary practice resolves a diagnostic question and acts on it within a single visit. That is also why the effect is so heavily weighted toward the office: these are encounters that begin and end in one room, on one day.

PART IV — HOW THESE REDUCTIONS LAND PRACTICE BY PRACTICE

The 90th-percentile organization faces four to six times the median

National and specialty totals establish where CMS's Modifier 25 Proposal policy would concentrate. But to examine closer what a given organization may experience, Jiro looked at Type 2 organization billing NPIs with at least 132 affected patient-days during the measured year (roughly eleven affected days per month). This is an analytical volume threshold, and it is not part of the CMS proposal. The resulting population is 15,773 organizations accounting for 93.1 percent of the modeled national total. Within that group the median modeled reduction is approximately \$18,500 and the 90th percentile approximately \$112,500.

The distance between the median and the 90th percentile is the clearest evidence that specialty alone is not sufficient for analyzing the potential impact of CMS's Modifier 25 Proposal. In dermatology the 90th-percentile organization faces a monetary impact roughly 4.7 times the median; in orthopedic surgery the ratio is 6.2. Procedure mix, the number of affected encounters, Medicare volume and organizational structure all determine where an organization lands in that range.

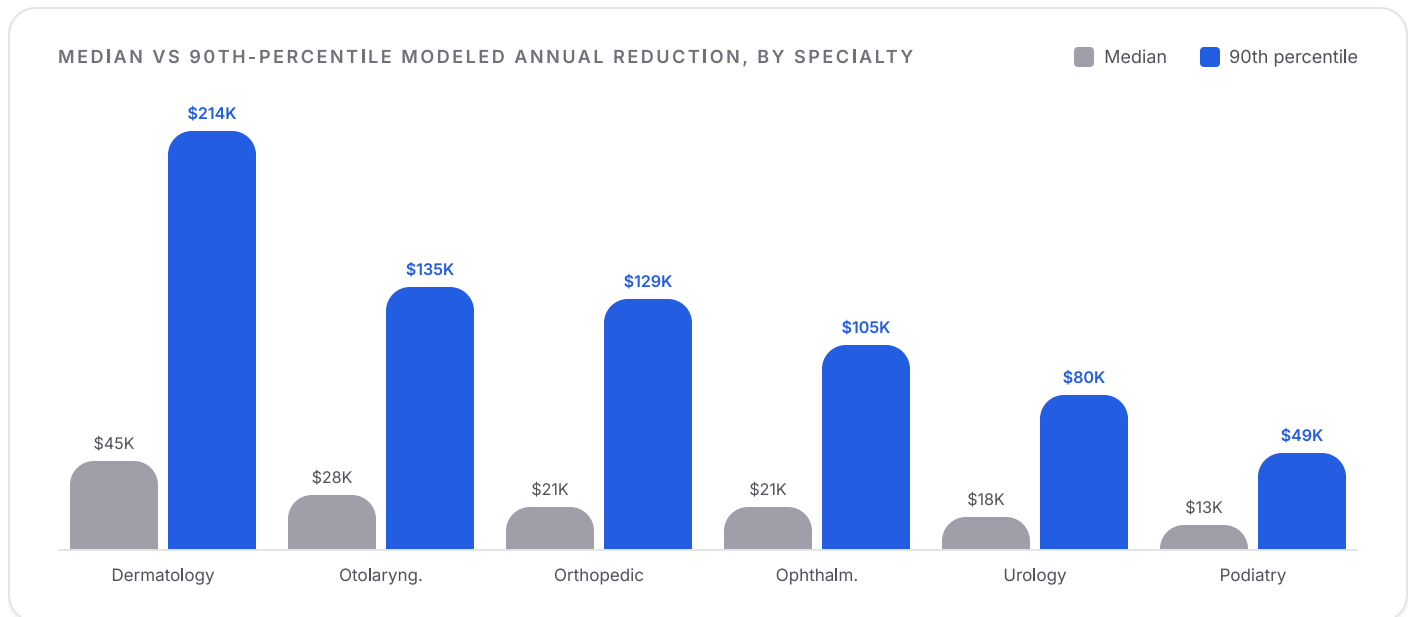


Figure 3. Median and 90th-percentile modeled annual reduction among Type 2 organization billing NPIs with at least 132 affected patient-days. Source: Jiro analysis of Medicare fee-for-service claims, October 2024 – September 2025.

The distribution is also heavily skewed at the top. Among higher-volume organizations, 1,795 face a modeled reduction of at least \$100,000, 526 at least \$250,000 and 49 at least \$1 million. Those 1,795 organizations — only 2.7 percent of all affected billing NPIs — account for 55 percent of the modeled national total.

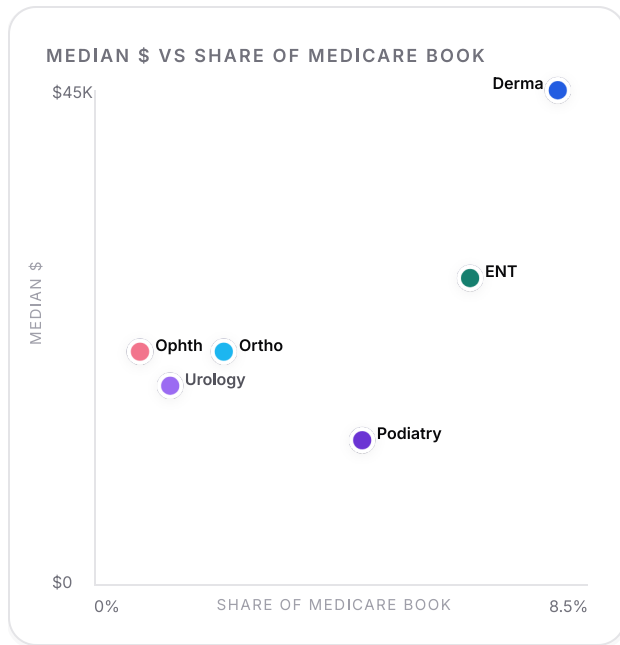
Modeled annual reduction	Orgs	Share of total
At least \$100,000	1,795	55.0%
At least \$250,000	526	32.9%
At least \$1 million	49	10.2%

Table 3. Concentration at the top of the distribution, among Type 2 organization billing NPIs with at least 132 affected patient-days. Share of national total is each group's modeled reduction as a percentage of \$889.0M.

PART IV — SCALE VERSUS MARGIN

Dollar exposure and proportional exposure are different questions

The organizations facing the largest dollar reductions are not always those facing the largest proportional ones. Measured against each organization's entire Medicare professional book, the median dermatology organization sees 8.0 percent of its Medicare payment affected and otolaryngology 6.5 percent, while orthopedic surgery and ophthalmology sit at 2.2 and 0.8 percent on comparable dollar figures.



Specialty	Orgs	Median	90th	% of book
Dermatology	3,835	\$45K	\$214K	8.0%
Otolaryngology	1,086	\$28K	\$135K	6.5%
Orthopedic surgery	1,459	\$21K	\$129K	2.2%
Ophthalmology	914	\$21K	\$105K	0.8%
Urology	668	\$18K	\$80K	1.3%
Podiatry	2,958	\$13K	\$49K	4.6%

Table 4. Practice-level distribution by specialty, Type 2 organization billing NPIs with ≥132 affected patient-days. Source: Jiro analysis of Medicare fee-for-service claims, October 2024 – September 2025.

Figure 4. Median modeled annual reduction plotted against median share of each organization's total Medicare professional payment, by specialty, among higher-volume Type 2 organizations. Source: Jiro analysis of Medicare FFS claims, Oct 2024 – Sep 2025.

Read together, the two measures separate organizations facing a question of scale from those facing a question of margin. A large group can absorb a substantial dollar reduction that is a small fraction of its Medicare business. A smaller single-specialty practice can face fewer dollars that represent a materially larger share of it. Those are different problems, and they call for different responses.

PART V — WHAT HAPPENS NEXT

CMS proposed a version of this in 2019 and did not finalize it

CMS proposed a narrower version of this policy in the CY 2019 Physician Fee Schedule and declined to finalize it after commenters objected. The agency recites those objections in the current proposed rule: that Modifier 25 already establishes the visit as significant and separately identifiable; that the RUC review process already removes duplicative cost, making this "an unnecessary second adjustment"; that CMS gave insufficient rationale for a 50 percent reduction rather than another figure; and that the

policy could prompt practices to bring patients back on a different day. Those are largely the same arguments dominating the 2026 record.

CMS has also invited comment on a smaller reduction, such as 25 percent. The final rule is therefore likely to resolve in one of three directions. Each outcome produces a materially different distribution than the historical case modeled here.

OUTCOME 01

Finalized as proposed

A 50 percent reduction, matching the surgical multiple procedure payment reduction.

OUTCOME 02

Reduced or narrowed

Finalized at a lower percentage — such as 25 percent — or a narrower scope.

OUTCOME 03

Not finalized

Withdrawn as in 2019, leaving current same-day payment policy in place.

What a national estimate cannot answer

National analysis establishes the size of a policy change. Specialty analysis establishes where it concentrates. Neither answers the question an individual organization has to resolve, which is what the change would mean for its own practice. As the distributions above show, two organizations in the same specialty may experience very different impacts.

The analysis behind this report is maintained at the organization level, including modeled exposure, the codes and service lines driving it, and position relative to specialty peers. Jiro intends to update it when CMS publishes the final rule.

METHODOLOGY

How the model was built

Data

Medicare fee-for-service professional claims, October 2024 through September 2025, with CY 2026 PFS relative value, global-period and multiple procedure payment reduction indicators.

Payment model

The highest-valued qualifying service is held at full payment and the next reduced by 50 percent. Services already subject to existing MPPR policy are accounted for, so the reduction is not double-counted. Additional same-day procedures are excluded from the headline figure and reported separately as a \$17.1M sensitivity.

Practice-level population

Type 2 organization billing NPIs with at least 132 affected patient-days, producing 15,773 organizations. This volume threshold is an analytical choice, not a CMS rule.

Setting

Evidence-based site of care, assigned from CMS hospital enrollment, NPPES taxonomy and commercial provider directories. Setting reflects where care appears to be delivered, not legal ownership.

Qualifying patient-day

A distinct combination of patient, billing NPI and calendar date on which both a Modifier 25 office/outpatient E/M visit and a procedure with a 0-, 10- or 90-day global period were furnished.

National population

All 67,018 affected billing NPIs, including Type 1 individual and Type 2 organization NPIs.

Specialty

The specialty accounting for the largest share of modeled reduction dollars, from the rendering NPI on Modifier 25 E/M lines, with directory-based fallback. Names are condensed for readability; "podiatry" corresponds to podiatric medicine and surgery.

No behavior change · Comment record

The model assumes observed billing patterns continue; it does not predict changes in scheduling, coding or service mix. Comment counts are derived by text search of the comment field in the Regulations.gov extract for Docket CMS-2026-2377; opposition is classified by explicit language and is an approximation.

LIMITATIONS

These figures are modeled exposure under the proposal as written, not a forecast of realized 2027 payment. CMS may revise or withdraw the proposal. A billing NPI may represent an individual physician, an organization or a multi-specialty group, and does not always map to a single legal practice. Specialty is assigned probabilistically and carries lower confidence for multi-specialty billing entities. The analysis covers Medicare fee-for-service professional claims and excludes Medicare Advantage and commercial payment. Published findings are aggregated; no organizations are named. Figures are rounded.

SOURCES AND DISCLOSURE

CMS, 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, 91 Fed. Reg. 43,842 (July 16, 2026); Modifier 25 provision at section II.D.3.c(58), 91 Fed. Reg. 43,907–43,909; specialty impact discussion at 91 Fed. Reg. 44,248.

American Medical Association et al., comment letter on the CY 2027 Physician Fee Schedule proposed rule (File Code CMS-1848-P), August 27, 2026, Regulations.gov Document ID CMS-2026-2377-16142.

Comment counts derived from the Regulations.gov record for Docket CMS-2026-2377, extract posted through September 21, 2026. Jiro analysis of Medicare fee-for-service claims, October 2024 – September 2025.

Jiro Health submitted a comment on the CY 2027 Physician Fee Schedule proposed rule addressing payment for clinician-directed clinical decision support software. That comment did not address the Modifier 25 proposal.

ABOUT JIRO

Jiro Health is a public benefit corporation that turns real-world practice data into personalized clinical, operational and financial intelligence for clinicians, benchmarked against relevant peers and updated continuously. Jiro is HIPAA compliant, SOC 2 certified and offers accredited CME.

-  HIPAA compliant
-  SOC 2 certified
-  Accredited CME

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