NANS
NORTH AMERICAN NEUROMODULATION SOCIETY

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September 12, 2025

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1832-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: File Code CMS-1832-P; Medicare Program; 2026 Payment Policies under the Physician Payment Schedule and Other Changes to Part B Payment and Coverage Policies; (July 16, 2025)

Dear Administrator Oz:

The North American Neuromodulation Society (NANS) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) Notice of Proposed Rule Making (Proposed Rule) on the revisions to Medicare payment policies under the Physician Payment Schedule for calendar year (CY) 2026.

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. Our members include 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.

This letter includes NANS recommendations and comments regarding the following proposed provisions of the 2026 MPFS Proposed Rule:

I. CY 2026 Proposed Conversion Factor
II. Efficiency Adjustment
III. Updates to Practice Expense Methodology – Site of Service Payment Differential
IV. Ambulatory Specialty Model

V. WISeR Pilot Program

I. Proposed Conversion Factor

The two separate conversion factors proposed for the 2026 Medicare Physician Fee Schedule (MPFS) are mandated by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to incentivize value-based care. One conversion factor is for participants in qualifying advanced Alternative Payment Models (APMs), and the other is for all other providers.

The dual conversion factor system aims to financially reward providers who take on higher accountability for patient care quality and cost, while providing a smaller update for those in the traditional fee-for-service system.

Beginning in 2026, the MPFS will use two different conversion factors:

- Qualifying APM Participants (QPs): Will receive an annual update of 0.75%.
- Non-Qualifying Participants (non-QPs): Will receive a lower annual update of 0.25%.

This payment gap is already visible in the proposed 2026 rates, which are higher for QPs than for non-QPs, even with the temporary 2.5% increase for all providers from recent legislation.

While the higher conversion factors for QPs are intended to incentivize participation in advanced APMs, many specialties face difficulty meeting the stringent participation thresholds. The dual conversion factors exacerbate the long-standing financial instability of the Medicare payment system, particularly for non-QPs, because:

- Growing payment gap: The payment differential between QPs and non-QPs will widen over time with each annual update, as mandated by MACRA.
- Misleading positive updates: The overall positive conversion factor update for 2026—the first in years—is temporary and partially offset by other budget-neutrality adjustments.
- Persistent cost pressures: The overall payment system continues to fail to account for the increasing costs of running a medical practice, a problem that affects all physicians but is heightened for those receiving a

The negative impact on many providers from the two conversion factors is intensified by other policies proposed in the 2026 rule.

- Efficiency Adjustment: A proposed 2.5% "efficiency adjustment" reduces the value of Relative Value Units (RVUs) for many non-time-based services, including surgical and diagnostic procedures. This change disproportionately affects procedural and diagnostic specialties, reducing their overall

payment.**We do not believe that physicians should be penalized due to any gains in efficiency. Moreover no clear data are presented to justify the selection of a 2.5% downward adjustment.**

- Site-of-Service Differential: A change in the practice expense methodology reduces indirect practice expense RVUs for services performed in facility settings (e.g., hospitals). This shift, which is budget-neutral, redistributes payments toward office-based services, negatively affecting facility-based providers.
- Exclusion of new data: The Centers for Medicare & Medicaid Services (CMS) has also decided not to use new survey data on practice costs, which we believe neglects the significant increase in practice costs over the last several years due to inflation.
- For many NANS physicians that are not heavily focused on time-based evaluation and management (E/M) services, the combination of a lower non-QP conversion factor and the efficiency adjustment can result in a net payment reduction despite the positive statutory update. This creates a volatile and unpredictable financial outlook for a significant portion of clinicians serving Medicare patients. **We are concerned that continued downward pressure on the conversion factor and other aspects of the MPFS will lead to further restrictions on access to care for Medicare beneficiaries.**

II. Efficiency Adjustment

CMS proposes to decrease the work RVUs and/or physician intra-service time for 7,267 physician services by 2.5 percent. NANS is concerned with this proposal because the cut is based on an assumption of increased physician efficiency, not on new data or physician input. Even brand-new services, for which efficiency gains could not already have been achieved, are included in this cut.

CMS would then compound these reductions with additional reductions every three years. CMS states that it will exempt 389 codes, including time-based services, E/M, care management, maternity care, and services on the CMS telehealth list, from this efficiency adjustment. CMS arrives at the 2.5 percent efficiency adjustment by tallying the last five years' private, non-farm, productivity adjustments in the MEI.

A recent study published in the Journal of the American College of Surgeons[1] found that the proposed efficiency adjustment is not supported by empirical surgical time data, as analysis of intra-service times from 1.7 million surgeries across 249 CPT codes and 11 specialties showed that overall operative times increased 3.1% from 2019 to 2023, with 90% of CPT codes having longer or similar operative times in 2023 compared to 2019.

[1] Childers, Christopher P MD, PhD[a,b]; Foe, Lauren M MPH[c]; Mujumdar, Vinita JD[c]; Mabry, Charles D. MD, FACS[d]; Selzer, Don J MD, MS, FACS[e]; Senkowski, Christopher K MD, FACS[f]; Ko, Clifford Y MD, MS, MSHS, FACS, FASCRS[g,h,i]; Tsai, Thomas C MD, MPH, FACS[c,j,k]. 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 ():10.1097/XCS.0000000000001588, August 13, 2025. | DOI: 10.1097/XCS.0000000000001588

NANS believe if implemented, the efficiency adjustment may intensify barriers to care, including longer wait times and challenges in access to specialty care. **We encourage CMS to abandon implementation of this 2.5% payment reduction as we believe there is significant risk of consequences to access to care for Medicare beneficiaries.**.

III. Updates to Practice Expense Methodology – Site of Service Payment Differential

NANS agrees with CMS that the pay differential between hospital outpatient departments and physician offices for the same services puts independent physician practices at a competitive disadvantage, particularly as practice expenses and administrative burdens climb. We are concerned that the proposed cuts to PE do not address the root cause of this differential, do not reflect resource costs incurred by practices in the facility setting, and create significant impacts to many individual physicians and other health care professionals. Importantly, this proposal could further drive health system consolidation, which is known to increase healthcare costs as competition drops. To achieve CMS' objective to bolster independent physician practices, CMS should work with the AMA to consider the new 2025 AMA Physician Practice Information (PPI) Survey results more fully when updating practice expesnse costs, including updating the PE/hour groupings.

We are pleased that CMS acknowledges that private physician practices need more money to stay afloat and compete with hospitals and health systems. One major source of the problem is that hospitals receive annual, inflation-based updates while physicians do not. As shown in the chart below, Medicare updates to hospitals totaled roughly 80 percent (or 2.5 percent per year on average) since 2001, while physician payments remained essentially flat. As mentioned above, we would greatly appreciate support from the Administration for congressional efforts to provide annual, inflation-based updates for physicians consistent with hospitals and nearly all other Medicare providers.

NANS also wishes to express our concerns that CMS' proposal to reduce indirect practice expense when a service is performed in a facility setting could have the unintended consequence of further incentivizing consolidation by hurting private practice physicians who provide services in hospital outpatient departments or ambulatory surgical centers. The results from the AMA's PPI survey showed $57 in indirect expenses per hour of direct patient care for hospital-based medicine and $62 for hospital-based surgery. These are not facility expenses. Respondents were instructed to only include costs related to the physician practice, such as coding and billing. Shifting all indirect payments to the facility fee would leave these independent practices uncompensated and create a financially unsustainable model for non-hospital-employed physicians. The physicians may have no choice but to sell their practice to a facility or corporate entity that can absorb their unpaid costs.

When physicians are directly employed by the hospital, ultimately the hospital may receive payment for both the professional and facility claims. However, hospitals typically charge back the physician related costs to the department or unit, resulting in reduced compensation. Therefore, the proposal would not account for costs

incurred by non-hospital-employed or hospital-employed physicians who provide services in the facility. **NANS strongly urges CMS to reconsider this proposal and to work with the AMA and physicians on an alternative based on the 2024 PPI Survey data that will support private practice physicians.**

IV. Ambulatory Services Model (ASM)

CMS is proposing to implement a new Ambulatory Services Model (ASM) payment model in 2027 in select geographic areas that would be mandatory for physicians who treat patients with heart failure or low back pain. CMS mandates participation in the ASM by randomly selecting approximately 25% of geographic areas (CBSAs and metropolitan divisions) for the model's implementation. Within these selected regions, eligible physicians and specialists who frequently manage heart failure or low back pain for Original Medicare beneficiaries are required to participate starting in January 2027. Participation is determined by the volume of chronic condition cases treated, not by the practice level.

The ASM model targets specialists such as general cardiologists (for heart failure) and anesthesiologists, pain management specialists, interventional pain management specialists, neurosurgeons, orthopedic surgeons, and physical medicine and rehabilitation physicians (for low back pain).

Under ASM, NANS members who frequently treat people with Original Medicare for low back pain in the outpatient setting within a selected geographic area would be financially responsible for the outcomes of their care. The potential consequences of this mandate are vast, including financial risks, increased burden on independent and small practices, along with the added burden of prior authorization for many pain therapies to treat low back pain through WISeR or the spinal cord stimulation hospital outpatient department prior authorization already in effect for original Medicare patients.

Financial risks and structure

- Mandatory financial cuts for most participants. The model is structured so that most participating physicians will receive pay cuts, regardless of their performance. A portion of the funds from lower-performing doctors is redistributed to high performers, with CMS keeping a significant percentage, limiting the potential for broad financial rewards.

- "Tournament" competition model. Instead of setting a clear, predefined performance standard, the ASM uses a competitive "tournament" approach. A physician's payment adjustment depends on how their performance compares to a majority of their peers each year. This creates intense, relative competition rather than rewarding all providers who meet a certain quality bar.Rather than engaging in this stressful competition, physicians may just choose to forgo caring for patients with Medicare, creating significant limitations in access to care for our seniors.

- Immediate financial risk. Unlike some other CMS models that offer a grace period, ASM participants face mandatory upside and downside risk from the first performance year. This could be financially disruptive for smaller practices. **It is not appropriate to assess penalties at the very beginning of a new, confusing program with which physicians and their staffs have no prior experience with the metrics and reporting methodologies.**

- High stakes for a small subset of patients. Physicians who treat as few as 20 Medicare patients with heart failure or low back pain per year could be required to participate. Their payment adjustments, however, would apply to all their Medicare Part B payments, even though ASM patients may only represent a small fraction of their practice. **Once again, by penalizing all of a physician's Part B payments for the care of a subset of patinets, CMS is incentivizing physicians to cease caring for Medicare patients.**

Burden on independent and small practices

- Potential for accelerated consolidation. NANS is concerned that the model could unintentionally drive further consolidation in the health care market. Independent practices may find the financial and administrative burdens too great to bear, pushing them toward larger hospital systems or networks. **Healthcare system consolidation invariably leads to higher regional healthcare costs.**

- Disadvantage for individual practitioners. The model assesses performance at the individual clinician level, rather than at the practice or group level. This puts significant financial pressure on individual specialists, as they cannot offset a single provider's lower performance with the stronger results of their colleagues.

- Complex administrative requirements. While the model aims to support collaborative care, it introduces prescriptive requirements for establishing formal Collaborative Care Arrangements (CCAs) with primary care providers. These include mandatory workflows and strict documentation rules that may be difficult for smaller practices to implement.

Implementation Concerns

- Arbitrary participation. The model mandates participation for eligible specialists in designated geographic areas, eliminating the opportunity for clinicians to voluntarily opt-in.

- Inadequate inclusion of non-physician providers. The model does not include non-physician practitioners, such as nurse practitioners and physician assistants, in its attribution methodology. While these providers can assist with patient care, their performance is not individually measured or rewarded under ASM.

- Payment delay. Payment adjustments are based on performance from two years prior, which can make financial planning difficult for practices. **Independent physician practices are already operating on extremely thin margins. This proposed lag time imposes more uncertainty in practice budgets and can lead to unexpected deficits years after patient care is provided.**

- Prescriptive beneficiary incentives. The beneficiary incentive framework proposed by CMS, which offers incentives for patient engagement, is highly prescriptive. The requirements for documentation and administration of these incentives may be challenging for smaller, independent practices to manage.

NANS believe the risks outweigh the benefits and encourages CMS to not implement this payment model.

V. WISeR (Wasteful and Inappropriate Service Reduction) Model

While not in the Proposed Rule, NANS would like to take this opportunity to comment on the WISeR program. While NANS understands the intent behind the name of the pilot prorgam, the idea that neurotechnology is "wasteful" and "inappropriate" is both inappropriate, incorrect, and will be harmful to ensuring that eligible patients receive these life improving technologies. The majority of neuromodulation therapies are employed as a late or last resort and provide an option for patients whose quality of life is severely impacted by neurologic disorders and have few other treatment options. We disagree with labeling these therapies as wasteful and low-value. For example, there has previously never been an assertion that deep brain stimulation (DBS) for the treatment of advanced Parkinson's disease, essential tremor, dystonia, or epilepsy is "wasteful" and inappropriately utilized. Vagus nerve stimulation for intractable epilepsy helps reduce seizures in patients at risk for sudden unexpected death in epilepsy (SUDEP). Trigeminal ganglion ablation procedures eliminate facial pain that prevents patients from eating, drinking, and talking and is often labeled "suicide pain" because of its severity. We have not seen any justification from CMS for the inclusion of these and other neuromodulation procedures in the WISeR pilot program. **Importantly, imposing new PA requirements for original Medicare patients will result in delays in care and continued deterioration of quality of life for these patients.** Moreover, this model will place an unmanageable burden on the administrative staffs of offices, as it adds time and complexity, without additional reimbursement for their efforts.

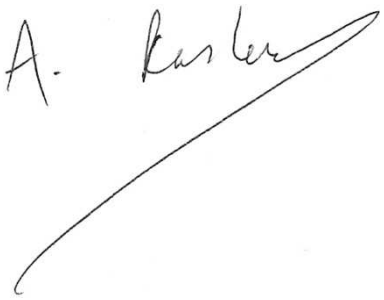
Delaying patient care while imposing significant additional administrative burdens on physician practices incentivizes physicians to reduce their participation in the Medicare program. We should not be implementing programs that impair access to care for patients who need it most.

NANS is also concerned that the review decisions under the WISeR pilot made by the third-party vendor AI systems will lack transparency. Algorithms and criteria used to approve or deny services are unclear, making it difficult for providers to understand or craft appeals of denials. **It is imperative that any decisions rendered as part of this pilot are transparent as to the data utilized by the AI system to come to the determination and provides a clear pathway to appeal the denial to a human being.**

NANS does not support the WISeR model, as WISeR expands the scope and burden of prior authorization demands, causing delays in medically necessary procedures. There are few other options for patients suffering from epilepsy, Parkinson's, tremor, dystonia, and chronic pain. It is critical that physicians are able to determine appropriate utilization based on a patient's individual needs while using evidence based practices that optimize safety and efficacy.

Thank you for your consideration of NANS comments on the CMS Proposed Rule on the revisions to 2026 Payment Policies under the Physician Payment Schedule and Other Changes to Part B Payment and Coverage Policies; (July 16, 2025). We commend CMS for its continued efforts to improve care quality and access. If you have any questions about our comments, please do not hesitate to contact Keri Kramer, NANS CEO, at kkramer@neuromodulation.org.

Sincerely,



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