NANS
NORTH AMERICAN NEUROMODULATION SOCIETY

111 N. Wabash Ave., Suite 100-3653,
Chicago, IL 60602

773.648.7845 | info@neuromodulation.org

September 11, 2026

Submitted Electronically

The Honorable Mehmet Oz, MD
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1833–P
P.O. Box 8013
Baltimore, MD 21244–8013

RE: Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program [CMS–1848–P]

Dear Administrator Oz,

The North American Neuromodulation Society (NANS) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) FY 2027 Proposed Physician Fee Schedule. NANS is a multi-specialty association of more than 1,600 physicians dedicated to the development and promotion of the highest standards for the practice of neuromodulation procedures in the diagnosis and treatment of the nervous system, including neurosurgeons, orthopedic spine surgeons, anesthesiologists, physiatrists, psychologists, urologists, and neurologists. We are committed to working with CMS and other stakeholders to promote the highest quality, most efficient patient care for patients dealing with chronic pain and other conditions that may be with targeted electrical, chemical, and biological technologies to the nervous system to improve function and quality of life.

Inadequate Physician Payment

The MPFS is the only major Medicare payment system not subject to an automatic, inflation-based annual update. The cumulative effect of that omission is substantial. Between 2001 and 2025, Medicare physician pay increased only 7 percent, or 0.3 percent per year on average, even though the cost of operating a medical practice increased 59 percent, or 2.0 percent per year on average. Adjusted for inflation in practice costs, Medicare physician pay declined 33 percent from 2001 to 2025, or 1.7 percent per year on average. In comparison, Medicare hospital updates totaled approximately 80 percent, or 2.5 percent per year on average, with inpatient services increasing by 83 percent and outpatient services by 80 percent. Congress has provided temporary relief in five of the last six years, but each of those adjustments has expired on its own terms. With the expiration of the most recent 2.5 percent update at

the end of CY 2026, physicians will once again see a net reduction to their Medicare payments for CY 2027, unless Congress acts to intervene. According to the Agency's own projections, the Medicare Economic Index will increase 2.5 percent over the same period.

Physician practices that have absorbed a quarter century of erosion simply cannot weather additional cuts. This rule advances several significant redistributive changes at once, and their combined effect falls hardest on the practices least able to absorb it. Small, independent, and rural practices operate on the thinnest margins, and for some, these changes would mean being paid less than it costs to deliver care, which could lead to more consolidation and less access to care and the transition of patients to high cost centers for the same level of care. The AMA shares CMS' goal of sustaining independent practice. However, if several policies proposed in this rule are finalized, that goal will be seriously jeopardized, and more physicians may become employees of healthcare systems, insurance companies, and venture-capital-backed entities.

CMS should not finalize these substantial payment changes without first publishing the specialty impact estimates that stakeholders need to appropriately evaluate them. The four major practice expense proposals, for example, are presented without disaggregated, specialty-level estimates, even though the proposals are interrelated and operate on the same practice expense relative value units (RVUs), making their combined effect impossible to assess from the aggregate tables alone. Several proposals also diverge from the analyses CMS itself commissioned: the RAND analysis underlying the indirect allocator modeled a policy that did not include the 10- and 90-day global period exclusion CMS now proposes. In this rule, CMS concludes that the data behind the indirect practice cost indices are too old to retain, while simultaneously relying on those same data elsewhere and declining to use the updated Physician Practice Information Survey data the AMA provided in January 2025. Before proceeding with several policies that will have such redistributive effects, we urge CMS to pause, collect the necessary data, publish the underlying analyses including specialty-level impact estimates, and continue to engage with the physician community.

We urge the Administration to bring Medicare physician payment updates more in line with rising practice costs by supporting congressional action to enact a permanent, inflation-based update tied to the Medicare Economic Index, including through the Patients First Act (H.R. 9693).

We are particularly concerned about the following proposals:

Updates to Payment Methodology

I. Conversion Factors

NANS appreciates that CMS proposes to implement the statutory updates required under section 1848(d) of the Social Security Act, as amended by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), together with a positive 0.53 percent budget neutrality adjustment reflecting proposed changes in work RVUs. We are deeply concerned, however, that these positive updates are more than offset by the expiration of the one-year 2.5 percent update that Congress provided for CY 2026. As a result, under current law, physicians would face a net Medicare payment cut in CY 2027. CMS proposes a qualifying APM conversion factor of $33.17, a decrease of 1.19 percent from CY 2026, and a nonqualifying APM conversion factor of $32.84, a decrease of 1.68 percent from CY 2026. In short, physicians are facing yet another year in which Medicare payment goes down while practice costs continue to climb.

Physicians continue to strongly advocate to Congress for permanent updates to the conversion factor that account for the growth in physician practice costs. The recurring pattern of temporary, expiring patches underscores why a one-year fix is no substitute for a durable, inflation-based update. Despite temporary updates in five of the last six years, Medicare physician payment has continued to erode as economic pressures on physician practices, including rising costs of rent, wages, supplies, and administrative burdens, have intensified. In contrast, hospitals have received far more robust payment updates year over year. Unlike physician payments, Medicare hospital updates totaled approximately 85 percent between 2001 and 2026, or 2.5 percent per year on average, with inpatient services increasing by 87 percent and outpatient services by 84 percent. CMS projects that the Medicare Economic Index (MEI) will increase by 2.5 percent for CY 2027, yet statutory updates for physician payment fall far short of that benchmark, widening the gap between payment and the cost of delivering care.

Inadequate physician payment has real-world consequences, accelerating the trend toward consolidation of independent physician practices and worsening seniors' access to care. These pressures are not borne equally. Small, independent, and rural practices, which operate on the thinnest margins and lack the scale to absorb administrative and input-cost increases, are least able to withstand another year of declining payment, and specialties with higher practice expenses are disproportionately exposed, as fixed statutory updates fail to track their rising costs. The bifurcated conversion factor further magnifies these disparities: physicians unable to participate in qualifying alternative payment models (APMs), often because no suitable model exists for their specialty or practice setting, absorb a steeper reduction than their qualifying participant (QP) counterparts, compounding the payment differential over time.

To protect Medicare for future generations, we urge the Administration to support congressional action to enact permanent, inflation-based updates for physician payments tied to the MEI. We specifically support the Patients First Act (H.R. 9693), which would establish an annual MEI-based update, reform budget

neutrality, replace the Merit-based Incentive Payment System, improve APM incentives, and create a new primary care payment pilot outside of budget neutrality. The need for this reform is reinforced by independent expert bodies. In its 2026 report, the Medicare Payment Advisory Commission (MedPAC) recommended increasing payment rates for physician services to bring fee-for-service (FFS) Medicare payment levels closer in line with providers' costs. Absent changes to the delivery system or payment updates through subsequent legislation, we believe beneficiaries will begin to have more restricted access to Medicare-participating physicians, and this will become an even greater issue as our population ages.

II. Practice Expense Methodology

For CY 2027, CMS proposes four distinct changes: a revised indirect allocator that excludes 010- and 090-day globals, elimination of the indirect practice cost indices over two years, a five percent stabilization cap, and a modifier based on allowed charges. The stabilization cap does not operate as described, because pooling later in the methodology produces cuts exceeding five percent for codes that are otherwise unchanged. These cuts would be on top of the 50 percent work adjustment implemented for CY 2026, which cut facility-based payment by seven percent overall and considerably more for some specialties and physicians.

***Before finalizing this proposal, NANS urges CMS to publish a detailed, code-level impact analysis, disaggregated by specialty, so that stakeholders can meaningfully assess and comment on its actual effects rather than the effects CMS assumes it will have*. CMS should repeal the proposed adjustment and pursue a more targeted alternative with stakeholders and defer the remaining PE proposals until specialty-level impact analyses are published for each, and phase in any resulting change over multiple years.**

III. Changes to the Ambulatory Specialty Model

NANS appreciates CMS's continued efforts to refine the Ambulatory Specialty Model (ASM) ahead of its January 1, 2027 launch date.[1] We support the Agency's proposal to replace MIPS Quality Measure #220 (Functional Status Change for Patients with Low Back Impairments) with MIPS Quality Measure #182 (Functional Outcome Assessment) in the ASM low back pain cohort quality measure set, as well as the proposal to permit voluntary submission of longitudinal patient-reported outcome (PRO) data to support future development of a PRO-based performance measure (PRO-PM). We believe these changes, if implemented thoughtfully, will result in more clinically meaningful and accurate measurement of quality and outcomes for ASM low back pain participants over time. We offer the following recommendations as CMS finalizes these policies.

[1] *Id.* at 43,964-43,997.

- ***Replacing MIPS Q220 with MIPS Q182.*** We support CMS's proposal to remove Q220 from the ASM low back pain quality measure set. Beyond the measure steward's decision to discontinue the measure, we note that the underlying instrument, the FOTO Low Back patient-reported outcome tool, is only rarely used in peer-reviewed clinical literature or clinical practice. Other instruments, such as the Oswestry Disability Index (ODI) and the Patient-Reported Outcomes Measurement Information System (PROMIS), are far more common and better validated PROM options for assessing functional status in low back pain patients. We therefore support CMS's proposal to replace Q220 with Functional Outcome Assessment (Q182), and we support the ability of ASM participants to optionally report using PROMIS under that measure.
- ***Using PRO data responsibly as CMS considers a future PRO-PM.*** As CMS gathers experience with voluntary PROMIS (and other PRO) data submitted under Q182, we urge the Agency to carefully review that data before relying on it to build any future mandatory PRO-PM. In particular, we encourage CMS to prioritize longitudinal outcomes that capture patient function, quality of life, and sustained symptom improvement, rather than measures weighted toward short-term results. Many low back pain therapies are evaluated based on their ability to deliver sustained improvements in pain relief, function, quality of life, and health care utilization; follow-up periods that are too short may not fully capture the benefits of evidence-based therapies and could inadvertently favor interventions with more immediate, but less durable, effects.

  Relatedly, any future PRO-PM should account for patient-specific factors, including baseline pain severity and the relative invasiveness of the procedure performed, that predictably affect the timing and magnitude of expected improvement. For example, a patient with lower baseline pain severity who receives a single injection may show score improvement on a shorter follow-up horizon than a patient with more severe baseline pain who undergoes a more advanced surgical procedure. A PRO-PM that does not risk-adjust for these differences, or that applies a uniform follow-up window across clinically distinct interventions, risks systematically disadvantaging ASM participants who treat more complex patients.

- ***Clarifying the patient population included in the ASM low back pain cohort.*** CMS should provide additional detail in the final rule regarding the specific diagnosis and procedure codes (“trigger codes”) that define a patient as included in an episode of low back pain care under ASM. The proposed rule references the existing MIPS Episode-Based Cost Measure (EBCM), but it is unclear whether that same code list and methodology would be used to select patients into the model itself, or would apply only to the cost sub-measure within the model. If CMS intends to use the EBCM code list and methodology to select patients into ASM, we urge the Agency to provide additional training and clear, accessible guidance for participating providers on precisely which

patients will be included, so that practices can plan staffing, workflows, and patient communication accordingly.

- ***Considering a voluntary phase-in given the implementation timeline.*** Given the complexity of the model and the short window (approximately two months) between finalization of this rule and the January 1, 2027 start of the ASM performance period, we recommend that CMS consider making ASM voluntary in its earlier performance years. A voluntary phase-in would give participating providers and their staff the time needed to complete CMS-provided training, build the infrastructure necessary for quality reporting and PRO data collection, and adapt clinical workflows before the model's requirements become mandatory. This approach is consistent with recommendations NANS has made elsewhere in this letter and in prior PFS comment letters: significant, complex program changes should be phased in over time rather than imposed on a compressed timeline that leaves little room for provider readiness.

IV. Proposed Changes to Payments Using Modifier –25

NANS submitted a letter on this proposal with many other concerned parties. The importance of this issue cannot be understated and therefore, we are providing additional comments for consideration.
NANS has deep concerns regarding CMS's proposal to reduce physician payment when a separately identifiable office/outpatient E/M visit reported with modifier -25 is furnished by the same physician (or a physician in the same practice) on the same day as a 0-, 10-, or 90-day global procedure. Under this proposal, CMS would pay the full PFS amount for the most expensive service, while all other surgical procedures or E/M visits furnished on the same day would be paid at 50% of the applicable PFS payment.

To report modifier -25, a physician must document that the service is significant and separately identifiable from the usual pre- and post-operative work included in the associated global surgical procedure. Although CMS suggests that efficiencies may be achieved when these services are furnished on the same day, the Agency does not present data demonstrating that the resources required to furnish the separately identifiable E/M service are reduced by 50%, or that any such efficiencies occur consistently across specialties and procedures.

If adopted, this proposal has significant implications. Consider joint injection CPT code 20610: office reimbursement is already minimal, and the J-code payment for steroids is so low that practices often must offset the medication cost with the procedure payment. If this policy is finalized, patients may need to return on a separate day for the injection. That would be especially burdensome for elderly patients with conditions such as knee arthritis and back pain. Today, a physician can evaluate both concerns during one visit and perform a knee injection in the office to save the patient time. A 50% reimbursement reduction would make that approach economically unsustainable and force patients to schedule another visit.

Accordingly, we request that CMS defer adoption of this proposal until it develops a more data-driven policy and presents it for public comment.

V. Coding and Payment for Remote Monitoring

For CY27, CMS is proposing a package of changes to reimbursement for remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM) services. Separately, CMS is soliciting comment on a more sweeping restructuring that would replace the current 17 RPM/RTM CPT codes with four new bundled Health Care Common Procedure Coding System (HCPCS) G-codes (GRPM1/GRPM2 and GRTM1/GRTM2) combining setup, device supply, data transmission, and at least 20 minutes of monthly treatment management into single monthly services.[2]

NANS appreciates CMS' continued attention to program integrity in the remote monitoring code families and we recognize the agency's proposals in this area respond directly to findings from the HHS Office of Inspector General (OIG).[3] We offer the following comments on three of the proposed changes to RPM/RTM policy: the restriction on furnishing these services through contracted staff; the proposed revaluation of the setup, device supply, and treatment management codes; and the request for comment on replacing the current 17-code family with four new HCPCS G-codes.

CMS should take a more tailored approach to the program integrity concerns identified by the OIG and should not finalize a blanket prohibition on furnishing RPM/RTM services through contracted staff.

For CY 2027, CMS proposes to allow Medicare payment for RPM or RTM services only when furnished by clinical staff who are direct employees of the billing practitioner or practice, effectively prohibiting practices from contracting with third-party companies to furnish these services beginning January 1, 2027. CMS explains that this proposal responds to OIG findings that some third-party arrangements involve clinical staff with little to no relationship to the beneficiary, the care team, or the billing practitioner, including reports of companies cold-calling beneficiaries to solicit monitoring services.

NANS shares CMS' concern with the specific practices OIG identified—arrangements in which a third-party vendor operates with minimal oversight by, or integration with, the billing practitioner, and

[2] 91 Fed. Reg. at 43,892-43,895.

[3] HHS Office of Inspector General, Additional Oversight of Remote Patient Monitoring in Medicare Is Needed, OEI-02-23-00260, Sep. 9, 2024, https://oig.hhs.gov/reports/all/2024/additional-oversight-of-remote-patient-monitoring-in-medicare-is-needed/ HHS Office of the Inspector General, Billing for Remote Patient Monitoring in Medicare, OEI-02-23-0261, Aug. 28, 2025, https://oig.hhs.gov/reports/all/2025/billing-for-remote-patient-monitoring/.

beneficiaries are solicited for services without a legitimate clinical basis. However, we are concerned that the proposed remedy is broader than the problem it is meant to solve. Not all contracted staffing arrangements resemble the conduct OIG described. Many practices, particularly small, independent, and rural practices without the volume or capital to build dedicated in-house monitoring teams, rely on contracted clinical staff or technology-enabled monitoring vendors who operate under the practice's general supervision, follow the billing practitioner's care plan, and otherwise satisfy all requirements of the "incident to" regulations at 42 C.F.R. § 410.26, except for the technical requirement of common-law employment. A blanket employment mandate would eliminate these compliant arrangements alongside the noncompliant ones OIG identified, with a disproportionate impact on exactly the practices least able to absorb the cost of hiring dedicated monitoring staff.

We urge CMS to pursue a more tailored approach that addresses the specific program integrity gaps the OIG identified without eliminating legitimate contracted staffing models. For example, CMS could require documentation demonstrating the billing practitioner's ongoing review and oversight of contracted staff, a written agreement establishing the practitioner's supervisory relationship with the contracted staff, or records of communication between the contracted staff and the billing practice, rather than conditioning payment on employment status alone. We note that CMS has specifically requested comment on how often third-party billing occurs today and how this policy could affect access to remote monitoring services. NANS urges CMS to weigh those comments carefully before finalizing a policy that could reduce beneficiary access to RPM/RTM, especially in underserved communities.

CMS should not finalize the proposed practice expense crosswalks for RPM/RTM setup, device supply, and treatment management codes without more accurate, current cost data.

CMS proposes to revalue the PE inputs for the RPM/RTM setup and device supply codes by cross-walking them to the direct PE inputs of CPT codes 99473 and 93270, and to eliminate PE inputs entirely for the treatment management codes (CPT codes 99470, 99457, 99458, 98979, 98980, and 98981), on the rationale that current valuations may not accurately reflect the resource costs involved and that CMS lacks robust invoice or pricing data for the devices typically used.

NANS appreciates CMS' transparency regarding the data limitations underlying this proposal, but we do not believe that acknowledged data gaps should be resolved by defaulting to lower-cost comparator codes. CPT code 99473 describes patient education and calibration for a simple self-measured blood pressure device, and CPT code 93270 describes a legacy electrocardiogram (ECG) event recorder; neither reflects the resource costs of the connected devices typically used in RPM/RTM today, which commonly include cellular or Bluetooth connectivity, embedded software and algorithms, and clinical-grade physiologic or therapeutic sensors. Cross-walking to these comparator codes risks setting payment substantially below the actual cost of furnishing these devices, which could discourage practices, particularly smaller practices in the non-facility setting from offering RPM/RTM services at all.

We urge CMS to solicit and formally evaluate data (such as invoice and pricing data for representative RPM/RTM devices and information on hardware, software, and connectivity costs) before finalizing any crosswalk. Should CMS proceed with reductions to these codes, NANS requests that CMS phase in the resulting payment changes rather than implement them in a single year.

If CMS replaces the current RPM/RTM code family with bundled HCPCS G-codes, the new codes must preserve practitioners' ability to bill for treatment management services when the monitoring device is not supplied by the billing practice.

CMS is seeking comment on replacing the current 17-code RPM/RTM family with four new HCPCS G-codes — GRPM1, GRPM2, GRTM1, and GRTM2 — that would consolidate device supply, data transmission, and treatment management into a single monthly bundled service for each of RPM and RTM. We support CMS' goal of reducing administrative burden and ensuring beneficiaries reliably receive all components of these services, particularly in light of OIG's finding that 43% of enrollees receiving remote patient monitoring did not receive all three service components.[4]

NANS has significant concerns with the structure of the proposed GRPM2 and GRTM2 codes as drafted. Both codes would require, as a condition of billing the code at all, that the billing practice furnish the device supply component alongside the treatment management component within the same monthly bundle. In practice, this would mean a practitioner could not bill for treatment management—the professional work of reviewing patient data, adjusting a treatment plan, and communicating with the patient or caregiver—whenever the monitoring device is not supplied directly by the billing practice. This scenario is common and clinically appropriate: patients frequently use durable medical equipment (DME) with integrated remote monitoring capability that is supplied by a DME supplier rather than the treating practice, or devices they have purchased themselves, or devices furnished and paid for through another Medicare benefit or another payer altogether. The clinical treatment management work a practitioner performs does not differ based on who supplied the underlying device, yet the bundled code structure as proposed would make that work unbillable in each of these scenarios.

The rule as proposed would effectively remove physicians' ability to bill for RPM/RTM professional services provided in conjunction with devices not billed by the physician, including DME with integrated monitoring and patient-purchased devices. We recommend that CMS address this issue in one of two ways. First, and preferably, CMS should preserve the ability to bill treatment management separately from device supply, as is the case under the current code family, rather than bundling the two into a single monthly service. This approach would still achieve CMS' administrative simplification goal with respect to the numerous device-supply and setup codes, while ensuring the professional treatment management service remains

[4] HHS Office of Inspector General, Additional Oversight of Remote Patient Monitoring in Medicare Is Needed, *supra* note, at 8-10.

billable regardless of the source of the monitoring device. Second, if CMS proceeds with a bundled code structure, it should create a treatment-management-only G-code, comparable to current CPT codes 99457, 99458, 98980, and 98981, that practitioners may bill when device supply or data access is furnished through another channel, such as the DME benefit, patient purchase, or another payer. The device supply chain and the professional monitoring service it supports should remain separable, so that coding policy does not inadvertently restrict beneficiary access to monitoring technologies based solely on how the device reached the patient.

Finally, we note that CMS has indicated it may use Hospital Outpatient Prospective Payment System (OPPS) data to help value the proposed G-codes. CMS should identify the specific OPPS comparator codes under consideration and provide stakeholders an opportunity to comment on those crosswalks before finalizing valuation, given that hospital outpatient device acquisition costs may not reflect the costs practices incur for the same devices in the office setting.

VI. SOFTWARE AS A MEDICAL SERVICE

For CY 2027, CMS proposes renaming "Software as a Service" (SaaS) to "Software as a Medical Service" (SaMS) and extending that framework to stand-alone algorithmic analyses performed on existing laboratory test data, proposing to remove 10 HCPCS codes from the Clinical Laboratory Fee Schedule (CLFS) and pay them with contractor pricing under the PFS. These proposals correspond to proposals contained in the CY 2027 OPPS proposed rule. [5]

CMS should finalize its proposal to change its terminology from SaaS to SaMS, and should continue working toward standardized, cross-agency definitions.

NANS supports CMS's proposal to change its terminology from "Software as a Service" to "Software as a Medical Service" to refer to software-based technologies that use algorithmic analysis to support clinical decision-making. We agree with CMS that the prior "SaaS" terminology, which is used across other industries to describe general cloud-based computing service models unrelated to health care, risked confusion when applied to technologies that provide a distinct medical function for purposes of OPPS payment policy. This concern echoes one NANS raised in our CY 2026 comment letter, in which we asked CMS to clarify the types of technologies it intended to capture in its SaaS policy and payment proposals,[6] and we appreciate that CMS's proposed terminology change is responsive to that request.

We encourage CMS to treat this terminology change as one step toward a more fully standardized definitional framework, rather than as the end point of that effort. As CMS continues to refine its

[5] 91 Fed. Reg. at 43,910-43,912.

terminology and its long-term payment framework, NANS again encourages the agency to coordinate with the FDA and other stakeholders to align OPPS terminology, to the extent practicable, with existing regulatory definitions applicable to these technologies. Standardized, cross-agency definitions will reduce ambiguity for manufacturers and hospitals alike and will support a more consistent payment approach as new SaMS technologies continue to enter the market.

We appreciate the opportunity to comment on this important, proposed rule. If we can provide any additional information, please contact Keri Kramer at kkramer@nans.org

Sincerely,

Magdalena Anitescu, MD, PhD
President, North American Neuromodulation Society