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September 10, 2025

SUBMITTED VIA ELECTRONIC MAILING

The Honorable Mehmet Oz

Administrator

Centers for Medicare & Medicaid Services

Department of Health and Human Services

Attention: CMS-1832-P, P.O. Box 8016

7500 Security Blvd

Baltimore, MD 21244-8016

**Re: CMS-1832-P; CY 2026 Payment Policies Under the Physician Fee
Schedule and Other Changes to Part B Payment and Coverage
Policies**

Dear Administrator Oz:

On behalf of the American Academy of Otolaryngology–Head and Neck Surgery (AAO-HNS)¹, I write in response to the calendar year (CY) 2026 Medicare Physician Fee Schedule (MPFS) and Quality Payment Program (QPP) proposed rule, as published in the July 16 version of the *Federal Register*.

The Academy appreciates the opportunity to comment on proposed provisions impacting otolaryngology-head and neck surgery. Despite the modest payment increases proposed by CMS and outlined in our comments below, the CY 2026 MPFS continues to raise concerns related to payment for physician work and practice expenses. The proposed increases to the CY 2026 conversion factor would be dramatically offset—especially for facility-based otolaryngologists—by negative adjustments to work relative value units (RVUs) proposed through updates to practice expense methodology and the Agency’s proposed “efficiency adjustment.”

The AAO-HNS wishes to provide detailed comments on several specific proposals contained in the proposed rule:

¹ The AAO-HNS is the world’s largest organization representing specialists who treat the ears, nose, throat, and related structures of the head and neck. The Academy has approximately 13,000 members.

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I. Physician Fee Schedule

A. Proposed CY 2026 Conversion Factor

For CY 2026, CMS proposes dual conversion factors for physicians participating in a qualifying alternative payment model (APM) and those who do not, as required under the *Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)*. Physicians participating in a qualifying APM will receive an increase of 0.75%, and physicians who do not participate in a qualifying APM will receive an increase of 0.25%. Additionally, the values of the updated conversion factors include:

- A temporary, one-time +2.50% increase as required by statute under the *One Big Beautiful Bill Act* (H.R. 1).
- A proposed +0.55% increase to account for proposed changes in work RVUs for some services.

While both proposed conversion factors (i.e., \$33.59 for qualifying APM participants and \$33.42 for non-participants) offer a positive update from CY 2025, the updates are insufficient to account for rising costs to operate physician practices, as measured by the Medicare Economic Index (MEI). Both conversion factors are also considerably less than both the primary care conversion factor (\$36.38) and the surgical conversion factor (\$39.45) in 1995. Moreover, absent congressional action, the temporary +2.5% adjustment is likely to expire at the end of 2026.

For more than 20 years, Medicare payment for physician services has been perennially cut due to strict budget neutrality requirements, and it fails to keep up with inflation. In fact, from 2001 to 2025, Medicare payment for physician services has been effectively cut by 33% when adjusted for inflation. As the Agency is well aware, physician services were subject to another 2.83% cut in 2025. This continued targeting of reimbursement for physician services creates financial instability for independent practices and consequently endangers access to care for Medicare beneficiaries.

The AAO-HNS strongly believes that continued reductions to Medicare physician payment will eventually lead to physicians opting out of the Medicare program entirely or limiting Medicare patients seen to the point of practical non-participation.

The AAO-HNS appreciates the Agency's efforts to propose new policies that allow for a positive budget neutrality adjustment, but we wish to express our concerns with these proposals in our comments below.

B. Separate Conversion Factors for APMs vs Non-APMs: Impact on Otolaryngology

We appreciate the Agency's efforts to encourage appropriate provider use of APMs through the proposed dual conversion factors outlined above. However, because very few otolaryngologist-head and neck surgeons currently qualify for APMs, most of our members will be ineligible for the higher +0.75% payment update and associated APM-related bonus payments authorized under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). As a result, the AAO-HNS is concerned that maintaining two separate conversion factors (0.75% vs. 0.25%) will, over time, compound payment inequities between certain specialties and primary care.

Many otolaryngologists operate in small or independent practice settings, which often lack the infrastructure to participate in APMs. Furthermore, many otolaryngology services are procedure-based, and the current APM landscape remains more tailored to primary care physicians and select specialists who manage longitudinal care. Although some otolaryngology practices may seek to join APMs as a result of the proposed dual conversion factor, opportunities for meaningful participation will remain limited for

many of our members, particularly the more than 50% of otolaryngologists in private practices.²

Therefore, the AAO-HNS urges CMS to prioritize the development of specialty-relevant APM opportunities that meaningfully reflect the models of care and patient populations managed by otolaryngologist-head and neck surgeons. Without expanding access to specialty-focused APMs, the proposed policy risks widening the gap between those who qualify for higher reimbursement and those who do not, further exacerbating existing financial pressures on small practices and potentially limiting patient access to care.

C. Proposed Efficiency Adjustment

i. Methodology and Justification for Proposed Efficiency Adjustment

The AAO-HNS joins our colleagues across the house of medicine in expressing our strong concerns and opposition to CMS's proposed efficiency adjustment to reduce the intra-service values for over 7,000 non-time-based CPT codes by 2.5% beginning in CY 2026. This unfounded approach represents a fundamental and concerning shift in Medicare payment policy—one that is not grounded in specialty-specific data and threatens to undermine both the integrity of the code valuation process and the clinical realities of modern surgical practice. **The Academy has serious concerns with CMS's justification of this payment adjustment and its proposed implementation, and we therefore urge CMS to withdraw this proposal in its entirety.**

CMS's hypothesis—that physicians uniformly become faster and more efficient at delivering care over time—is

² American Academy of Otolaryngology-Head and Neck Surgery. (2024, September 11). The 2023 Otolaryngology Workforce. <https://www.entnet.org/wp-content/uploads/2025/04/2023-Otolaryngology-Workforce-V2.pdf>

fundamentally flawed and lacks empirical evidence. CMS provides no substantive data that proves procedures are invariably performed faster over time. In fact, a study recently published by the American College of Surgeons proves the opposite: over 90% of CPT codes had longer or similar operative times in 2023 compared to 2019, and all measures of procedure complexity increased during the same time period.³ For the 10% of procedures that have indeed become faster over time, this efficiency should not be viewed as a problem to be corrected; rather, more efficiently-performed services should be viewed as a natural byproduct of experience and innovation that already informs the code valuation process through the American Medical Association (AMA) Relative Value Scale Update Committee (RUC).

Furthermore, this proposal would fundamentally redefine the current valuation standard in the MPFS. The current system is based on the “typical patient”—a clinical standard that appropriately accounts for comorbidities and case-by-case perplexity. CMS’s proposed efficiency adjustment would instead establish payment based on the fastest and most streamlined possible version of care. This efficiency-based standard discounts the time, judgment, and care required for the majority of Medicare beneficiaries, who often present with multiple chronic conditions and more complex needs. Recent data indicate that 6 in 10 Americans have at least one chronic disease, and 4 in 10 have two or more chronic diseases—a rate that is likely even higher in the Medicare population.⁴ Surgeons are routinely treating older, sicker, and more complex patients who require

³ Childers C, Foe L, Mujumdar V, et al. Longitudinal Trends in Efficiency and Complexity of Surgical Procedures: Analysis of 1.7 Million Operations Between 2019 and 2023. *Journal of the American College of Surgeons*, 2025. DOI: 10.1097/XCS.0000000000001588

⁴ Buttorff C, Ruder T, Bauman M. Multiple Chronic Conditions in the United States. Rand Corp.; 2017

individualized care. Ignoring this context erodes the foundation upon which the Fee Schedule was built.

Equally troubling is the potential risk that this efficiency adjustment poses to patient safety. Since the 1999 release of *To Err Is Human* by the Institute of Medicine, which is known throughout the field of public health to have kick-started the national push for patient safety, the healthcare system has made tremendous progress in reducing medical errors by emphasizing quality, safety, and appropriate time for clinical decision-making.⁵ Moving toward an efficiency-based payment model contradicts that progress—especially for patients with complex cases, who are routinely seen by otolaryngologist-head and neck surgeons. Shorter intraservice times will reduce surgeries' values and push surgeons to rush complex procedures, compromising safety protocols and incentivizing throughput over thoughtful care. Moreover, prioritizing surgical speed over surgical quality is likely to undermine the savings that this proposal seeks to achieve. Rushed procedures increase the risk for medical error, which leads to higher downstream costs. These are the very dynamics the patient safety movement sought to correct. CMS should not pursue savings at the expense of safety—doing so risks reversing more than two decades of cultural and operational improvement in U.S. healthcare delivery.

CMS proposes to apply this efficiency adjustment to all non-time-based codes, even those that were recently developed or re-surveyed by the RUC. However, this ignores the reality that in many specialties, particularly surgical fields like otolaryngology, efficiency gains are already reflected in the valuation of new and recently reviewed codes. Applying this

⁵ Bates DW, Singh H. Two Decades Since *To Err Is Human*: An Assessment of Progress and Emerging Priorities in Patient Safety. *Health Aff (Millwood)*. 2018;37(11):1736–1743. doi:10.1377/hlthaff.2018.0738

blanket reduction, even to codes recently surveyed and reviewed within the past five years, creates a double-discount that is both inappropriate and unsupported by evidence.

Finally, without a termination point, the repeated application of this efficiency update will result in a continual devaluation of intraservice time—and therefore RVUs—until the value of a service becomes disconnected from the actual work involved in treating patients. **At a minimum, if CMS moves forward with an efficiency adjustment in final rulemaking, we urge CMS to exclude recently reviewed codes from this adjustment and set a defined sunset or review period for the policy.**

ii. RUC Valuation Process

The Academy supports the concept of using multiple sources of data to inform overall rate setting within the MPFS. That said, we urge CMS not to remove the critical role that practicing physicians' expertise and input play through the AMA RUC survey process. Specifically, while we think it prudent to compare the data from RUC surveys with data such as electronic health record (EHR) logs and time-motion data from hospital systems to inform the Agency's code valuation process, we do not support eliminating the use of the AMA RUC survey data in its entirety from the Medicare valuation process. Further, we do not agree with the Agency's insinuation that physicians participating in a RUC survey should be seen as "conflicted" simply because they are sharing their real-world patient experiences. Retaining a pathway for physicians to inform the time and intensity of the work they undertake is an essential component to ensuring accurate and equitable valuation of Medicare services.

The AAO-HNS urges CMS to continue utilizing the AMA RUC recommendations to inform rate-setting for services covered within the MPFS. We also encourage the Agency to compare the information provided by the AMA RUC recommendations with other available data (including EHR logs and time-motion studies) to ensure its accuracy, and to adjust recommendations, if necessary, through rulemaking.

iii. Revision of G2211 Utilization Estimates as an Alternative Solution to Generate Medicare Savings

The CY 2024 MPFS Final Rule finalized separate payment for the office/outpatient (O/O) evaluation and management (E/M) visit complexity add-on code, HCPCS code G2211. The AAO-HNS supported the implementation of G2211 in our comments to the Agency in September 2023, acknowledging that the code would allow physicians to receive well-deserved payment for the additional resources required to provide comprehensive, team-based longitudinal care.⁶ The AAO-HNS also agreed with the Agency's initial utilization estimates for the code, assuming that otolaryngologists would report G2211 with approximately 50% of all office visits. The Agency's high utilization estimates for G2211 resulted in significant implications for the budget neutrality threshold, causing CMS to reduce payment from nearly all other services through a decrease in the Medicare Conversion Factor.

CMS initially predicted that G2211 would be billed with 38% of all O/O E/M visits upon initial implementation and 54% of all O/O E/M visits once fully adopted. While we initially supported these estimates, Medicare claims data analysis indicates that the previous administration severely

⁶ AAO-HNS CY 2024 MPFS NPRM Comment Letter – Final:
<https://www.regulations.gov/comment/CMS-2023-0121-20160>

overestimated the utilization of G2211; in fact, 2024 data suggest that the actual use of G2211 was only 11.2% across all providers, generating less than \$400 million in Medicare spending compared to the \$1 billion originally projected.

2024 G2211 Medicare Utilization Across All Provider Types

G2211 2024 Medicare Utilization	24,654,894
99202-99215 2024 Medicare Utilization	219,332,635
G2211 % in 2024	11.2%
CMS Assumption Used for Budget Neutrality Adjustment	38%

2024 G2211 Medicare Utilization Among Otolaryngologists

G2211 2024 Medicare Utilization for Otolaryngology	35,053
99202-99215 2024 Medicare Utilization for Otolaryngology	4,203,255
G2211 % in 2024 for Otolaryngology	0.83%

Although CMS did not break down G2211 utilization estimates across specialties, the Agency acknowledged in previous rulemaking that surgical specialties would have the lowest utilization (compared to primary care specialties and other non-surgical specialties) because surgeons are less likely to establish longitudinal care relationships with patients. 2024 Medicare claims data for otolaryngology suggest that G2211 was billed with less than 1% of office visits—a stark difference from our initial 50% estimate.

While we understand that CMS cannot retroactively alter budget neutrality calculations for prior years, **we ask that CMS reassess future assumptions for G2211 utilization.** Given the data above, it is evident that the revision of existing G2211 utilization estimates would lead to a positive budget neutrality adjustment and an increase to the

Medicare conversion factor—possibly replacing the need for the Agency’s proposed efficiency adjustment. **We urge CMS to refine its modeling based on actual claims data and account for specialty-specific utilization patterns to ensure a more accurate and equitable distribution of Medicare payments moving forward.**

D. Payment for Medicare Telehealth Services

i. Proposal to Modify the Medicare Telehealth Services List and Review Process

CMS is proposing to streamline the process for adding services to the Medicare Telehealth Services List. Specifically, CMS is proposing to simplify the review process by removing the distinction between “provisional” and “permanent” services and removing steps for determining whether a service can be furnished using an interactive, two-way audio-video telecommunications system.

The Academy agrees with CMS’s proposal to remove Step 4 and Step 5 from the review criteria. These steps were duplicative, difficult to meet, and did not appropriately account for clinician judgment. Removing them simplifies the process and ensures services that deserve to make the list do so efficiently.

The Academy also agrees with the proposal to remove the distinction between “provisional” and “permanent” services, which would mean all services currently listed as provisional would permanently move to the Telehealth Services List. This change appropriately accounts for clinician judgment and reduces administrative burden, while preserving CMS’s authority to remove services if safety or quality concerns arise.

Telehealth continues to be an essential way for AAO-HNS members to treat patients who do not have the ability to

make regular in-person visits. Many patients undergoing audiological or speech-language pathology care are very far from, or are unable to drive to, their nearest physician's office. The effort and cost involved in arranging alternative transportation can make regular in-person therapy unfeasible. Adding the audiology and speech-language pathology codes that were previously on the provisional list to the permanent list will give our members the certainty they need to continue to provide these services in their practice.

The Academy supports CMS's proposals to simplify the pathway for the addition of procedures to the Telehealth Services List and the Agency's deference to provider experience and expertise in determining whether services can effectively be provided via telehealth. **We support the proposals above and urge the Agency to finalize them within the 2026 final rule.**

ii. **Requests to Add Services to the Medicare Telehealth Services List for CY 2026**

CMS is proposing to add two Auditory Osseointegrated Sound Processor codes to the telehealth services list: HCPCS code 92622 and HCPCS code 92623. **The Academy supports adding these services to the Telehealth Services List.** These codes allow a provider to perform diagnostic analysis, programming, and verification of any type of auditory osseointegrated sound processor via telehealth. This often involves telemetry of a bone-anchored device that facilitates converting sound energy to be received by the inner ear. Allowing these tests to be done via telehealth will reduce travel burdens for older adults and patients with limited mobility, while permitting real-time verification and outcome measures.

iii. **Frequency Limitations on Medicare Telehealth Subsequent Care Services in Inpatient and Nursing Facility Settings, and Critical Care Consultations**

CMS is proposing to permanently remove frequency limitations for subsequent inpatient visits, subsequent nursing facility visits, and critical care consultations. **The Academy supports removing this limitation.** We agree with CMS's assessment that physicians can use their complex professional judgment to determine whether they can safely furnish a service via telehealth. We share CMS's goal of balancing increasing physician and patient choice of service modality with consideration of patient safety for all Medicare beneficiaries.

iv. **Direct Supervision via Use of Two-Way Audio/Video Communications Technology**

CMS proposes to permanently adopt a definition of direct supervision that allows the physician or supervising practitioner to provide such supervision through real-time audio and visual interactive telecommunications (excluding audio-only). **The Academy supports this proposal.**

While we agree with CMS's proposal to exclude 10-day and 90-day global surgery services from this definition, we urge CMS to include services with 000 global surgery indicators. CMS is correct that services with a 000 global surgery indicator generally do not pose the same potential risk to patient safety as services with a 010 or 090 global surgery indicator may have. Several procedures performed by otolaryngologists in this code set, such as nasal endoscopy, epistaxis control, flexible laryngoscopy, and removal of impacted cerumen, are all recognized as very safe procedures that do not pose significant risk to the patient. Allowing for these procedures to be performed under direct supervision through real-time audio and visual interactive telecommunications is appropriate. Again, it is

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best to let physicians judge how patients undergoing these simple, safe procedures should be supervised.

E. Determination of Practice Expense RVUs

i. Updates to Direct Practice Expense Inputs

CMS Code	HCPCS Codes	CMS 2024 Price	Recommended Price	Year 1 (CY 2025) Price	Year 2 (CY 2026) Price	Year 3 (CY 2027) Price	Final (CY 2028) Price
SA042 pack, cleaning and disinfecting endoscope	306	\$19.43	\$31.29	\$22.40	\$25.36	\$28.33	\$31.39
SA041 pack, basic injection	111	\$10.45	\$17.28	-	\$12.73	\$15.00	\$17.28
SA048 pack, minimum multi-specialty visit	4568	\$5.02	\$1.98	-	\$4.01	\$2.99	\$1.98
SA052 pack, post-op incision care (staple)	1079	\$4.80	\$9.90	-	\$6.50	\$8.20	\$9.90
SA053 pack, post-op incision care (suture & staple)	469	\$5.47	\$11.54	-	\$7.49	\$9.52	\$11.54
SA054 pack, post-op incision care (suture)	1708	\$4.62	\$10.34	-	\$6.53	\$8.43	\$10.34

The Academy appreciates the Agency’s commitment to ensuring accuracy in pricing for direct practice expense inputs, including supply packs, within the MPFS. As indicated in Table 6, many of the proposed adjustments to supply packs will impact the practice expense for otolaryngology procedures, and as such, **we agree with and support CMS’s proposals to update the costs for these supply packs within the 2026 final rule.**

ii. Development of Strategies to Update Practice Expense Data Collection and Methodology

While the Academy acknowledges the trend of physicians increasingly practicing in part, or exclusively, in facility settings rather than in physician offices, we disagree with CMS’s assumption that this translates to lower indirect practice expenses compared to physicians who practice

solely in the office setting. **We are concerned that this policy is likely to result in unintended consequences, including further incentivizing medical practice consolidation.**

When a private practice physician performs a service or procedure in the facility setting, physician practices remain responsible for coding and billing for the physician's claim, as well as scheduling. Physician practices continue to employ administrative staff, and their clinical staff often support services that are performed in the facility setting. In addition, for surgical procedures with global codes performed in the facility setting, the bundled postoperative office visits are often performed in the physician's office, even if the major surgery was performed in the facility setting.

For the reasons outlined above, we urge CMS to consider all available sources of information outlined in the proposed rule, including AMA Physician Practice Information (PPI) survey results and RAND Health Care data, when evaluating potential adjustments to indirect practice expense costs within the MPFS. We do not believe the proposed 2.5% reduction is reasonable given the lack of clarity regarding how the Agency derived this figure. We therefore urge CMS not to finalize this seemingly arbitrary reduction for 2026. Instead, **CMS should collaborate with RAND and the AMA to identify what, if any, modifications to indirect practice expense inputs should be made, and if applicable, propose such changes in future rulemaking.**

iii. **Use of OPFS Data for Physician Fee Schedule Rate Setting**

Related to the discussion above, the Academy supports the principle of using multiple sources of data to inform overall rate setting within the MPFS. However, we strongly caution

CMS against diminishing the critical role of practicing physicians' expertise and input as reflected through the AMA RUC survey process. These surveys provide specialty-specific information that cannot be captured solely through administrative or facility-based data sources, including data obtained through the Hospital Outpatient Prospective Payment System (OPPS).

To echo our comments above in section C.ii., while comparing RUC survey findings with other data sets may be appropriate, OPPS data were developed for facility payment purposes and do not reflect the full scope of physician practice costs. Relying too heavily on OPPS data risks undervaluing physician services in the MPFS because these data exclude key practice-level expenses, including administrative responsibilities, care coordination, and the bundled postoperative care delivered in physician offices.

Therefore, OPPS data, while beneficial, should be utilized as a supplemental source of data—not a substitute for the RUC survey valuation process. **We do not support eliminating the use of the AMA RUC survey data from the Medicare valuation process, and we urge CMS to continue treating RUC survey data as a foundational component of the MPFS valuation process.**

F. Strategies for Improving Global Surgery Payment Accuracy

The AAO-HNS appreciates the Agency's efforts to refine and improve payment accuracy for procedure shares associated with global surgery packages. However, the Academy maintains our previous stance regarding the current valuation process for global surgical packages: **we do not agree with CMS's conclusion that the current valuation of global packages is inaccurate and therefore do not believe revisions to the valuation methodology are warranted.**

We understand that CMS is soliciting public feedback on strategies to improve accuracy in the valuation of global surgical packages, particularly with respect to procedure shares. The Academy has reviewed each of the three alternative approaches proposed by CMS to recalculate procedure shares moving forward, and we do not support their adoption. The options as proposed rely on incomplete or flawed data sources, problematic assumptions, and valuation techniques that do not align with clinical realities.

Therefore, the Academy urges CMS to maintain its current methodology for assigning procedure shares.

G. Valuation of Services

i. Potentially Misvalued Services Under the Physician Fee Schedule

1. Fine Needle Aspiration (CPT Codes 10021, 10004, 10005, and 10006)

The Academy appreciates CMS's discussion of this family of codes and agrees with the Agency's assessment that they do not require reevaluation at this time, given that they have recently undergone multiple rounds of review. We respectfully request that CMS finalize its decision not to require resurvey of this code set within the 2026 final rule.

2. Nasal Sinus Irrigation (CPT Codes 31000 and 31002)

The Academy appreciates CMS's discussion of this family of codes within the proposed rule. After conducting research into the current usage of the codes via the "CMS 2023 Medicare Physician & Other Practitioners - by Provider and Service" publicly available provider data file, it appears that virtually the entire volume of CPT code 31002 is being driven by one practice with the specialty designation of Allergy / Immunology (158 of 296 total claims reported in the RUC 2025 Medicare

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database). If this practice's volume is removed, otolaryngology remains the actual dominant specialty for both codes, and the apparent change in dominant specialty is not occurring. For CPT code 31000, otolaryngology remains the dominant specialty in the RUC database at approximately 80% of utilization. We would also like to acknowledge the lack of non-facility payment for CPT code 31002. Based on the current RUC database, this procedure is performed over 80% of the time in the physician's office. We therefore believe this code should have a value in the non-facility setting.

Regarding the issue of practice expense and whether the Cyclone® device is typically used for the 31002 procedure—the Academy does not believe that this device is considered “typical” for this procedure at this time, but we acknowledge that this could change in the future. This change in work and supply cost may represent a need for a new standalone code, which could be considered at some point in the future.

3. Unattended Sleep Studies

The AAO-HNS appreciates the opportunity to comment on the valuation of CPT code 95800 (sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (e.g., by airflow or peripheral arterial tone, and sleep time)). We acknowledge and understand the shift in equipment required to complete the procedure; however, we agree with CMS's indication that this code is not misvalued at this time. A coding application was submitted for the February 2025 CPT® Editorial Panel meeting, and therefore, any considerations for adjusting this code should be

held and evaluated once the RUC submits its final recommendations for the upcoming CY 2027 MPFS proposed rule.

ii. Valuation of Specific Codes

1. Tympanostomy (CPT Code 0583T)

The Academy appreciates CMS's commitment to providing quality care for patients of all age groups. We appreciate the opportunity to revisit the use of tympanostomy tube insertion in the office setting in the CY 2026 MPFS proposed rule. We previously supported and continue to appreciate the finalization of the add-on code G0561 to more adequately address the costs associated with this service but also acknowledge the need for physician choice. Currently, there are two options on the market for pediatric in-office ear tubes; one is adequately valued utilizing the G-code that was finalized last year. The second option incorporates an anesthetic system in addition to the device, which is not captured by using the G-code. The AAO-HNS believes that both procedures are valid and relevant within certain patient populations. Therefore, allowing physicians the opportunity to choose which procedure is best for a particular clinical scenario is critical in ensuring proper shared decision-making.

The AAO-HNS believes that a national price for both in-office tympanostomy procedure codes is necessary to adequately account for the technological and procedural differences between CPT code 0583T and HCPCS code G0561.

Additionally, we appreciate CMS's careful consideration of the valuation of CPT code 0583T.

The rule proposes a crosswalk to CPT code 31295 [nasal/sinus endoscopy with maxillary sinus ostium dilation (e.g., balloon dilation) via transnasal or canine fossa]. From our perspective, while the procedures are clinically different, the physician's work, time, and resource needs are similar. Therefore, we support the use of 31295 as a crosswalk to obtain a value for 0583T.

2. Hearing Device Services (CPT Codes 9X01X, 9X02X, 9X03X, 9X04X, 9X07X, 9X08X, 9X09X, 9X10X, 9X11X, 9X12X, 9X13X, and 9X14X)

The AAO-HNS appreciates the opportunity to comment on the payment status codes for these new CPT codes. We disagree with CMS's proposal to continue to assign non-payable status codes to each of these codes. We would like to reiterate the AMA RUC proposal, which recommends contractor pricing for each of these codes. This code set is valuable and largely utilized by patients who rely on Medicare benefits, and limiting these services will cause unnecessary access to care issues for a vulnerable population of healthcare recipients.

II. Quality Payment Program

A. Scoring and Data Completeness

i. Performance Threshold

The AAO-HNS supports the proposal to maintain the performance threshold through the 2028 performance period. This promotes consistency and avoids creating a moving target amid evolving factors such as measure availability and shifting benchmarks.

ii. Final Scoring/Performance Category Reweighting: CMS on Rural and Small Practice Disparities in QPP Scoring and Payment Adjustments

We appreciate CMS's continued efforts to refine and evolve the program to better reflect the diversity of practices across the country. As part of our analysis of 2023 QPP Experience Report data, we identified consistent and statistically significant disparities in performance outcomes between rural and non-rural practices, as well as between small and large practices.

iii. Key Findings: Final Scores and Payment Adjustments

Rural practices received significantly lower average final scores compared to non-rural practices by 1.17 points ($t = 13.032$, $df = 60298$, $p < 0.001$) as well as significantly lower average payment adjustments (0.16% vs. 0.29%, $t = 12.351$, $df = 60130$, $p < 0.001$). However, rural sites outperformed non-rural sites in the quality performance category, with an average quality score of 66.29 out of 100 compared to 64.37 for non-rural sites. This difference was statistically significant ($t = -13.495$, $df = 62,883$, $p < 0.001$).

Similar patterns emerged when comparing small and large practices, with smaller practices generally receiving lower overall scores and payment adjustments. Simple linear regression models revealed that for every 10 additional providers in a group, the model predicted a 0.0019 percentage point increase in payment adjustment ($p < 0.001$) and a 0.01265 point increase in final score ($p < 0.001$).

Specialty analysis revealed disparities for select specialties (i.e., podiatry), which were significantly scoring lower with lower payment adjustments.

iv. Recommendation

The AAO-HNS urges CMS to consider additional policies that could help improve equity and fairness in scoring rural and small practices. Specifically, we recommend:

1. Enhanced risk adjustment or stratification of scoring algorithms that more fully account for practice setting, size, and resource availability;
2. Expanded technical assistance and reporting support for small and rural practices that may face barriers to navigating complex reporting requirements;
3. Further exploration of disparities in scoring components, such as Promoting Interoperability and Cost categories, which may disproportionately penalize low-resource and rural settings; and
4. Consideration of bonus points to recognize high clinical performance in the Quality performance category.

CMS has made strides in promoting value-based care. However, a truly equitable payment system must reward high-quality care wherever it is delivered, including rural regions and under resourced communities. **We hope CMS will use these high-level findings as an opportunity to take a deeper dive into the Agency's data to refine scoring methodologies and improve alignment between performance and reward.**

B. Quality Performance Category

i. Removal of Health Equity from High Priority Definition

If CMS intends to remove health equity from the definition of a high priority measure, then AAO-HNS recommends eliminating the high priority designation altogether. The designation adds administrative complexity with little programmatic value. In reviewing the 2025 quality measure inventory, we note that approximately 75% of measures already qualify as high priority under the current definition, rendering the distinction largely meaningless. Rather than continuing with a diluted and burdensome designation, CMS should consider streamlining the program by removing it entirely.

C. Cost Performance Category

i. Cost Measure Inventory

Within the Cost Performance Category, there is currently limited applicability for many specialties, including otolaryngology.

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Collaborating with specialty societies such as the AAO-HNS would allow CMS to develop more meaningful and accurate cost measures tailored to specific clinical contexts. These societies bring essential expertise that can ensure cost measures account for the complexity and variation in specialty care, rather than defaulting to broad, non-specific measures like Medicare Spending Per Beneficiary (MSPB) or Total Per Capita Cost (TPCC), which often fail to reflect specialty-specific resource use.

ii. Total Per Capita Cost (TPCC) Measure

The AAO-HNS agrees with the added logic to exclude candidate events initiated by an advanced care practitioner Taxpayer Identification Number-National Provider Identifier (TIN-NPI) if all other non-advanced care practitioner TIN-NPIs in their group are excluded based on the specialty exclusion criteria.

iii. Informational-Only Feedback Period

The AAO-HNS supports the use of an informational-only feedback period for new cost measures, as it provides practices with critical time to understand the measure's design and how it will impact their cost score. We urge CMS to ensure full transparency in how cost scores are calculated so that practices can make informed and meaningful adjustments to improve performance.

D. MIPS Value Pathways

i. Subgroup Reporting

The AAO-HNS fully supports CMS's proposal to allow groups to self-attest to their specialty composition (single vs. multispecialty) during the Merit-Based Incentive Payment System (MIPS) Value Pathway (MVP) registration process, rather than having CMS make this determination.

There are numerous cases where otolaryngology practices may be categorized as multispecialty based on taxonomy codes or NPI listings, even though they function with a single clinical focus. Allowing self-attestation provides a more practical and accurate

reflection of how care is delivered within these groups. The Academy has consistently raised this concern during support calls and public forums, and we are pleased to see CMS acknowledge and address it through this proposal.

ii. Traditional MIPS Transition to MVP

While CMS has stated its intent to fully transition to MVPs by the CY 2029 performance period / 2031 MIPS payment year (89 FR 62012), the AAO-HNS remains hesitant to support this timeline due to the ongoing lack of clarity around how the Quality Performance Category will be sustained, coupled with the lack of Cost Measures and limited growth in its inventory.

Currently, the vast majority of relevant and clinically meaningful quality measures originate from Qualified Clinical Data Registries (QCDRs), which are commonly comprised of medical societies. Yet, under the evolving MVP framework, there is no clear path for QCDR measures to remain part of the program. Without a defined mechanism to incorporate these specialty-driven measures, CMS risks severely limiting the clinical relevance and diversity of quality reporting options available to specialists.

We strongly urge CMS to partner with specialty societies that have invested significant resources in developing and testing quality measures. These collaborations are essential to ensure the MVP framework remains meaningful across diverse clinical domains.

Moreover, the current Call for Measures process is broken. Developers receive minimal feedback, and the lack of transparency has demoralized many who have consistently contributed to CMS's quality infrastructure. Burnout among measure developers is real and growing, and without improvements in communication, engagement, and support, CMS will struggle to sustain innovation and participation in quality measurement.

iii. Reinstatement of AAO16: Age-Related Hearing Loss:

Audiometric Evaluation

AAO-HNS supports the reinstatement of **AAO16: Age-Related Hearing Loss Audiometric Evaluation** but remains perplexed as to why the measure was removed from the MVP in the first place.

The Academy proactively reconfigured and tested its QCDR data to reflect the updated clinical guidelines, and we submitted those results in a data-driven comment during last year's rulemaking process. However, CMS did not respond to or acknowledge this input and remained silent all year. The removal of AAO16 had a direct and negative impact on otology-focused practices that intended to transition to MVPs this year but were left without a sufficient number of relevant quality measures. We urge CMS to adopt a more collaborative and transparent approach when refining MVPs, particularly when changes affect specialty practices that rely on clinically aligned, high-quality measures.

E. Core Elements in an MVP

The AAO-HNS appreciates the opportunity to provide comments on CMS's Request for Information regarding Core Elements in MVPs. We support initiatives that strive to reduce clinician burden and enhance meaningful performance measurement. However, we have concerns about the feasibility, fairness, and potential unintended consequences of implementing a Core Elements requirement across MVPs.

i. **Specialty Diversity Makes Comparability Challenging**

The AAO-HNS strongly cautions against assuming that a standard subset of quality measures can generate directly comparable performance data across or even within specialties. The clinical diversity among specialties, and even among subspecialties, means comparability is inherently flawed without robust risk adjustment and case-mix considerations. Attempting to compare "apples to oranges" risks inaccurate conclusions, misleads patients, and penalizes clinicians treating complex or heterogeneous

populations; this would be considered the status quo or a step backward.

ii. Meaningful Measures Are Specialty-Specific

What is meaningful to one specialty may be irrelevant and perhaps inappropriate for another. Selecting a uniform subset of "core" quality measures for each MVP risks diluting clinical relevance and could create additional reporting burdens without improving care quality. Clinicians may be required to report on measures that do not reflect the realities of their practice or patient population, compounding the issue of checkbox-style compliance.

iii. Impact on Scoring and Measure Burden

As referenced, if an MVP includes four required quality measures and the Core Elements subset comprises multiple measures, those Core Elements could account for more than 50% of a clinician's quality score. Without understanding CMS's intent of remaining at four submitted quality measures or increasing the requirements, this change would either represent an increase in quality reporting requirements, which directly contradicts the original intent of MVPs, or would reduce the specialty specificity and may not reflect the clinician's full practice.

iv. Driving Innovation Through QCDR Engagement

The AAO-HNS urges CMS to consider an alternative approach: CMS should steward a limited subset of very basic measures applicable across all specialties, while QCDRs retain responsibility for developing, maintaining, and advancing specialty-specific measures. By stepping back from direct measure maintenance, CMS can foster innovation, promote more rigorous outcome measures, and establish clearer MVP intent—an element currently lacking in the program.

v. Transition Beyond Traditional MIPS

With the anticipated sunset of traditional MIPS, it is critical to maintain a pathway for QCDR measures to be developed, tested,

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and refined. Many of today's MIPS measures originated in QCDRs, and sustaining this pipeline is essential for ensuring MVPs evolve in a clinically meaningful and relevant way.

vi. Leveraging Qualified Registries

Further discussion is needed on the role of Qualified Registries in supporting measure reporting. Many registries lack the clinical expertise to implement MIPS Clinical Quality Measures (CQMs), which are discretely codified with rigid data elements and often subject to misinterpretation. QCDRs, by contrast, are uniquely positioned to ensure clinical validity, specialty alignment, and accuracy in reporting.

vii. Recommendation

While the pursuit of more meaningful reporting is commendable, this approach threatens to undermine the MVP framework's promise of reduced burden, increased specialty relevance, and clinician engagement. **We encourage CMS to adopt a balanced approach: steward a small set of basic cross-specialty measures, while empowering QCDRs to lead specialty-specific measure development.** This framework would reduce burden, drive innovation, produce more rigorous outcomes, and ensure MVPs achieve their intended purpose.

F. RFI Response: Assigning MVPs via Procedural Billing Codes

The AAO-HNS appreciates CMS's intent to align clinicians with relevant MVPs. However, we strongly urge caution in using procedural billing codes for assignment.

This approach must be carefully tested with specialty input to ensure it reflects real-world practice. CMS should avoid repeating the issues seen with the cost measure rollout, which lacked transparency and caused confusion among clinicians. If implemented, we recommend a slow, phased implementation with:

1. **Clear and publicly shared assignment logic**, thresholds, and timelines;
2. **Voluntary participation in early phases**, allowing clinicians to opt in or appeal assignments;
3. **A long eligibility determination window** to account for variation in services; and
4. **Education and support resources** well in advance of rollout.

Automated MVP assignment has the potential to misalign reporting and increase burden. CMS should prioritize flexibility, transparency, and collaboration.

G. RFI Response: Anticipated Approach to FHIR-Based eCQM Reporting

The AAO-HNS encourages CMS to broaden its perspective and fully engage with specialty society partners as it considers the future of digital quality measurement, particularly the use of Fast Healthcare Interoperability Resources (FHIR)-based electronic Clinical Quality Measures (eCQMs).

Many specialty societies, including the AAO-HNS, have moved beyond traditional MIPS reporting and are now leading specialty-specific, clinically meaningful quality improvement. Our members are developing relevant quality measures, peer learning networks, and patient-centered strategies, alongside research platforms that harness real-world data to inform care, support digitized guideline development, and generate evidence that matters.

While FHIR has potential as a data standard, an overemphasis on FHIR eCQMs risks stifling innovation by imposing a rigid, one-size-fits-all approach. Specialty societies possess deep clinical insight, trusted networks, and the infrastructure to drive change, if granted timely access to usable data.

H. Specialty Societies as Catalysts for Quality and Real-World Evidence

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i. Use Cases for Registry and Clinical Data

Specialty societies are uniquely positioned to bridge quality improvement and research. The AAO-HNS is using registry and clinical data to:

1. Identify variation and gaps in care;
2. Validate measures across diverse populations;
3. Inform guidelines and real-world practice;
4. Monitor clinical practice guideline key action statement adherence; and
5. Support national efforts in real-world evidence.

However, current barriers, data silos, interoperability challenges, and technical rigidity continue to limit impact. CMS must support a more flexible data ecosystem to unlock the full potential of specialty initiatives.

ii. Recommendations

1. Recognize specialty societies as essential partners in quality measurement and real-world evidence generation by empowering them to design the MVPs and quality measures that reflect the realities of specialty care and ensure clinical relevance.
2. Avoid exclusive reliance on FHIR eQMs. Encourage diverse digital tools and registry-based innovations.
3. Unlock a research-driven pathway to facilitate medical advancements.
4. Enable affordable, timely data access for specialty societies to support quality, research, and continuous learning.

I. RFI Response: Transition of the PDMP Measure to a Performance Measure

The AAO-HNS supports the use of Prescription Drug Monitoring Programs (PDMPs) to promote responsible prescribing. Evidence shows that frequent PDMP use is associated with reduced or altered prescribing of controlled substances, including opioids, and increased

use of alternative therapies.⁷ However, we urge CMS to delay converting the Query of PDMP measure from an attestation-based to a performance-based structure until PDMPs are more fully integrated into EHRs. The literature consistently identifies poor integration, multistep login processes, and workflow disruption as barriers that increase administrative burden.⁸ Even with integration, the actual impact on prescribing behavior is modest.⁹

Recommendations:

1. Maintain the current attestation format until widespread EHR integration enables seamless, one-click PDMP access.
2. Avoid penalizing providers who lack integrated systems due to factors outside their control.
3. Approach expansion of covered drug types cautiously, ensuring clinical relevance and feasibility across state systems.

In summary, while PDMPs play an important role in reducing misuse of controlled substances, the shift to a performance-based measure should be deferred until technical and workflow challenges are resolved. The AAO-HNS does not recommend transitioning the PDMP measure from attestation to performance-based measurement.

J. RFI Response: Data Quality: Barriers to Effective Health Information Exchange in the Current Data Environment

Clinicians today are often held hostage by the limitations and practices of their EHR systems, which serve as a significant barrier to effective health information exchange. While registries and other data

⁷ Mehta S, Brown W, Ferguson E, Najera J, Pantell MS. The association between prescription drug monitoring programs and controlled substance prescribing: a cross-sectional study using data from 2019 National Electronic Health Records Survey. *J Am Med Inform Assoc*. 2023;30(6):1042-1046. doi:10.1093/jamia/ocad053.

⁸ Holmgren AJ, Apathy NC. Evaluation of Prescription Drug Monitoring Program Integration With Hospital Electronic Health Records by US County-Level Opioid Prescribing Rates. *JAMA Netw Open*. 2020;3(6):e209085. Published 2020 Jun 1. doi:10.1001/jamanetworkopen.2020.9085

⁹ Neprash HT, Vock DM, Hanson A, et al. Effect of Integrating Access to a Prescription Drug Monitoring Program Within the Electronic Health Record on the Frequency of Queries by Primary Care Clinicians: A Cluster Randomized Clinical Trial. *JAMA Health Forum*. 2022;3(6):e221852. Published 2022 Jun 5. doi:10.1001/jamahealthforum.2022.1852

submission partners work diligently to support clinicians with comprehensive MIPS reporting, often for under \$300 annually, which include dashboards, support calls, newsletters, data processing, and audit preparation, many EHR vendors impose exorbitant fees and technical obstacles that directly hinder participation.

In some cases, solo providers are quoted upwards of \$20,000 simply to export or transmit their clinical data to a clinical data registry. Other EHR vendors outright refuse to cooperate or only provide partial, low-value extracts that do not reflect the true quality of care being delivered, which impacts MIPS quality scores. These incomplete datasets make it extremely difficult to produce valid quality reports, and in many instances, clinicians abandon the process altogether out of frustration and financial strain.

Registries strive to alleviate this burden by acting as intermediaries: negotiating with vendors, parsing fragmented data, and resolving integration issues. However, these efforts are time and resource intensive, often requiring nearly a year to establish even basic data feeds from certain EHR platforms. The burden is particularly heavy on small practices, which lack negotiating power and internal IT support to navigate these obstacles independently.

At Reg-entSM, the Academy's otolaryngology clinical data registry, we navigate these barriers every day, working directly with clinicians, practices, and vendors to overcome the very challenges that stall progress elsewhere. This daily experience positions us as a best-in-class partner with the credibility to make recommendations and set expectations for what true data-driven quality improvement should look like. Until EHR vendors are held accountable for the interoperability burdens they impose, the goals of value-based care, transparency, and data-driven quality improvement will remain out of reach for many clinicians.

Conclusion

The American Academy of Otolaryngology–Head and Neck Surgery appreciates the opportunity to provide comments and recommendations regarding these important policies on behalf of our members. We look forward to working with CMS as it continues its efforts to improve patient access to quality care and reduce regulatory burdens for clinicians. If you have any questions or require further information, please contact healthpolicy@entnet.org.

Sincerely,



Rahul K. Shah, MD, MBA
Executive Vice President and CEO
American Academy of Otolaryngology-Head and Neck Surgery