Do No Harm

September 11, 2026

Submitted electronically via www.regulations.gov

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, Maryland 21244

Re: Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies, 91 Fed. Reg. 43842 (July 16, 2026); File Code CMS-1848-P; RIN 0938-AV82; Docket No. CMS-2026-2377 – Section II.H, Current Procedural Terminology (CPT) Request for Information

Do No Harm is a nonprofit organization with over 50,000 members, including physicians, nurses, medical students, patients, and policymakers. Do No Harm is committed to keeping identity politics out of medical education, research, and patient care. We submit this comment in response to the Current Procedural Terminology (CPT®) Request for Information in Section II.H of the proposed rule.

We write for a narrow purpose: to urge the Centers for Medicare & Medicaid Services (CMS) to treat this Request for Information as the beginning of reform rather than the end of an inquiry. We take no position here on which alternative CMS should adopt, and we offer no preferred replacement for the current coding standard. Our concern is with the arrangement itself. Federal regulation has entrenched a single private association's monopoly over the code set that defines physician services, and the revenue that flows from that monopoly is neither spent for the benefit of patients nor answerable to the physicians the association claims to speak for. That alone justifies the agency's decision to ask these questions and to keep pursuing the answers.[1]

[1] Kurt Miceli, Trump Lucks Into a Plan to Reform the AMA, Wall St. J. (July 26, 2026), https://www.wsj.com/opinion/trump-lucks-into-a-plan-to-reform-the-ama-300d7b0e.

I. Federal Reliance on CPT Has Untethered the AMA From Its Medical Mission

The American Medical Association (AMA) developed the CPT coding system in the 1960s and holds the copyright, so it collects licensing royalties for use of the codes.[2] As the proposed rule correctly observes, it is agency regulation – not the Health Insurance Portability and Accountability Act of 1996 – that made CMS's Healthcare Common Procedure Coding System (HCPCS) and the AMA's CPT-4 the national coding standard for physician services. The statute says nothing about CPT; only the Department of Health and Human Services' (HHS) implementing regulation does.[3] A private organization's revenue stream is therefore a creature of federal rulemaking, making it properly the subject of federal reconsideration.

The consequences of that arrangement are visible in the AMA's own finances. In 2025 the association earned roughly $340 million from royalties and credentialing products – nearly two-thirds of its revenue.[4] Physician dues now account for approximately 6 percent of the AMA's revenue. An organization founded in the nineteenth century to represent physicians and to advance the practices that let them improve patients' lives now draws the great bulk of its support from a government-mandated code set rather than from the professionals it claims to represent. It does not need to reflect physicians' views or fight for their needs because it receives the money either way.

II. The Revenue That Federal Policy Guarantees Is Not Spent to Benefit Patients

Financial independence from the profession has coincided with the AMA's ideological capture. The association has led the medical establishment in demanding "diversity, equity, and inclusion" at every level of medical education, practice, and policy, and it maintains that priority to this day.[5] It has likewise championed hormonal and surgical sex-rejecting interventions for children confused about their sex under the euphemism of "gender-affirming care."[6] It has doubled down on both commitments even as public opposition has grown and as other countries have retreated from these dubious interventions.

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[2] Am. Med. Ass'n, The Purpose of the CPT® Coding System & the CPT® Editorial Panel, https://www.ama-assn.org/about/cpt-editorial-panel/purpose-cpt-coding-system-cpt-editorial-panel (the AMA first developed and published CPT in 1966); Am. Med. Ass'n, CPT® Licensing Frequently Asked Questions (FAQs), https://www.ama-assn.org/practice-management/cpt/cpt-licensing-frequently-asked-questions-faqs ("The AMA holds the copyright to the CPT code set and related derivative products."); Am. Med. Ass'n, Internal End User License Agreement Royalty Rates for 2026 and 2027, https://compliance.ama-assn.org/hc/en-us/articles/16197630737431-Internal-End-User-License-Agreement-Royalty-Rates-for-2026-and-2027.

[3] 45 C.F.R. § 162.1002(a)(5); see CY 2027 PFS Proposed Rule, 91 Fed. Reg. 43842, § II.H (July 16, 2026).

[4] Am. Med. Ass'n, 2025 AMA Annual Report, https://www.ama-assn.org/system/files/2025-ama-annual-report.pdf; see also Miceli, supra note 1.

[5] See, e.g., Am. Med. Ass'n, Policy D-200.985, Strategies for Enhancing Diversity in the Physician Workforce, https://policysearch.ama-assn.org/policyfinder/detail/diversity%20admissions?uri=%2FAMADoc%2Fdirectives.xml-0-505.xml (the AMA "unequivocally opposes" legislation that would curtail race-conscious admissions); Am. Med. Ass'n, Policy D-295.963, Continued Support for Diversity in Medical Education, https://policysearch.ama-assn.org/policyfinder/detail/dei?uri=%2FAMADoc%2Fdirectives.xml-0-851.xml (committing the AMA to advocate for resources to establish and maintain DEI offices at medical schools).

[6] Am. Med. Ass'n, AMA Board Newsletter, https://cloud.e.ama-assn.org/newsletter (stating that AMA policy on access to and provision of "gender-affirming care" remains unchanged).

The AMA is not the only medical organization advocating these things, but it is by far the most powerful, and its endorsement frequently and incorrectly settles debates. Even lawmakers who oppose ideology in medicine find it difficult to argue against what is falsely presented as the voice of American physicians. Federal policy should not be funding that voice. Guaranteeing an activist organization the resources it needs to promote DEI-driven medicine and pediatric sex-rejecting interventions was not one of the original purposes of the CPT arrangement.

III. The AMA Does Not Speak for American Physicians

The association's claim to represent the profession is no longer believable. Three of four American physicians belonged to the AMA in the 1950s;[7] fewer than one in five do today, and more than 43 percent of that remaining group are medical students or residents.[8] Its officers and council members are chosen by roughly 700 physicians in the AMA's house of delegates – about 0.23 percent of the membership.[9] A 2011 study found that most physicians who left the AMA did so because they concluded it no longer represented physicians, and 77 percent of respondents, members and nonmembers alike, disagreed with the statement: "The AMA's stance and actions represent my views."[10]

Our own research points in the same direction. Last year Do No Harm worked with a professor at Florida State University to poll physicians in Florida. Two-thirds supported Florida's prohibition on hormonal and surgical "sex change interventions" for children, and an even larger share rejected key tenets of DEI, including race-conscious college or university admissions.[11] Because, beginning in medical school, the medical profession skews more liberal than the country as a whole, those results are especially revealing.[12]

This matters directly to the questions CMS has posed. The 21-member AMA Board of Trustees approves nominees to the CPT Editorial Panel, the "governing body charged with the ongoing maintenance of the CPT code set," and also selects the chair and AMA representative to the Relative Value Scale Update Committee (RUC), which makes recommendations to CMS on physician payment values.[13] The Medicare Payment Advisory Commission has rightly warned for nearly two decades that CMS has over-relied on

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[7] Science vs. 'Wokeism': The Growing Tensions Between the Doctors' Lobby and the GOP, Politico (Sept. 30, 2023), https://www.politico.com/news/2023/09/30/how-the-culture-wars-are-fueling-a-rift-between-the-gop-and-the-doctors-lobby-00119211.

[8] Am. Med. Ass'n, A-26 Handbook: Informational Reports, https://www.ama-assn.org/system/files/a26-handbook-informational-reports.pdf.

[9] Am. Med. Ass'n, Delegates & Federation Societies, https://www.ama-assn.org/house-delegates/hod-organization/delegates-federation-societies.

[10] Jackson & Coker, Survey: Physician Opinions of the American Medical Association (Sept. 2011), https://www.kff.org/wp-content/uploads/sites/3/2015/06/jc-ama-surveyfullpresentation.pdf; see also Miceli, supra note 1.

[11] Ctr. for Accountability in Med. & Do No Harm, What Rank-and-File Physicians Think About DEI and Pediatric "Gender-Affirming Care": Evidence from Florida (Nov. 2025), https://donoharmmedicine.org/wp-content/uploads/What-Physicians-Think-about-DEI-and-GAC-in-Florida-11-21-25.pdf.

[12] Erica Frank, Jennifer Carrera & Shafik Dharamsi, Political Self-characterization of U.S. Medical Students, 22 J. Gen. Internal Med. 514 (2007), https://pmc.ncbi.nlm.nih.gov/articles/PMC1829428/.

[13] Am. Med. Ass'n, AMA Announces Board of Trustees for 2026-2027, https://www.ama-assn.org/press-center/ama-press-releases/ama-announces-board-trustees-2026-2027; Am. Med. Ass'n, Composition of the RVS Update Committee (RUC), https://www.ama-assn.org/about/rvs-update-committee-ruc/composition-rvs-update-committee-ruc; Am. Med. Ass'n, RVS Update Committee (RUC), https://www.ama-assn.org/about/rvs-update-committee-ruc/rvs-update-committee-ruc.

specialty societies with a financial stake in the outcome.[14] That conflict is only further heightened when the organization at the center of the process is insulated from the profession it purports to represent and free to spend the proceeds on political advocacy.

IV. Conclusion

Patients do not need an activist organization operating as a medical authority – they need institutions that equip physicians to heal them and a payment system built on codes that align with medical necessity rather than on a copyright that funds activism. Do No Harm does not presume to tell CMS which path to take, and we recognize that any change to the national coding standard is a substantial undertaking that will require careful attention to potential disruption. But the agency is right to have opened this question, and the answer should not be the current, damaging status quo.

We are grateful for the opportunity to comment and welcome the chance to provide further information.

Respectfully submitted,

Stanley Goldfarb

BOARD CHAIRMAN

Do No Harm

[14] Medicare Payment Advisory Comm'n, Testimony: Options to Improve Medicare's Payments to Physicians (May 8, 2007), cited in 91 Fed. Reg. at § II.H.