September 7, 2025

Submitted electronically via: http://www.regulations.gov

The Honorable Dr. Mehmet Oz

Administrator

Centers for Medicare & Medicaid Services

Department of Health and Human Services

Attention: CMS-1832-P

P.O. Box 8016

Baltimore, MD 21244-8016

Re: Comments on the Calendar Year (CY) 2026 Medicare Physician Fee Schedule (PFS) and Other Changes to Part B Payment and Coverage Policies Proposed Rule (CMS-1832-P)

Dear Dr. Oz:

On behalf of the American Society of Pain and Neuroscience (ASPN), we are writing to provide comments on the Centers for Medicare & Medicaid Services' (CMS) proposed rule for the CY 2026 Revisions to Payment Policies under the Medicare Physician Fee Schedule (PFS) and Other Changes to Part B Payment and Coverage Policies, as published in the Federal Register on July 16, 2025. ASPN is a multidisciplinary professional society dedicated to advancing the field of pain medicine and neuroscience through education, research, and advocacy. Our members include interventional pain physicians, neurosurgeons, orthopedic surgeons, anesthesiologists, and other specialists who provide comprehensive care to patients suffering from chronic pain,

including through interventional spine procedures, chronic care management, and telehealth services.

We appreciate CMS's efforts to update the PFS in a manner that supports access to high-quality care while addressing fiscal sustainability. ASPN supports several aspects of the proposed rule that align with our mission to improve patient outcomes in pain management. However, we also have significant concerns regarding certain proposals that could adversely impact our specialty and patient access to essential services. Below, we highlight key positive elements, express our opposition to specific components, propose alternatives, and offer additional comments on areas affecting pain management, interventional spine care, chronic care management, and telehealth/telemedicine services.

I. Support for Increased Reimbursement for Office-Based Procedures

ASPN commends CMS for proposals that would enhance reimbursement for office-based (non-facility) procedures, which are critical to interventional pain management and spine care. The proposed updates to practice expense (PE) methodology, including the site-of-service payment differential, would result in a 4 percent increase in non-facility payments while reducing facility-based payments by 7 percent. This adjustment recognizes the higher costs associated with maintaining independent office settings, such as administrative staff, clinical support, and equipment for procedures like epidural injections, facet joint interventions, and neuromodulation therapies. By incentivizing office-based care, CMS is promoting cost-effective, accessible treatment options that reduce the need for more expensive hospital outpatient or ambulatory surgical center settings. This aligns with evidence showing that office-based interventional procedures improve patient convenience, lower overall healthcare costs, and maintain high safety standards. We urge CMS to finalize these provisions to support the sustainability of independent practices in pain medicine.

Additionally, the positive 0.55 percent budget neutrality adjustment stemming from the review of potentially misvalued services, combined with the temporary 2.5 percent conversion factor increase, provides much-needed relief. For specialties like interventional pain management, where procedures often involve non-time-based services, these updates help offset ongoing inflationary pressures and ensure continued access to innovative treatments.

II. Opposition to the Proposed Value-Based Care Model ("ASM")

While ASPN supports the broader goals of value-based care to improve quality and efficiency, **we strongly oppose the proposed enhancements to the Medicare Shared Savings Program (MSSP), which we interpret as the "Advanced Shared Savings Model" (ASM)** referenced in related discussions. The MSSP's increased emphasis on accountable care organizations (ACOs) and advanced alternative payment models (APMs) places undue administrative burdens on smaller, independent practices common in pain management and neuroscience. Many of our members operate in rural or underserved areas where participation in large-scale ACOs is

impractical due to limited resources and patient volumes. The proposed changes could exacerbate consolidation trends, forcing specialists into hospital-affiliated models that reduce competition and increase costs for beneficiaries.

Furthermore, the model's focus on shared savings may not adequately account for the complexity of chronic pain patients, who often require multimodal interventions not easily captured in standard quality metrics. We are concerned that this could lead to under-reimbursement for high-value services like spinal cord stimulation or intrathecal drug delivery, potentially limiting access for vulnerable populations. ASPN recommends that CMS delay implementation of these MSSP enhancements and instead prioritize flexible, specialty-specific value-based pathways that better suit interventional pain and spine care.

III. Proposal for a Taxonomy Modifier to Enhance Reimbursement

To address disparities in reimbursement and better reflect the specialized nature of interventional pain management**, ASPN proposes the introduction of a taxonomy-based modifier for claims submission.** This modifier would be tied to providers' National Provider Identifier (NPI) taxonomy codes (e.g., 208VP0014X for Interventional Pain Medicine, 2081P2900X for Physical Medicine & Rehabilitation: Pain Medicine, 207LP2900X Anesthesia:Pain Management) and allow for adjusted payments that recognize the additional expertise, risks, and costs involved in procedures such as radiofrequency ablation or vertebroplasty. Like existing modifiers for anesthesia or surgical services, this could provide a modest uplift (e.g., 5-10 percent) for qualifying specialists, ensuring fair compensation without broad budget neutrality impacts. This approach would promote transparency in reimbursement by linking payments directly to provider qualifications, reducing valuation error, and incentivizing advanced training in pain neuroscience. We believe this would align with CMS's goals of accuracy in the PFS and encourage further dialogue on its feasibility.

IV. Need for Greater Transparency

ASPN emphasizes the critical need for enhanced transparency across the PFS rulemaking process, particularly in data collection for practice expenses and audit programs. The proposed use of the Physician Practice Information (PPI) Survey data is a step forward; however, concerns remain about low response rates and representativeness, especially for specialties like ours, which have unique cost structures (e.g., high-cost supplies for implantable devices). **We urge CMS to publicly share detailed methodologies for incorporating PPI data into Medicare Economic Index (MEI) weights and to collaborate with stakeholders on future surveys**. Additionally, in line with our advocacy for audit integrity, we support reforms to Medicare-administered audit programs to introduce fairness, reduce burdensome appeals, and ensure auditors are held accountable for errors. Greater transparency in these areas would build trust and improve the accuracy of reimbursement for pain management services.

V. Comments on Other Relevant Provisions

1) ***Telehealth and Telemedicine Services:*** We applaud CMS's proposals to permanently lift frequency limits on telehealth for subsequent hospital inpatient/nursing facility visits, as well as critical care consultations, and to allow permanent virtual direct supervision. These changes are vital for chronic pain patients in rural areas who benefit from remote monitoring and follow-up. However, we oppose limiting virtual teaching physician supervision to non-metropolitan areas, as this could hinder resident training in urban pain programs. **ASPN supports adding more pain-specific services to the Medicare Telehealth List and simplifying the process for adding these services to ensure that all telehealth services are treated as permanent.**
   We also urge **CMS to reconsider requiring an in-person mental health visit within 6 months prior to a telehealth-based service**. This would significantly impact the ability of telehealth to be used for psychological evaluations required as a prior-authorization requirement by nearly all payers for selected pain interventions, such as Spinal cord stimulation and Targeted drug delivery.
2) ***Chronic Care Management (CCM):*** The proposed intake activities for pain management services, including support for opioid treatment initiation, are positive steps toward addressing the opioid crisis and chronic pain. **We encourage CMS to expand CCM coding to better encompass multidisciplinary approaches in neuroscience, such as behavioral health integration for sickle cell disease or other chronic conditions**.
3) ***Valuation of Specific Codes:*** ASPN appreciates CMS's acceptance of 89 percent of RUC recommendations, including for lower extremity revascularization codes, which may indirectly benefit interventional pain work. However, **we urge careful review of codes for high-cost supplies in pain procedures (e.g., neuromodulation implants) and consideration of G-codes or OPPS data to ensure accuracy.**
4) ***Urgent Care Centers and Other Impacts***: We seek clarification on potential add-on codes for E/M visits in urgent care settings, as many pain exacerbations are commonly presented there. ASPN also aligns with broader concerns about access, echoing MedPAC's warnings on the gap between input costs and payments, and supports permanent MEI-tied updates.
5) ***Efficiency Adjustment:*** In the 2026 PFS Proposed Rule, CMS proposes applying a 2.5% decrease to the work RVUs and physician intra-service time of most services in the MPFS on the assumption that physicians have gained efficiency in providing them. This includes new services, surveyed for physician time and work within the past year. The decrease would be applied to 8,961 physician services. CMS arrives at a 2.5% efficiency adjustment by tallying the last five years' productivity adjustments in the MEI. However, physicians do not receive an MEI-based update even though other Medicare providers receive a productivity adjustment applied to their annual baseline updates (e.g., hospital market basket minus productivity). This proposal, combined with the AMA/Specialty

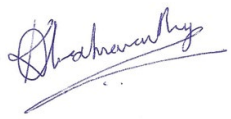
Society RVS Update Committee's recommendations on individual CPT codes, results in the 0.55% budget neutrality adjustment to the conversion factor**. ASPN does not support any efficiency adjustment policies within the Physician Fee Schedule without a concurrent automatic update to the conversion factor based on MEI**. Moreover, we recommend:

a. Exempting additional codes relevant to pain management (e.g., those for neuromodulation and injections) and tying future adjustments to empirical data rather than historical MEI productivity factors.
b. Extend the timeline beyond 3 years to allow time for new technologies to be adopted and efficiencies to be gained.
c. Exempt new CPT codes from the adjustment until sufficient real-world use data are obtained.
d. Ensure/confirm time-based codes are excluded.

ASPN is committed to collaborating with CMS to refine these policies and ensure they support innovation in pain and neuroscience care. We offer our expertise and are available to participate in discussions, technical advisory groups, or further rulemaking processes.

Thank you for considering our comments. We look forward to the final rule and to continuing our partnership to advance patient-centered care.

Sincerely,



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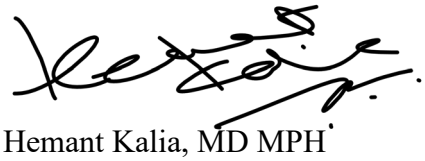

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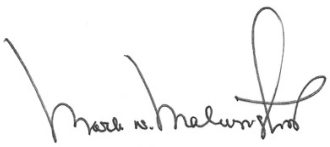

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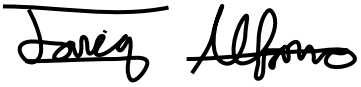

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