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VIA ELECTRONIC TRANSMISSION

September 12, 2025

The Honorable Mehmet C. Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
ATTN: CMS-1832-P
P.O. Box 8013 Baltimore, MD 21244-1850

Re: CMS-1832-P. Medicare and Medicaid Programs; CY 2026 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

Dear Administrator Oz:

On behalf of the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS), representing more than 4,000 neurosurgeons nationwide, we thank you for your public service and determination to lead the Centers for Medicare & Medicaid Services (CMS). In your first term, you have a unique opportunity to do what your predecessors did not: fundamentally re-examine Medicare physician payment policy — particularly the Medicare Physician Fee Schedule (MPFS) — and treat it as the structural foundation of America's health care ecosystem.

For decades, the MPFS has operated without meaningful reform, with annual updates that lag behind inflation and practice costs, while alternative payment models have proven largely unworkable. Since 2001, Medicare physician reimbursement has fallen 33 percent in real terms, even as practice overhead has risen nearly 50 percent.[1] This chronic underpayment has destabilized the economics of independent practice, particularly for physicians whose payer mix is heavily Medicare-based and who lack commercial revenue to offset losses. Practices in rural, underserved, and lower-income communities are especially vulnerable, as are specialties that provide high-volume care to seniors. In these settings, reimbursement shortfalls leave few options beyond downsizing, closure, or sale to larger health systems. Hospitals, in turn, often acquire these practices and convert them into hospital outpatient departments (HOPDs) that bill Medicare at significantly higher rates for the same services. The result is a steady decline in competition and a shrinking independent workforce, with the share of U.S. physicians in private practice falling from about 60% in 2012 to less than 47% in 2022.[2]

[1] American Medical Association, Chart: Medicare Updates Compared to Inflation in Practice Costs (2001 – 2025), https://www.ama-assn.org/system/files/2025-medicare-updates-inflation-chart.pdf.
[2] Schpero, W. L., Richards, M. R., Bleser, W. K., McWilliams, J. M., & Saucke, M. (2023), Differences in hospital outpatient department billing among system-affiliated physician practices, Health Services Research, 59(1), 3–13.

The consequences for patients are painfully visible. Clinician-led practices care for nearly 34 million Americans enrolled in Original Medicare — almost half of all beneficiaries, including more than 3.3 million under 65 living with disabling conditions or end-stage renal disease.[3] In rural areas, where nearly 58 percent of seniors rely on traditional Medicare, access is especially fragile. Between 2019 and 2024, rural America lost nearly 9,500 independent physicians and experienced a 42 percent reduction in independent rural practices, leaving fewer than 12,500 to serve these communities today.[4] When practices close, patients are forced to travel long distances, leave their communities, or delay care until emergencies arise — outcomes that are harder, costlier, and too often irreversible.

There is, however, momentum for a different path. President Trump, HHS Secretary Kennedy, and leaders in Congress have made clear that making America more competitive and renewing our commitment to patient-centered care requires a strong and sustainable physician practice infrastructure. The MPFS is not a bookkeeping exercise; it is the backbone of physician care delivery, shaping not only Medicare but also Medicaid, commercial insurance, and the trajectory of U.S. health care markets for years to come. Under your leadership, CMS has the chance — and the responsibility — to restore stability, preserve independent practices, and foster genuine competition that benefits patients, physicians, and taxpayers alike.

We recognize that reforming the MPFS alone will not solve every problem facing America's health system. Many policies across CMS have contributed to market failures we face today. But payment policy remains a decisive factor — one that has been neglected for too long. In the pages that follow, we offer a clear set of recommendations aimed at stabilizing physician payment, strengthening independent practice, and ensuring Medicare beneficiaries retain timely access to evidence-based care.

EXECUTIVE SUMMARY

Conversion Factor

We acknowledge the proposed increase in the Medicare conversion factor, partially driven by policy proposed by CMS and partially driven by recent legislative requirements that will go into effect in 2026. While we would like to see Congress enact a permanent inflationary adjustment tied to the Medicare Economic Index, we were active in encouraging Congress to implement the 2.5% increase to the Medicare conversion factor for 2026, which was signed into law. However, according to the information in the proposed rule, the overall impact of provisions for neurosurgery is a decrease of 5 percent, an unsustainable reduction given significant financial pressures on neurosurgeons due to rising costs and cuts in reimbursement over the past two decades.

2.5 Percent "Efficiency" Reduction and Support for the RUC Process

These positive updates for 2026 do not represent a comprehensive solution to longstanding issues with the physician payment system. They are offset in many cases by the proposed 2.5 percent across-the-board "efficiency" reduction, which we firmly oppose. The recommended cuts are arbitrary, and the

[3] U.S. Centers for Medicare and Medicaid Services (CMS), Medicare Monthly Enrollment, https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment.
[4] Physicians Advocacy Institute, PAI-Avalere Report: Rural Areas Face Steep Decline in Independent Physicians and Practices, https://www.physiciansadvocacyinstitute.org/PAI-Research/Rural-Physician-Employment-and-Acquisition-Trends-2019-2024.

characterization of the AMA/Specialty Society Relative Value Scare Update Committee (RUC) process is unfounded.

Global Surgical Codes

- **CMS RFI on Global Surgical Codes**. We appreciate the RFI on Global Surgical Codes and note the four approaches CMS raises as possible "solutions." We support maintaining the current process for valuing Global Surgical Codes using the RUC to address any outlier concerns.

- **Increasing the E/M Values in the Global Periods**. As we have for many years, we continue to urge CMS to immediately increase the 010- and 090-day global codes to reflect the proportionate increase in value for evaluation and management (E/M) codes to maintain the relativity of the fee schedule and comply with the Medicare statute prohibiting specialty payment differentials. This is the only action that CMS should take regarding the surgical global periods at this time.

Practice Expense (PE) Relative Value Units (RVUs)

- **Low Volume Overrides.** We support the AMA/Specialty Society Relative Value Scale Update Committee (RUC) recommendations for low-volume services.

- **Medicare Economic Index and AMA PPI Survey.** We support the AMA Physician Practice Information (PPI) Survey and were disappointed to see that CMS has not agreed to accept the survey data. We urge CMS to delay implementation of any modifications to the indirect practice expense methodology until the 2024 PPI survey data are implemented.

- **Update to Practice Expense Methodology—Site of Service Payment Differential.** We oppose the CMS proposed methodology to reduce indirect practice expense when a service is performed in a facility setting.

CMS Valuation of Specific Codes

- **CMS Acceptance of RUC-Recommended Values**. We appreciate the agency's acceptance of most RUC-passed values, which are based on valid, clinically relevant information that preserves relativity. We believe the RUC is the entity best positioned to provide recommendations to CMS on resource inputs for work, PE, and professional liability valuations and to establish values for E/M and other physicians' services. **We disagree with CMS's criticism of the RUC, which is unfounded and mischaracterizes the significant work provided to CMS free of charge by expert physicians volunteering their time.**

- **Endovascular Therapy with Imaging (CPT codes 61624, 61626, 75894, and 75898).** We urge CMS to restore the RUC-passed work value of 20.00 for CPT code 61624 and 15.31 for CPT code 61626.

- **MR Guided Focused Ultrasound.** CMS has asked for feedback on whether CPT code 61715 should be priced in the "non-facility" setting. We believe CMS should wait to address this issue until the scheduled re-review by the RUC in 2007.

- **E/M Visit Complexity Add-on. HCPCS code G2211.** We implore CMS to correct the utilization estimate for this code to make a prospective adjustment to the 2026 Conversion Factor in the final rule.

Merit-Based Incentive Payment System (MIPS)

- **MIPS Performance Threshold.** We strongly support retaining the threshold at 75 points for the CY 2026 performance period through CY 2028.

- **Sunsetting Traditional MIPS and Full Transitioning to MVPs by 2029.** We urge CMS to maintain MVPs as a voluntary pathway for clinicians, alongside traditional MIPS.

- **Modifications to Previously Finalized MVPs.** We are concerned about the arbitrary construction of the Surgical Care MVP, as well as measures in the MVP that CMS has inaccurately classified as "neurosurgical."

- **MVP Subgroups**. We oppose mandating subgroup reporting for multi-specialty group practices participating through the MVP pathway starting in 2026. If CMS moves forward with this policy, we strongly support its proposal to allow MVP participants to attest to the composition of their group, as well as its proposal to revise the definitions of single and multispecialty groups.

- **Core Elements MVP RFI.** We do not see value in potentially requiring MVP participants to report one quality measure from a subset of "core" measures since these measures will not provide patients or clinicians with meaningful, focused information regarding a specific condition or treatment.

- **Measure Procedural Codes RFI.** We strongly oppose CMS potentially using procedural codes in the future to assign clinicians to MVPs. Clinicians should continue to be allowed to self-select MVPs most relevant to their practice and patient population.

- **MIPS Measure Inventory.** We strongly disagree with CMS's assumption that reducing the MIPS quality measure inventory will reduce program complexity and burden. Specialists need more, not fewer, relevant measures.

- **Benchmark Methodology Updates for Administrative Claims Measures**. While we do not believe these measures are appropriate for MIPS since they do not capture costs within the direct control of individual clinicians, if CMS opts to maintain them, then we urge it to finalize its proposed improvements to the benchmarking methodology.

- **Transition Towards Digital Quality Measurement RFI.** We appreciate these efforts, but request that CMS consider ongoing challenges related to the implementation of electronic clinical quality measures (eCQMs).

- **Cost Measure Information Feedback Period.** We strongly support CMS's proposal to provide a 2-year informational-only feedback period for new cost measures prior to tying scores to payment.

  Updates to the Total Per Capita Cost (TPCC) Measure. We urge CMS to retire this long-problematic measure from MIPS. At the very least, we support revisions to ensure that specialties, such as neurosurgery, are not the unintended target of this primary care-focused measure. Given the seriousness of this issue, we strongly urge CMS to apply any finalized improvements to this measure starting with the 2025 performance period, rather than 2026.

Qualifying Participants (QP) in Advanced Alternative Payment Models (APMs)

- **Increasing the Number of Specialists Eligible for QP Status.** We support CMS's proposals to increase specialty eligibility for QP status, but also request that CMS urge Congress to make technical changes to the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to extend the expiring APM incentive payment and return QP thresholds to their previously lower level. It is equally critical that CMS work with specialty societies to develop meaningful and clinically appropriate specialty-focused APMs.

Ambulatory Specialty Model (ASM)

- We have significant concerns with this model and strongly urge CMS not to move forward with it as currently designed. At the very least, CMS should exclude surgeons from this model and work directly with surgical specialists treating spine patients to develop more appropriate voluntary opportunities to improve patient outcomes and the overall value of care.

DETAILED COMMENTS

1. Conversion Factor and Rate Setting

We acknowledge the proposed increase in the Medicare conversion factor, partially driven by policy proposed by CMS and partially driven by recent legislative requirements that will go into effect in 2026. While we would like to see Congress enact a permanent inflationary adjustment tied to the Medicare Economic Index, we were active in encouraging Congress to implement the 2.5% increase to the Medicare conversion factor for 2026 that was signed into law, and we are pleased to see our efforts come to fruition. Further, beginning in 2026, qualifying Alternative Payment Mode (APM) participants will receive a statutorily required 0.75% annual update, while non-qualifying clinicians will receive a 0.25% annual update. These changes result in the establishment of two separate conversion factors, both of which are projected to increase: 3.84% for qualifying APM participants and 3.32% for non-qualifying clinicians. This is the first time since 1998 that more than one conversion factor has been used. However, CMS estimates that the overall impact of provisions of the proposed rule for neurosurgery is a decrease of 5 percent. This is an unsustainable reduction, given the significant financial pressures on neurosurgeons due to rising costs and cuts in reimbursement over the past two decades. This decrease will inevitably result in reduced access to neurosurgical care for Medicare beneficiaries.

We echo the comments of the American Medical Association (AMA), the Alliance of Specialty Medicine, the American College of Surgeons (ACS), and the majority of medical specialty societies expressing our deep concern regarding the lack of a permanent baseline neutrality adjustment to the CY 2026 conversion factor to correct for the over projection in the utilization of the visit add-on code G2211, which contributed to a substantial cut in the CY 2024 conversion factor.

2. Efficiency Adjustment (Proposed 2.5% Work RVU Reduction)

CMS is proposing to establish an "efficiency adjustment" to the work RVUs, as well as corresponding updates to the intraservice portion of physician time inputs for "non-time-based services." According to the information in the proposed rule, this would result in an overall cut of 1 percent decrease for neurosurgery in 2026, coming in addition to the cut of an estimated 4 percent resulting from other provisions, including changes to the indirect practice expense. CMS's proposal is based on its questionable assumption that both the intraservice portion of physician time and the work intensity (including mental effort, technical effort, physical effort, and risk of patient complications) would

decrease as the practitioner develops expertise in performing the specific service. The RUC already has a process to review procedures using new technology, and we provide more detail on that process below. We join the RUC, the AMA, the Alliance of Specialty Medicine, the American College of Surgeons, and virtually the entire house of medicine in opposing the across-the-board cut. It is unfounded and is based on a lack of understanding and a mischaracterization of the RUC process. We urge you to heed the thorough and thoughtful detailed analysis provided by the RUC, and we highlight some of these points below.

CMS has historically and appropriately relied on survey data provided by the AMA RUC to estimate practitioner time, work intensity, and practice expense for the purpose of establishing RVUs for the codes used for payment under the MPFS. However, CMS has not relied on AMA RUC recommendations exclusively. We strongly disagree with the CMS concerns about the quality of AMA RUC survey data and find the CMS rationale for the across-the-board cuts unconvincing and an inappropriate approach designed to reach the shared goal of efficient and effective valuation of Medicare services. Indeed, for neurosurgery, we have conducted robust surveys with good sample sizes, appropriate and well-vetted reference service lists for comparison, and updated typical clinical vignettes. CMS has suggested that there are conflicts of interest that influence the quality of survey data. Yet, the very first question on a RUC survey asks about conflicts of interest, and those with disputes are not permitted to continue to complete the survey. All conflicts are reviewed by RUC staff, and if other existing data suggests a conflict of interest, a survey response can be redacted from the ultimate calculation of time and intensity, which is then reviewed by the RUC. In addition, all individuals presenting recommendations to the RUC must submit and attest to any conflicts, which are made available to the full RUC. Not infrequently, the RUC will disallow an advisor or other presenter from participation to prevent a conflict. Except in the rare situation in which a vendor list is permitted and clearly noted, the RUC effectively screens out those with industry conflicts.

The AMA CPT Editorial Panel and the RUC have worked for many years to account for changes in primary care management services. CMS describes specific concerns raised by commenters in the context of evaluation and management (E/M) services, including that E/M services are not amenable to efficiency gains because they are primarily time-based, and the current system leads to passive devaluation due to budget neutrality requirements. This is not true. Based on CPT and RUC recommendations, CMS has implemented several increases and changes to E/M codes since the inception of RBRVS, aimed at reducing physician burden and better reflecting the work and intensity of complex patients with multiple co-morbidities. These have resulted in substantial increases in the value of E/M services that have not been uniformly applied across instances of E/M work. In 2021, CMS took the unprecedented step not to use the increased value in the RVU of the E/M services to the CPT codes in the global surgical package. E/M services comprise a significant portion of the RVUs in global surgical codes, yet the work values have not increased commensurate with the increases in E/M codes. By not increasing the values of the E/M portion of the global surgical codes, those codes are now untethered from the valuation of the E/M services. The result is a loss of relativity within the fee schedule, a situation that will only worsen as E/M services continue to increase in value. CMS unilaterally decided to pay physicians of different specialties dissimilar rates for the same work, violating the Medicare statute against specialty payment differentials. In applying the “work efficiency” adjustment to the work RVU for CPT codes with a 010- or 090-day surgical global period, CMS is also decreasing the work value of the bundled E/M visits by 2.5 percent. This would increase an even larger discrepancy between the payment level of a stand-alone E/M visit and the E/M visits bundled into a surgical global payment. CMS must return payment for E/M visits bundled into surgery global payment at the same level as standalone visits. We are eager to work with the RUC and CMS to ensure the number and level of visits included within the global are accurate. Still, CMS should fix the E/M inequity before second-guessing the RUC process with respect to E/M versus procedural services. Unless the discrepancy between the standalone E/M value

and the E/M value incorporated into global codes is corrected, the relativity of code values that forms the foundation of RBRVS will be stretched to the point of breaking.

CMS highlights its concerns about accounting for efficiencies gained in non-time-based services (e.g., procedures, radiology services, diagnostic tests), contending that procedures become more efficient as the services become more common, professionals gain more experience, technology is improved, and other operational improvements (including but not limited to enhancements in procedural workflows) are implemented. We question this contention and note a recent study from the ACS that found that empirical surgical time data do not support the proposed efficiency adjustment.[5] Intra-service time data (i.e., skin-to-skin operative time) from 2019 and 2023 were compared for 1.7 million surgeries across 249 CPT codes and 11 surgical specialties from the National Surgical Quality Program registry. The study concluded that "Overall, operative times increased by 3.1% (CI 3.0-3.3%, p<0.001) in 2023 compared to 2019, or 0.8%/year (CI 0.7-0.8%/year, p<0.001). At the procedure level, 90% of CPT codes had longer or similar operative times in 2023 compared to 2019." In addition, a new study in the *Annals of Surgery*, "U. S Surgical Practice: 23-Year Trends in Medicare Procedures and Reimbursement," looked at the 10 most commonly performed procedures by 11 surgical specialties, including neurosurgery, and found that overall, surgical procedure volume has increased over the study period, with a sharp decline due to the COVID-19 pandemic, which gradually increased over the following two years, but that reimbursement rates continue to decline across the board, with the majority of surgical CPT codes decreasing in value over the study period.[6] This study is the first to analyze surgical trends in the Medicare population at large from 2000 to 2022, revealing a consistent decline in reimbursement rates for the surgical specialties studied.

In the proposed rule, CMS cites a statistic that, on average, 25.49 years have passed since a code's valuation has been reviewed by the AMA RUC (or 17.69 years if excluding never-reviewed codes). We question the validity and relevance of this analysis and provide additional details below in our discussion of the RUC Relativity Assessment Workgroup (RAW) process.

We have played a crucial role in the RUC since its inception in November 1991 by providing expert input to panel members and AMA staff, conducting surveys, and presenting recommendations to help develop accurate codes and appropriate valuation. A history of the development of the RUC by the ACS notes the strong contribution of neurosurgery from the inception and during the first Five-Year Review of the MPFS.[7] Robert Florin, MD, a neurosurgeon who served as one of the first members of the RUC, was instrumental in developing the Intraservice Work per Unit of Time (IWPUT) methodology for measuring intensity of services.[8] For the purposes of the RBRVS, physician work is determined by time and intensity, which is made up of technical skill and physical effort, mental effort and judgment, and psychologic stress. Time alone cannot be used to measure physician work. We support the RUC as the best entity for developing relative value units (RVUs) for the MPFS due to its physician-driven, data-

[5] Childers, Christopher P MD, PhD; Foe, Lauren M MPH; Mujumdar, Vinita JD; Mabry, Charles D. MD, FACS; Selzer, Don J MD, MS, FACS; Senkowski, Christopher K MD, FACS; Ko, Clifford Y MD, MS, MSHS, FACS, FASCRS; Tsai, Thomas C MD, MPH, FACS. 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

[6] Singh, R, et al., (2025) US Surgical Practice: 23-year Trends in Medicare Procedures and Reimbursement. Annals of Surgery 10, 1097, published ahead of print.

[7] Mabry CD, McCann BC, Harris JA, Martin J, Gage JO, Fischer JE, Opelka FG, Zwolak R, Borman K, Preskitt JT Sr, Collicott PE, McGinnis L Jr, Cohn I. The use of intraservice work per unit of time (IWPUT) and the building block method (BBM) for the calculation of surgical work. Ann Surg. 2005 Jun;241(6):929-38; discussion 938-40. doi: 10.1097/01.sla.0000165201.06970.0e. PMID: 15912042; PMCID: PMC1357172.

[8] Florin RE. Rasch analysis in measurement of physician work. J Outcome Meas. 2000;4:564–578

informed process. The RUC's expertise in clinical practice, combined with its rigorous review process and focus on transparency, ensures that RVUs are aligned with the resources required to provide services to Medicare patients. Below are additional details on our support for the RUC process:

- **Physician Expertise and Clinical Knowledge**. The RUC is composed of 32 practicing physicians and other healthcare professionals who have in-depth knowledge of the time, effort, and resources required to perform specific medical services. In addition, the RUC advisory committee includes 300 advisors from over 100 physician and health-care professional organizations. All of these physicians and health care professionals volunteer their time and effort (and take time away from their families and their medical practices) to lend their expertise to the process of valuing all the services provided under the RBRVS system. The input from RUC members and advisors ensures that the valuation process reflects the realities of clinical practice, rather than being solely based on administrative or financial data. Many of the RUC members and advisors have served for a decade or more. Neurosurgeons have contributed years in service to the RUC and include Byron Pevehouse, MD, who served as a RUC member from the establishment of the panel until 1994; Robert Florin, MD, who served from 1994 to 2001; Gregory Przybylski, MD, who served from 2001 to 2018; and now G. Edward Vates, MD, carries on the work. These dedicated neurosurgeons have provided their time, expertise, and insight to study and review the work of services provided by physicians other than neurosurgeons. They are serving as RUC members, not as advocates for their specialty, because RUC rules prohibit a RUC member from commenting on a proposal presented by their own specialty, a duty that our RUC members take very seriously. This is a crucial point: RUC members give up their time not only for the three RUC meetings each year, but also spend considerable time in evening virtual committee meetings and reviewing submissions ahead of the meetings. This level of excellence to maintain the MPFS is entirely without charge to the taxpayer and an enterprise that could never be replicated by the agency alone.

- **Data-Driven Methodology**. The RUC employs a rigorous survey process to collect data on physician work, practice expenses, and other pertinent factors for each service, carefully assessing the time, intensity, and clinical judgment required. This data is then used to develop recommendations for RVUs that are submitted to CMS. Every procedure involving new technology that is valued by the RUC is tagged for re-review within 3 years to assess the accuracy of the initial valuation and to consider efficiencies that may evolve as physicians gain more experience with the procedure. A recent example in neurosurgery is the newly valued MR-guided Functional Ultrasound CPT code 61715, which was presented to the RUC in January 2024 and included in the CY 2025 MPFS. This service is on the “new technology” list and will come up for a review in 2027.

- **Transparency and Accountability.** The RUC publishes meeting dates, minutes, and recommendations on the AMA website. This transparency allows stakeholders and the public to review the RUC's work and provide feedback. The RUC's open process helps to ensure that the recommendations are fair, accurate, and aligned with the needs of the Medicare program. CMS has participated in RUC meetings since its beginning. CMS medical officers and other staff have the opportunity to comment on every proposal presented at a RUC meeting. In addition to CMS staff who regularly attend RUC meetings, researchers and staff from government and private agencies, as well as other stakeholders, are welcomed by the RUC and often attend the meetings.

- **Continuous Improvement and Adaptation.** We recognize that healthcare is constantly evolving, and we have worked with the RUC to identify and address misvalued services. The RUC RAW

screens MPFS codes on an ongoing basis, taking into account new technologies, changes in clinical practice, and feedback from stakeholders. Often, this process results in a re-survey of the codes. The RAW has examined approximately 2,924 potentially misvalued codes, representing nearly 95 percent of MPFS services. RUC recommendations have led to reductions and deletions in over 1,600 services, resulting in an estimated annual redistribution of more than $5 billion. With respect to E/M codes, we, CPT and RUC advisors, have worked with medical specialty society colleagues to assess the current state of medical practice. Virtually all physicians provide E/M visit services, and ensuring that these services may be selected based on the complexity of medical decision-making and not just on time is important.

Again, the RUC's combination of physician expertise, data-driven methodology, transparency, and focus on continuous improvement makes it the best entity to develop RVUs for the MPFS. We encourage CMS to continue working with the RUC to ensure a fair and accurate physician payment system.

3. Global Surgical Codes (RFI and Global Period Issues)

For more than a decade, the HHS Office of Inspector General (OIG) has questioned the number and level of E/M visits in global surgical packages, beginning with its widely discredited 2012 report and continuing through the July 2025 report recommending that CMS improve its methodology for collecting postoperative visit data.[9, 10] In response, CMS has repeatedly sought data on services furnished during global periods, including commissioning RAND to collect information on postoperative visits. As we detailed in our September 2019 comments on the CY 2020 MPFS proposed rule, that process was poorly structured, difficult to operationalize, and produced incomplete data that were never validated. We agree with the ACS, AMA, RUC, and other stakeholders that the RAND analysis is unreliable, and we continue to strongly oppose any changes to global code payment based on those reports.

As CMS notes, MACRA continues to prohibit the agency's previous proposal to convert all 10- and 90-day globals to 0-day globals. As we have stated above, we believe the RUC process is the most effective and efficient way to review the valuation for procedures, including those reported with global periods. To the extent there may be specific outlier global surgical procedures that have not recently been reviewed by the RUC, CMS can follow well-established precedent by identifying those specific codes as potentially misvalued and allow the RUC to conduct a thorough review without implementing burdensome disruptions to surgeons and their patients. After all the ineffective efforts to question whether E/M services are actually being provided in global surgical services, we are left concluding that CMS is using this issue to achieve a pre-determined goal to reduce the value of surgical services.

In the CY 2025 MPFS, CMS finalized a proposal to require the use of the appropriate transfer of care modifier (modifier -54, -55, or -56) for all 90-day global surgical packages in any case when a physician plans to furnish only a portion of a global package both when there is a formal, documented transfer of care (current policy) and when there is an informal, non-documented but expected, transfer of care. Separately, CMS also created HCPCS code G0559 to capture the additional time and resources spent in

[9] U.S. Department of Health and Human Services, Office of Inspector General, (2012), Musculoskeletal global surgery fees often did not reflect the number of evaluation and management services provided (OEI-07-10-00421), https://oig.hhs.gov/reports/all/2012/musculoskeletal-global-surgery-fees-often-did-not-reflect-the-number-of-evaluation-and-management-services-provided/.

[10] U.S. Department of Health and Human Services, Office of Inspector General, (2025), CMS should improve its methodology for collecting Medicare postoperative visit data on global surgeries (OEI-04-20-00481), https://oig.hhs.gov/reports/all/2025/cms-should-improve-its-methodology-for-collecting-medicare-postoperative-visit-data-on-global-surgeries/.

providing follow-up post-operative care by a physician or other qualified health care professional who did not perform the surgical procedure and who has not been involved in a formal transfer of care agreement. CMS has not yet shared the collected data from this initiative. We support the use of a modifier in those rare cases when a surgeon does not provide the post-operative care. Instead, a provider from another specialty, perhaps someone closer to the patient's home, provides the care. This year, CMS is seeking comments on strategies to improve the accuracy of payment for global surgical packages and is soliciting input on the best approach to utilize these data in the future. Specifically. CMS has asked for feedback on four options for gathering data on services provided to patients receiving procedures with a global period. We offer comments on those specific proposals below:

- **Approach A. Status Quo.** We acknowledge the fact that CMS has requested comments on the global surgical payment system and, therefore, the agency believes that there are inaccuracies in these codes. We support the current system with possible adjustments developed in coordination with the RUC. Over the last ten years, CMS has been seeking a major change to address a payment convention that is not a significant issue. We doubt that any remaining high-volume surgical codes have not been flagged and reviewed by a RUC RAW screen. CMS has more than fulfilled its obligation to scrutinize global surgical codes and should make no significant changes until taking up the overdue task of restoring full value to the E/M visit services in the global periods.

- **Approach B. Reverse Building Block Methodology.** CMS outlines an option for addressing Global Surgical codes using the "reverse building block" method, in which the codes are converted to 000-day global services, and the value for the E/M services is stripped out and reported separately. As we and the RUC have noted over many years, this approach is entirely inappropriate. E/M services within a global period are not simply additive to the overall service's work value. Using a reverse building block approach to systematically remove the bundled E/M services would drastically undervalue many surgical procedures. Such a change could negatively impact Medicare beneficiaries by requiring co-payments for each post-operative visit, thereby increasing their out-of-pocket costs and potentially adversely affecting the coordination of post-operative care. The surgeon takes on the responsibility and liability for all care related to the surgery for the full global period. In an environment in which CMS is bundling many services, dismantling care provided for global surgical services would be a step backward. In summary, the reverse building block approach is an overly simplistic and formulaic proposal that fails to accurately reflect the complexity, intensity, and associated care coordination involved in surgical services.

- **Approach C. Use of the CPT code 99024**. Since July 1, 2017, Medicare has required surgeons from nine states (Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon, and Rhode Island) to report on post-operative visits for certain procedures during 010 and 090-day global periods using the no-pay procedure CPT code 99024. CMS contracted with RAND to produce an analysis and reports related to the use of CPT code 99024 in Medicare claims data. The AMA provided an extensive assessment of the inaccuracies with RAND's evaluation in their comments on the CY 2022 MPFS proposed rule. We, the AMA, the ACS, and many other societies continue to believe that the data for CPT code 99024 does not accurately capture and underrepresents the number of visits in global surgical procedures, given the limited participation of eligible physicians, as well as the current difficulty CMS and RAND researchers have encountered in aligning CPT code 99024 with specific CPT codes. According to RAND's most recent report on 99024 from 2021, only 47 percent of the physicians and other health care professionals who were expected to participate in the effort actually submitted tracking code 99024. Fifty-three percent of physicians eligible for this data collection project were either not

aware of the requirement to participate or were unable to participate for another reason. In addition, only 17 percent of eligible physicians were classified as "robust reporters," indicating that a majority of those who did participate did so intermittently or did not begin until partway through the reporting period. If most of the eligible physicians did not participate for a CPT code, which was the case for many codes, the median count of post-op visits would be zero, irrespective of what study participants reported. The mean number of visits would be greatly understated. According to the 2021 RAND Report[11], participation also varied widely by both specialty and state. Primary care physicians only participated at a rate of 16 percent, and Nurse Practitioners (NPs)/Physician Assistants (PAs) only at a rate of 23 percent; these specialties collectively account for nearly 40 percent of the 40,000 eligible physicians in the nine states and perform a large proportion of the 010-day global services included in the study. The participation rate by state varied widely, with the highest participating state, North Dakota, participating at a rate 4 times higher than that of the lowest participating state, Nevada. CMS notes that this is their preferred option, but we do not agree. **Because of the unreliability of data on reporting of CPT code 99024, we do not support this approach.**

- **Approach D. Total Physician Time Methodology.** This approach would calculate procedure work RVUs for global surgical packages by multiplying the total physician time (in minutes) for each global procedure by the ratio of physician time allocated to postoperative visits. This approach aims to enhance the accuracy of payments for global surgical services by taking into account the total time spent by the physician, encompassing both pre-operative and post-operative care**.** CMS notes that they do not prefer this approach because it could only be updated when the code is revalued and it relies on the number of visits currently build into the global surgical packages. **We do not support this approach.**

CMS Failure to Increase E/M Values in Global Surgical Payment. In 2021, CMS took an unprecedented step and decided not to apply the increased values in the RVU of the E/M services to the CPT codes in the global surgical package. However, E/M services may comprise up to 40% of the RVU for any particular CPT code reported as a global surgical service. By not increasing the values of the E/M portion of the global surgical codes, those codes are now untethered from the valuation of the E/M services. The result is a loss of relativity within the fee schedule. With the refusal to incorporate E/M updates into the global procedures, CMS unilaterally decided to pay physicians of different specialties dissimilar rates for the same work, violating the Medicare statute against specialty payment differentials.

We, along with the ACS, the AMA, the RUC, and virtually all other medical specialty societies, have urged CMS to apply E/M office visit increases to the visits bundled into global surgery payments. The surgical specialties participated in the RUC survey for these codes, and their data were the same as, and often greater than, those of primary care and other specialties. CMS has emphasized the robust survey utilized in the valuation of E/M office visits, and this survey demonstrates what the law requires. All physicians should receive the same payment for the same service. In 2024, CMS updated the work RVUs and work times of maternity procedures with an "MMM" global period to reflect any relevant E/M updates associated with the MMM global period. However, CMS continues to stay silent on the issue of incorporating E/M increases into the global surgical periods.

[11] Andrew W. Mulcahy, Zachary S. Predmore, Soeren Mattke, Susan L. Lovejoy, Brian O. Wynn, and Lindsay Barham, *Using Claims-Based Estimates of Post-Operative Visits to Revalue Procedures with 10- and 90-Day Global Periods*, RAND Corporation Research Report RRA203-3 (2021), https://www.rand.org/pubs/research_reports/RRA203-3.html

We continue to urge CMS to apply the RUC-recommended changes to the E/M component of the 10- and 90-day global surgery codes to maintain the relativity of the fee schedule and to comply with the Medicare law's prohibition on specialty payment differentials. We believe this step should be taken before any other requirements for global surgical services should be undertaken.

4. Practice Expense and Indirect PE Methodology

Low Volume Overrides

We appreciate CMS's policy of using expected specialty overrides for certain low-volume services. The RUC performed an analysis to identify all codes that meet the criteria to receive a specialty override under this CMS policy and drafted updated recommendations for CY 2026. The specialty assignments for these codes are intended to appropriately represent the professional liability risk that is inherent in the code itself and reflected in the professional liability risk of a single specialty. The purpose of assigning a specialty to these codes is to avoid the major adverse impact on professional liability insurance (PLI) and practice expense (PE) relative value units (RVUs) that result from errors in specialty utilization data, magnified in representation (percentage) by small sample size. Further, the impact of these errors on the performing specialties can be severe due to the true overall code utilization being related to non-Medicare beneficiaries (frequently children). In addition, the proposed specialty overrides are intended to appropriately represent the expected indirect practice expense for each service. **We support the RUC recommendations for low-volume services**, and we appreciate CMS reviewing specialty assignment for exceptionally low-volume codes, as occasional small errors or miscoding in one year can cause the lead specialty utilization data to be inaccurate.

PPIS Survey and the MEI

We participated in the AMA Physician Practice Information (PPI) survey, which was shared with CMS in January 2025. We are disappointed that CMS did not propose to factor in the PPI Survey data in updating practice expense relative values to adjust Medicare Economic Index (MEI) weights, impacting the distribution of RVU components. Independent of the PPI Survey, CMS chose to modify the indirect practice expense methodology to redistribute indirect practice costs from facility-based services to non-facility-based services. This change in practice expense methodology, which only recognizes 50 percent of the physician's work on facility-based services in the indirect cost method, results in a dramatic shift in payment between sites of service.

The PPI data are the most recent and relevant numbers on physician practice costs and hours. In their comments on the CY 2026 MPFS proposed rule, the AMA RUC provides a thorough analysis and assurances for the concerns raised by CMS about the survey data. CMS states that "we intend to work with interested parties, including the AMA, to understand whether and how such data should be used in PFS rate setting in future rulemaking." We urge CMS to delay implementation of any modifications to the indirect practice expense methodology until the 2024 PPI data are implemented.

Updates to Practice Expense Methodology—Site of Service Payment Differential

For neurosurgeons, most procedures are highly intense, complex, and involve the delicate structures of the brain and spine. Consequently, neurosurgeons provide the majority of their surgical services in the facility setting, and contrary to the contention of CMS, there are very clear indirect practice expenses when a procedure is performed in the facility setting. The RUC has provided CMS with a detailed review of the CMS proposal. We echo their comments and especially highlight the issues of practice expense for E/M work in global surgical codes. **To accurately reflect true practice costs, CMS should reconsider**

its proposed methodology to reduce indirect practice expense when a service is provided in a facility setting, as it does not accurately reflect resource costs incurred by neurosurgical and other specialties and leads to a substantial cut in payment, which CMS estimates as a reduction of -4 for neurosurgery. Again, we urge the agency to carefully review the data and analysis provided by the RUC and from the PPI Survey.

5. Valuation of Specific Codes and Payment Policies

Endovascular Therapy with Imaging (CPT codes 61624, 61626, 75894, and 75898)

We urge CMS to restore the RUC-passed work value of 20.00 for CPT code 61624 and 15.31 for CPT code 61626. We, along with the SIR, ACR, and ASNR, held a virtual meeting with CMS staff to review the reasons why the proposed reduction to the RUC-passed values is not appropriate. We thank the staff for their time and attention to our concern at that meeting.

Below are detailed comments on the valuation of these codes.

61624

For CPT code 61624, CMS disagreed with the RUC-recommended work RVU of 20.00 and proposed a work RVU of 17.06, which reflects a direct crosswalk to CPT code 49622 *Repair of parastomal hernia. Any approach (that is, open, laparoscopic, robotic), initial or recurrent, including implantation of mesh or other prosthesis, when performed; incarcerated or strangulated* (work RVU = 17.06, 150 minutes intra-service and 255 minutes total time) and falls below the survey 25th percentile.

The RUC recommendation was based on the 25th percentile work RVU from robust survey results and favorable comparison to top key reference service codes 33477 *Transcatheter pulmonary valve implantation, percutaneous approach, including pre-stenting of the valve delivery site, when performed* (work RVU = 25.00, 180 minutes intra-service time and 276 minutes total time) and 61645 Percutaneous arterial transluminal mechanical thrombectomy and/or infusion for thrombolysis, intracranial, any method, including diagnostic angiography, fluoroscopic guidance, catheter placement, and intraprocedural pharmacological thrombolytic injection(s) (work RVU = 15.00, 100 minutes intra-service time and 241 minutes total time) which appropriately bracket the surveyed code.

CMS states, “The lower work RVU proposal of 17.06 reflects the significant decreases in both intra-service time and total time for CPT code 61624.” However, CMS makes a flawed assumption that the intraservice and total time values assigned initially to the code were somehow related to either a survey or some other direct measure of work. In fact, CPT code 61624 had never been surveyed and was “created” for the purpose of determining a value for the code. Thus, the physician time source should be noted as “CMS/Other.” The RUC database note "Do Not Use to Validate for Physician Work" was added because the RUC has not validated the physician's time. CPT codes 61624 and 61626 were created for CPT 1992, and the original physician work values were established by CMS, formerly Health Care Financing Administration (HCFA). The 1992 Final Rule indicates: "Physician work value established by HCFA. It may have been a refinement of a Harvard value, or a gap fill for a code for which Harvard did not provide a value. These include codes reviewed by carrier medical directors." The physician time was allocated from the total time assigned by HCFA and not surveyed. Therefore, the times that existed before the most recent survey are 'invented values' created by CMS, unrelated to any accurate determination of true physician time and effort. For CMS to say that the time has gone down based on invented time values for these codes is double jeopardy. We disagree with the CMS proposal and emphasize the fact that the existing times of CPT code 61624 are not valid for comparison or valuation.

We also disagree with the CMS proposed crosswalk, as it fails to consider the physician work necessary to perform this service. Beyond comparing the intra-service time, it is unclear whether any other criteria were used to identify the crosswalk code. CMS did not properly justify the decrease in this code and failed to consider the survey results. Moreover, the comparison code does not seem to be selected based on a clinical comparison of the work. CPT code 49622 is not a valid crosswalk code for the following critical reasons:

- **CPT 61624, a highly specialized neurointerventional procedure** for precise catheter-based embolization of small, critical cranial or spinal arteries, demands intricate neuroanatomical and hemodynamic knowledge with high neurological sequelae risk if mishandled. This fundamentally contrasts with CPT 49622, an open surgical abdominal wall hernia repair, which operates on entirely different organ systems and poses vastly dissimilar physiological challenges. Performing CPT 61624 requires specialized training in neurointerventional radiology or neurosurgery, encompassing advanced imaging (DSA, Cone-beam CT), microcatheter manipulation, embolization material selection, and immediate neurological complication management (e.g., stroke, hemorrhage), a level of neurovascular expertise and life-threatening risk management far beyond that for hernia repair.

- **Resource utilization also differs significantly**: 61624 needs expensive, dedicated neurointerventional angiography suites, advanced fluoroscopy, specialized microcatheters, guidewires, coils, liquid embolics, and continuous intra-procedural neurological monitoring, incurring substantial imaging, contrast, and radiation costs. This contrasts with CPT 49622's reliance on less specialized, standard OR equipment. The clinical staff for 61624 consists of highly trained neurointerventional nurses and technologists with expertise in radiation safety and neuro-monitoring, which leads to higher personnel costs. Post-procedure, 61624 often necessitates intensive neurological monitoring in a dedicated neuro-ICU due to delayed complication risks, unlike uncomplicated hernia repair.

- **Finally, procedures involving the central nervous system, like 61624, inherently carry a higher malpractice risk** due to potential severe and permanent neurological injury, directly impacting malpractice premiums for neurointerventional specialists. The decision-making complexity, unforgiving anatomy, and catastrophic outcome potential for 61624 are in no way comparable to 49622. Consequently, cross-walking CPT 61624 to 49622 significantly undervalues the physician work, practice expense, and malpractice expense of this complex neurointerventional procedure, urging CMS to reconsider.

CMS supported its proposed crosswalk by citing CPT code 33224 *Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, with attachment to previously placed pacemaker or implantable defibrillator pulse generator (including revision of pocket, removal, insertion, and/or replacement of existing generator)* (work RVU = 9.04, 135 minutes intra-service time and 204 minutes total time) and CPT code 93590 *Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, mitral valve* (work RVU = 21.70, 135 minutes intra-service time and 223 minutes total time). Neither of these codes resonate with the surveyed code for a number of specific reasons:

CMS's reliance on CPT 33224 (cardiac pacing electrode insertion) and 93590 (percutaneous paravalvular leak closure) for crosswalking CPT 61624 (neurointerventional embolization) is inappropriate. While transcatheter, CPT 33224 involves macroscopically different cardiac venous anatomy and primarily mechanical lead placement, lacking the intricate neurovascular expertise, microcatheter precision, and direct neurological risk management crucial for 61624. Similarly, CPT 93590 targets larger cardiac

structures with mechanical closure devices. In contrast, 61624 navigates extremely small (sub-millimeter), delicate arterial microvasculature of the brain/spine, requiring precise embolic agent deployment to avoid devastating, irreversible neurological deficits. The advanced 3D angiographic guidance and real-time hemodynamic interpretation vital for the 61624 procedure's high cognitive load and risk assessment are also incomparable to the imaging for either cardiac procedure. These cardiac procedures fundamentally fail to capture the unique neuroanatomical complexity, microvascular manipulation precision, high cognitive burden, or the severe potential for neurological morbidity and mortality inherent to CPT code 61624.

CMS provides the crosswalk code and other reference codes at a similar time in support of its proposed value. However, it appears most of these comparison codes were arbitrarily selected as CMS does not provide any clinical foundation for the comparison of the surveyed code to the crosswalk code. Furthermore, these comparison codes often seem to have been selected solely for their similar work RVUs or service period times to the Agency's desired reduction. We recommend that CMS consider the clinical input from practicing physicians when valid surveys are conducted, rigorous review by specialty society committees is performed, and the RUC has conducted a review of magnitude estimation and cross-specialty comparison.

We urge CMS to accept the RUC-passed work RVU of 20.00 for CPT code 61624.

61626

For CPT code 61626, CMS disagreed with the RUC-recommended work RVU of 15.31 and proposed a work RVU of 13.46 which reflects a direct crosswalk to CPT code 49594 *Repair of anterior abdominal hernia[s] [that is, epigastric, incisional, ventral, umbilical, spigelian], any approach [that is, open, laparoscopic, robotic], initial, including implantation of mesh or other prosthesis when performed, total length of defect[s]; 3 cm to 10 cm, incarcerated or strangulated* (work RVU = 13.46, 120 minutes intra-service and 225 minutes total time) and falls below the survey 25th percentile.

The RUC recommendation was based on the 25th percentile work RVU from robust survey results (n=122) and favorable comparison to top key reference service MPC code 37244 *Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation* (work RVU = 13.75, 90 minutes intra-service time and 166 minutes total time) and second key reference service code 33477 *Transcatheter pulmonary valve implantation, percutaneous approach, including pre-stenting of the valve delivery site, when performed* (work RVU = 25.00, 180 minutes intra-service time and 276 minutes total time) which appropriately bracket the surveyed code.

CMS states, "The lower work RVU proposal of 13.46 reflects the significant decreases in both intra-service time and total time for CPT code 61626." However, CPT code 61626 had never been surveyed. Thus, the physician time source should be noted as "CMS/Other." The RUC database note "Do Not Use to Validate for Physician Work" was added because the RUC has not validated the physician time. CPT codes 61624 and 61626 were created for CPT 1992, and the original physician work values were established by CMS, formerly Health Care Financing Administration (HCFA). The 1992 Final Rule indicates: "Physician work value established by HCFA. It may have been a refinement of a Harvard value, or a gap fill for a code for which Harvard did not provide a value. These include codes reviewed by carrier medical directors." The physician time was allocated from the total time assigned by HCFA and not surveyed. Therefore, the times are not valid for relative comparison to the current survey or to other codes. We disagree with the CMS proposal and emphasize this important point that the existing times of CPT code 61626 are not valid for comparison or valuation.

We also disagree with the CMS proposed crosswalk as it fails to consider the physician work necessary to perform this service. Beyond comparing the intra-service time, it is unclear whether any other criteria were used to identify the crosswalk code. CMS did not properly justify the decrease to this code and failed to consider the survey results. Moreover, the comparison code does not seem to be selected based on a clinical comparison of the work. CPT code 49594 is not a valid crosswalk code when juxtaposing several aspects of these two codes

CPT 49594 (abdominal hernia repair) is an invalid crosswalk for CPT 61626 (extracranial head/neck embolization) due to fundamental anatomical, technical, and resource disparities. CPT code 49594 involves macroscopic musculoskeletal/visceral repair via open/laparoscopic means, demanding general surgical skills. In contrast, 61626 is a percutaneous, transcatheter neurovascular procedure targeting delicate, often microscopic, head and neck vessels. It requires specialized interventionalist training, advanced angiography suites, continuous imaging, microcatheter precision, and meticulous embolic agent deployment to prevent severe neurological/functional deficits, unlike hernia repair, which uses standard OR equipment and has minimal imaging needs. The real-time cognitive burden and catastrophic risks associated with CPT code 61626's high-stakes microvascular navigation are incomparable to those of hernia repair's complexity. This proposed crosswalk significantly misrepresents the physician work, practice expenses, and malpractice risks inherent to specialized neurointerventional embolization.

CMS supports its proposed crosswalk by citing CPT code 55881 *Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation* (work RVU = 9.80, 120 minutes intra-service time and 202 minutes total time) and CPT code 93580 *Percutaneous transcatheter closure of congenital interatrial communication* (that is, Fontan fenestration, atrial septal defect) with implant (work RVU = 17.97, 120 minutes intra-service time and 210 minutes total time). Neither of these codes resonate with the surveyed code as the proposed crosswalk to CPT 55881 (transurethral prostate ablation with MRI guidance) and CPT 93580 (percutaneous transcatheter closure of congenital interatrial communication) fails to capture the unique complexity and critical risk profile of the surveyed neurointerventional procedure (assuming 61624 or 61626 from the previous context). While CPT 55881 involves advanced imaging, its anatomical target (prostate) and the nature of tissue ablation (thermal destruction) are fundamentally different from precise neurovascular embolization, which demands microcatheter navigation in extremely delicate and vital arterial systems. Similarly, CPT 93580, while a transcatheter procedure, targets a macroscopic cardiac defect with relatively large devices, contrasting sharply with the intricate, often microscopic, vessel occlusions performed in the brain or spinal cord, where the consequences of even minor collateral damage can be catastrophic neurological deficits. Neither of these cited procedures demands the same level of real-time angiographic interpretation, microvascular precision, or the acute management of severe neurological complications inherent to the surveyed neurointerventional work.

CMS provides the crosswalk code and other reference codes at a similar time in support of its proposed value. However, again, it appears most of these comparison codes were arbitrarily selected as CMS does not provide any clinical foundation for the comparison of the surveyed code to the crosswalk code. Furthermore, these comparison codes often seem to have been selected solely for their similar work RVUs or service period times to the Agency’s desired reduction. We recommend that CMS consider the clinical input from practicing physicians when valid surveys are conducted, rigorous review by specialty society committees is performed, and a review of magnitude estimation and cross-specialty comparison has been conducted by the RUC.

We urge CMS to accept a work RVU of 15.31 for CPT code 61626.

75894 and 75898

We note that CMS is proposing the RUC-recommended work RVUs for CPT codes 75894 and 75898, but is seeking comment regarding the proposed values due to concerns with the survey data and variations in work values and intra-service times reported by the survey respondents. While we acknowledged some uncertainty regarding the vignette and who would perform the service and in what circumstances, the validity of the survey times and values was not in question. The RUC had never surveyed CPT codes 75894 and 75898. Thus, the physician time source as included in the RUC database is "CMS/Other." These services were not surveyed in the Harvard Study and had never been reviewed by the RUC or CMS. Instead, the assigned times were input by CMS over 30 years ago at the inception of the RBRVS using an unknown methodology and, therefore, are not valid for relative comparison to the current survey or to other codes. **We reiterate our strong support for the survey and agree that the proposed RUC-recommended values at the 25th percentile accurately reflect the work involved in performing these services. We urge CMS to accept a work RVU of 2.25 for CPT code 75894 and a work RVU of 1.85 for CPT code 75898.**

Practice Expense

We appreciate that CMS is proposing the RUC-recommended direct PE inputs for CPT codes 61624, 75894, and 75898 without refinement. However, CMS is seeking comment regarding the clinical labor time for CA021 Perform procedure/service---NOT directly related to physician work time using L041A Vascular Interventional Technologist. During this time, the tech is in the procedure room and assists in operating the C-arm, acquires images and circulates during critical times of the procedure. For 75894, the typical time is 60 minutes and 45 minutes is typical for 75898. We urge CMS to accept the direct practice expense inputs for CPT codes 75894 and 75898 as submitted, including 60 and 45 minutes of CA021 clinical staff time, respectively.

From a clinical perspective, obtaining truly informed consent for a neurovascular embolization of the head or neck is an exceptionally complex and time-intensive process that routinely exceeds two minutes. Patients and their families require a comprehensive discussion of the anatomy involved, the specific pathology, the transcatheter technique, the specific embolic agents to be used, and a detailed review of all potential risks, including but not limited to, stroke, hemorrhage, cranial nerve injury (e.g., facial droop, vision changes, voice changes depending on location), infection, radiation exposure, and the risks associated with general anesthesia or deep sedation. Many of these procedures are performed for conditions with high stakes (e.g., severe epistaxis threatening airway, highly vascular tumors), necessitating careful explanation of the emergent nature vs. elective risks. Given the intricate anatomy, the potential for permanent functional impairment, and the often anxiety-provoking nature of procedures in the head and neck, a minimum of 5 minutes is a more realistic and medically necessary allocation for obtaining truly informed consent and addressing patient and family questions for CPT 61626, which is crucial for ethical practice and patient safety.

MR Guided High Intensity Focused Ultrasound (CPT code 61715)

In the proposed rule, CMS asks whether CPT code 61715, MR Guided High Intensity Focused Ultrasound, should be priced in the "non-facility" setting. CMS is seeking comments on appropriate non-facility direct PE inputs (clinical labor, disposable supplies, and medical equipment), and/or appropriate crosswalk codes for non-facility direct PE inputs for CPT code 61715. We do not believe that CPT code 61715 is typically performed in the "non-facility" setting. When the code was presented at the RUC in January 2024, the RUC placed the code on the New Technology list to be reviewed by the RUC in three years to

ensure correct valuation, patient population, and utilization assumptions. **We recommend that the question of site of service be deferred until the service comes up for re-evaluation by the RUC in 2007.**

E/M Visit Complexity Add-on. HCPCS code G2211.

In 2024, Medicare began paying for HCPCS code G2211 *Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established) (work RVU = 0.33, 11 minutes intra-service and total time*), which was developed to be reported along with office E/M visits when there is a longitudinal relationship between the physician and patient, and the physician serves as the continuing focal point for medical services that are part of ongoing care related to a patient's single, serious condition or a complex condition. Under the Medicare statute, CMS annually adjusts the Medicare Conversion Factor to maintain budget neutrality, meaning that increases in payment for one service must be offset by corresponding decreases elsewhere, so that overall Medicare spending does not rise solely due to changes in RVUs. To determine the budget neutrality adjustment needed for G2211, an estimate of how frequently G2211 would be billed in 2024 was required. The final estimate that CMS included in the MPFS Final Rule for 2024 was that G2211 would be billed with 38 percent of all office/outpatient E/M visits reported in 2024, which was an unrealistically high estimate that grossly inflated the volume of G2211 reports expected in 2024. As was obvious to us, the RUC, the AMA, the ACS, and virtually all specialties, CMS now states that G2211 was reported with only 10.5 percent of office visits. Consequently, the conversion factor was artificially deflated based on the predictably faulty projection by CMS.

In May 2025, the AMA submitted a letter showing that G2211 utilization in the first two quarters of 2024 was markedly lower than the 38 percent assumption implemented by CMS. Specifically, utilization increased steadily each week but stabilized at 13 percent by week 24 (through week 39). The AMA projected that G2211 would represent approximately 11.2 percent of office/outpatient E/M visits in 2024. This analysis, echoed by the ACS, AANS, CNS, and other societies, demonstrated that CMS had overestimated the expected cost of G2211 by roughly $1 billion. The CY 2026 MPFS proposed rule now confirms that these projections were accurate and that the original estimate was substantially overstated.

While we understand CMS's position that it cannot make retrospective corrections, we urge the agency to revise its utilization estimate prospectively and adjust the 2026 conversion factor accordingly. To reduce the conversion factor on the basis of an overestimation this significant, and then decline to correct the error going forward, undermines confidence in the accuracy of the payment system and imposes unwarranted financial strain on physicians.

6. Quality Payment Program

We echo comments submitted by the Alliance of Specialty Medicine on the topics discussed below. For two of the topics—modifications to previously finalized MIPS Value Pathways (MVPs) and the Ambulatory Specialty Model (ASM)— we provide additional commentary specific to neurosurgery:

MIPS Performance Threshold

We strongly support CMS' proposal to retain the MIPS performance threshold at 75 points for the CY 2026 performance period through CY 2028.

Sunsetting Traditional MIPS and Full Transitioning to MVPs by 2029

We urge CMS to maintain MVPs as a voluntary pathway for clinicians, alongside traditional MIPS, so that clinicians have a choice of reporting pathways that best reflect their patient populations and practice needs. The MVP framework is not a sufficient departure from traditional MIPS and fails to address the underlying problems with the program that have limited meaningful specialist engagement and hindered progress toward higher-quality care. Incrementally adjusting a fundamentally flawed program will not, by design, generate meaningful quality signals. A market-driven system that rewards patient choice and physician innovation would provide better feedback than current arbitrary and bureaucratic scoring formulas.

Modifications to Previously Finalized MVPs

We continue to have concerns about the arbitrary construction of the Surgical Care MVP and even stronger concerns about the specific measures in that MVP that CMS is now classifying as "neurosurgical" under CMS' new MVP clinical groupings proposal. Within the Surgical MVP, CMS proposes to designate the following measures as "neurosurgical":

- 459: Back Pain After Lumbar Surgery
- 461: Leg Pain After Lumbar Surgery
- 471: Functional Status After Lumbar Surgery

As we have expressed numerous times in the past, we oppose the use of 459: Back Pain After Lumbar Surgery in the MIPS program, in general. While improvement of a patient's back pain after lumbar surgery is an important clinical goal, many other equally important factors need to be considered for a successful outcome, such as correcting and preventing neurologic deficits and maintaining normal skeletal alignment. Put another way, a lumbar spine operation may still be high-quality from a technical and clinical standpoint, even if the patient's back pain remains constant.

There is also a lack of internal consistency between the quality and cost measures included in the Surgical Care MVP labeled as "neurosurgical." For example, quality measures Q461: Leg Pain After Lumbar Surgery, Q471: Functional Status After Lumbar Surgery, and Q459: Back Pain After Lumbar Surgery each capture lumbar fusion or discectomy/laminectomy without fusion. On the other hand, the cost measure, Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels, only focuses on fusions. Furthermore, the lumbar fusion quality measures are evaluated at one year post-operation, whereas the lumbar fusion acute episode cost measure ends at 90 days post-operation. As a result, these quality and cost measures are misaligned and do not evaluate the same patient populations in the same manner. These disparities will not only result in inaccurate assessments of value but also lead to unfair outcomes. Still, they will create an incentive to delay care, such as physical therapy, until after the acute cost measurement episode has ended.

We also remind CMS that the field of neurosurgery is much broader than spine surgery. While some neurosurgeons specialize in spine surgery, others subspecialize in completely different aspects of care that are not reflected in these measures, including cerebrovascular surgery (e.g., to treat aneurysms), surgical treatment of brain tumors, stereotactic and functional surgery (e.g., to treat movement disorders), and neurotrauma. In addition, these measures do not cover the majority of the field of pediatric neurosurgery (e.g., brain tumors, birth defects, hydrocephalus), which does very little in the way of spine surgery. Further complicating the attribution of these measures to neurosurgery is the fact that many orthopedic surgeons also perform spine surgery. By characterizing these three spine measures as

"neurosurgical," we are concerned that it gives the impression that MIPS "covers" our specialty and that all neurosurgeons have meaningful measures to choose from, which is not the case.

We are also concerned that the Surgical MVP includes what CMS misperceives as broad, cross-cutting surgical measures that apply across surgical specialties, such as Q355: Unplanned Reoperation within the 30-Day Postoperative Period and Q357: Surgical Site Infection. Although the title and description of these two measures seem to suggest that they are broadly applicable across surgical specialties, the denominator codes are almost exclusively focused on general surgery and do not reflect the range of surgical procedures or specialties seemingly captured by the Surgical Care MVP. Importantly, none of the CPT codes representing neurosurgical procedures are included in the denominator of either of these measures. Instead, these measures focus almost exclusively focused on general surgery. Even the debridement codes, for example, are not generally applicable across surgical specialties and instead concentrate on debridement involving genitalia and the abdominal wall. In the rare instances where there are more specialty-specific codes, they are not clinically appropriate. As a result, most neurosurgeons could not even report these measures, which will make it challenging, if not impossible, for them to rely on this MVP to satisfy program requirements. Finally, the two general surgery measures in this MVP include a considerable range of procedural complexity, from the insertion of lines/ports/feeding tubes (relatively minor procedures) to pelvic exenterations and complex tumor resections (more major, high-risk procedures). Yet, there is no risk adjustment in these measures to account for this variability.

Overall, mislabeling measures as "neurosurgical" and assuming neurosurgeons can report general surgery measures that exclude core neurosurgical codes risks distorting care patterns, penalizing surgeons for metrics unrelated to their actual practice, and misleading the public and policymakers about the quality of neurosurgical care. ***We request that CMS conduct a comprehensive re-evaluation of these measures to address these serious concerns. We also remind CMS of the importance of considering the actual specifications of a measure and its clinical context when populating MVPs (and when attempting to pair quality and cost measures) rather than making assumptions based on a measure's title***.

MVP Subgroups

We would ideally like to see CMS reverse its earlier decision to mandate subgroup reporting for multi-specialty group practices participating through the MVP pathway starting in 2026. In the absence of such a reversal, we strongly support CMS's proposal to allow a group practice registering for MVP reporting at the group practice level to attest to either meeting CMS's definition of a single specialty group or else a multispecialty group that meets the definition of a small practice beginning with the CY 2026 performance period. We strongly prefer that CMS provide practices with the flexibility and autonomy to self-declare the composition and focus of their group as an alternative to using claims data to designate a group as either a single or a multispecialty group. ***We simultaneously support CMS's proposal to revise the definitions of single and multi-specialty groups to account not only for the specialty types in the group, but the group's clinical focus, which will ensure that multi-specialty groups with a single clinical focus (e.g., neurosurgical care) would not be required to form subgroups for purposes of MVP reporting.*** We refer to CMS to comments submitted by the Alliance of Specialty Medicine, which recommend minor edits to CMS's revised definitions of single and multi-specialty groups to ensure they are mutually exclusive and reflect the intent of these proposed updates.

Core Elements MVP RFI

We question the value of potentially requiring MVP participants to report one quality measure from a subset of "core" measures since these cross-cutting measures will not provide patients or clinicians with

meaningful, focused information regarding a specific condition or treatment. Cross-cutting measures should only be included in MVPs if they remain optional.

Measure Procedural Codes RFI

We strongly oppose the use of procedural codes to assign clinicians to MVPs. CMS should instead continue to allow clinicians to self-select MVPs to report, and to select specific measures and activities from within their chosen MVP that are most relevant to their practice and patient population.

MIPS Measure Inventory

We strongly disagree with CMS's assumption that reducing the MIPS quality measure inventory will reduce program complexity and burden. There are numerous other aspects of the program— including the siloed performance categories, each of which has its own reporting and scoring policies— that make compliance unnecessarily challenging. For specialists to participate in this program meaningfully, they need access to additional specialized measures; not less.

Benchmark Methodology Updates for Administrative Claims Measures

Ideally, we do not believe the current administrative claims measures are appropriate for MIPS, as they do not capture costs within the direct control of individual clinicians. These types of measures should instead be reserved for programs that focus on facility-level and/or alternative payment model (APM) entity-level accountability. However, if CMS opts to maintain these measures, then we urge it to finalize its proposed improvements to the benchmarking methodology.

Transition Towards Digital Quality Measurement RFI

We appreciate efforts to transition to more seamless and automatic methods of reporting and analyzing quality data, but request that CMS consider ongoing challenges related to the implementation of electronic clinical quality measures (eCQMs), including the significant resources needed to invest in new technologies, infrastructure, and staff training, as well as ongoing interoperability challenges.

Cost Measure Information Feedback Period

We strongly support CMS's proposal to provide a 2-year informational-only feedback period for new cost measures prior to tying scores to payment.

Updates to the Total Per Capita Cost (TPCC) Measure

According to the 2023 QPP Public Use File,[12] Among all neurosurgeons who received a score in the cost category in 2023, 88% were scored on the TPCC measure and had an average score of 4.6 out of 10 points. These numbers are very concerning in light of the fact that neurosurgeons, as a specialty, are specifically excluded from this measure. The TPCC measure exemplifies the futility of attempting to assign global cost accountability to specialists through claims-based attribution. Holding neurosurgeons responsible for costs well outside their control is not just unfair; it reflects a fundamental flaw in CMS's attempt to centrally manage costs without price signals. The inevitable result is distorted incentives, misattribution, and reduced patient access.

[12] Centers for Medicare & Medicaid Services, *Quality Payment Program experience*, retrieved September 7, 2025, from https://data.cms.gov/quality-of-care/quality-payment-program-experience.

We urge CMS to retire this problematic measure from MIPS. At the very least, this measure must undergo significant revisions to ensure that specialties such as neurosurgery, which are not the intended target of this primary care-focused measure, are not unintentionally held accountable for this measure. We appreciate CMS' proposals to revise this measure to ensure it only accounts for costs within the direct control of the physician and excludes all specialties as intended. Still, we do not believe the second proposed criteria, which would exclude Advanced Care Practitioners from attribution only in situations where 100% of physicians in a group are excluded based on the specialty exclusion criteria, is an adequate approach.

We urge CMS to consider alternative approaches to ensure that excluded specialists are not scored on this measure, such as the use of self-reported Patient Relationship Codes or other similar attestations. We also strongly urge CMS to apply any finalized improvements starting with the 2025 performance period, rather than 2026, to mitigate the recurrent negative impact this flawed measure has had on specialties like ours.

Qualifying Participants (QP) in APMs

We support CMS' proposals aimed at increasing the number of specialists who are eligible for QP status, including its proposal to add an individual level calculation to QP determinations for all eligible clinicians participating in an Advanced APM and its proposal to expand the definition of "attribution-eligible beneficiary" to include any beneficiary who has received a covered professional service furnished by the eligible clinician (rather than just an E/M service), beginning with the 2026 QP performance period. However, the impact of these proposals will be limited since the thresholds to qualify for QP status have increased significantly under the statute. As such, we request that CMS urge Congress to make technical changes to the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to extend the expiring APM incentive payment and return QP thresholds to their previously lower level to encourage continued movement toward value-based payment models, especially among specialists who have had little opportunity to engage meaningfully in APMs to date. It is equally critical that CMS work with specialty societies to develop meaningful and clinically appropriate specialty-focused APMs.

7. Ambulatory Specialty Model (ASM) Proposal

We have significant concerns with the proposed Ambulatory Specialty Model (ASM) and strongly urge CMS not to move forward with the model as currently designed. At the very least, CMS should exclude surgeons from this model and work directly with the AANS, the CNS, and other surgical specialists treating spine patients to develop more appropriate voluntary opportunities to improve patient outcomes and the overall value of care.

At a broader level, We do not believe that mandatory participation is appropriate in a model that imposes downside risk; requires the reporting of a specific set of measures with no flexibility to select measures most relevant to the individual clinician's patient population (especially when most of the measures are not even relevant to specific specialists required to participate in the model); and relies on an untested performance framework. We are disappointed to see CMS double down on its commitment to policies that are either untested or already problematic under this model. For example, the ASM relies on the MVP framework, which has not yet been widely adopted by clinicians and preserves many of the fundamental flaws of traditional MIPS, including the four siloed MIPS performance categories, a limited measure inventory that fails to offer many specialists measures that are truly relevant and meaningful to their practice, and misaligned quality and cost measures that provide inaccurate assessments of overall value. The ASM also would require physicians to participate and report as *individual* clinicians, even if

they have historically reported MIPS as part of a group or APM entity. Our experience with MIPS over the past nine years has demonstrated that physician services are too heterogeneous to be captured by centrally defined metrics. Reverting to individual measurement and accountability will perpetuate long-standing challenges, including administrative burden and the ability to meet case minimum thresholds high enough to ensure measure accuracy and reliability. Individual measurement also contradicts CMS's goal of encouraging greater team-based care and care coordination, which is critical to moving the needle on quality and efficiency.

The financial design of the ASM raises additional concerns and further undermines its viability. Under the proposed model, clinicians could be subject to financial penalties as high as 12 percent of Medicare Part B spending in the later years of the model, exceeding the maximum 9 percent penalty under MIPS, which could disproportionately affect small and resource-constrained practices, as well as clinicians with more complex patients or limited experience in value-based care. Also of concern is the fact that these payment penalties would apply to all of a physician's Part B services and not just services related to the management of low back pain, which enhances the negative impact. Moreover, unlike MIPS, which is designed to be budget neutral, the ASM reduces the amount of funds available for payment adjustments by 15 percent right off the top. While this approach guarantees savings for the Medicare program, it does so by significantly reducing the amount of funds available to be redistributed to high-performing clinicians, thereby weakening incentives under the model at a time when inflation-adjusted Medicare Part B payments to physicians have decreased by 33 percent since 2001.

The proposed rule says that ASM was designed "with a focus on clinicians who commonly treat patients in the ambulatory setting, develop longitudinal relationships with patients, and co-manage beneficiaries with primary care clinicians." However, a patient could be attributed to a physician under ASM regardless of whether the physician was managing the care of the patient's low back pain. Once attributed, the physician would be held accountable for all spending related to low back pain for these patients during the next 12 months. We oppose reducing a physician's payments based on how much Medicare is spending for a patient if the physician is not actively managing the care of that patient. Instead, we urge CMS to explore other models that would allow physicians to use Patient Relationship Codes to report the nature of their relationship with attributed patients rather than relying simply on MIPS episode-based cost measures.

We are also concerned that the ASM would not provide any opportunity for participants to transition out of MIPS and participate in an Advanced APM, which was one of the primary goals of MACRA. CMS characterizes the ASM as an "alternative payment model" and discusses how specialists have had limited opportunities to engage in APMs to date, as well as the need to more directly engage specialists in value-based payment models. Yet, the ASM does nothing to satisfy that goal since the model is little more than MIPS and, according to CMS, would not qualify as an Advanced APM. As a result, ASM participants would not be eligible for QP status, or the exemption from MIPS and the higher differential conversion factor update tied to QP status. This is extremely disappointing as neurosurgeons have had few meaningful opportunities to qualify for the QP track of the QPP to date.

In regard to the model's "low back pain" cohort, in particular, We are very concerned with CMS' proposal to include neurosurgeons and orthopedic surgeons on the list of eligible participants given the model's focus on chronic care management and the proposed set of quality and cost measures. Under CMS' proposal, physicians would be eligible for mandatory participation under the ASM Low Back cohort based on attribution of a minimum number of patients under the MIPS Low Back Pain episode-based cost measure.

The Low Back Pain episode-based cost measure was developed with the active input of a neurosurgical clinical expert, who was nominated to serve on the measure development workgroup. In the 2022 National Summary Data Report,[13] which summarized field testing results for the Low Back Pain cost measure, CMS listed the most frequently attributed specialties. As noted below, the two top attributed specialties were chiropractors and physical therapists, which are clinicians that CMS is proposing to explicitly exclude from this model. It is worth noting that no surgical specialties were represented in the top three attributed specialties under this measure.

Table 4. Most Attributed Specialties by Number of Episodes

Cost Measure	Most Attributed Specialty			Second Most Attributed Specialty			Third Most Attributed Specialty		
	Specialty	# of TIN-NPIs	# Episodes	Specialty	# of TIN-NPIs	# Episodes	Specialty	# of TIN-NPIs	# Episodes
Emergency Medicine	Emergency Medicine	52,314	11,708,890	Physician Assistant	12,798	1,499,163	Nurse Practitioner	7,288	838,253
Heart Failure	Cardiology	10,232	461,908	Internal Medicine	3,868	126,485	Cardiac Electrophysiology	1,227	67,761
Low Back Pain	Chiropractic	24,200	1,411,472	Physical Therapist in Private Practice	11,046	381,408	Physical Medicine and Rehabilitation	3,524	318,259

In materials distributed exclusively to measure development workgroup members following field testing, Acumen presented more detailed data showing the top seven attributed specialties, which has been summarized in the table below. Neurosurgeons did not make that list either. Once again, the top four attributed specialties represented clinicians that CMS is not even proposing for inclusion in the ASM. Even orthopedic surgeons, the fifth most frequently attributed specialty, were attributed patients under this measure far less frequently than chiropractors and physical therapists, making up only 5 percent of all attributed clinicians. During the development of the measure, the workgroup had numerous discussions about how surgeons were not the intended target of the measure and how there was another more appropriate cost measure in MIPS— the Lumbar Fusion cost measure— that focused more directly on spine care provided by the surgeon.

Low Back Pain Cost Measure Field Testing Results

Specialty	# of Attributed TIN-NPIs
Chiropractic	24,200
Physical Therapist	11,046
Internal Medicine	5,803
Family Practice	5,381
Orthopedic Surgery	3,619
Physical Medicine and Rehabilitation	3,524
Nurse Practitioner	3,020

Given these numbers, it seems illogical and shortsighted to mandate participation in ASM from neurosurgeons, or any surgeon for that matter, while at the same time excluding chiropractors and physical therapists, which were the top clinician types targeted and captured by this measure.

On the quality side, not a single quality measure proposed for inclusion in the ASM is included in the MIPS Neurosurgery Specialty Set. This is a clear indication that CMS has already determined that the quality measures proposed for the low back pain cohort are not relevant to neurosurgery. In fact,

[13] Centers for Medicare & Medicaid Services. (2021, December 17). National summary data report on the five episode-based cost measures (Winter 2022 field testing). https://www.cms.gov/sites/default/files/2022-01/2021-12-17-national-summary-data-report.pdf.

measure 220: Functional Status Change for Patients with Low Back Impairments was developed by physical therapists and is intended to evaluate the quality of therapy, chiropractic, and nursing facility services. It primarily focuses on rehabilitation services rather than care provided by specialists such as neurosurgeons. Nevertheless, CMS has proposed to exclude physical therapists, chiropractors, and other non-physician practitioners from this model, while including neurosurgeons, whose care is not even captured by the measure. Additionally, measure 220 requires use of the Focus on Therapeutic Outcomes (FOTO) Low Back Patient-Reported Outcome tool,[14] which is not used by neurosurgeons who instead commonly use tools such as the Oswestry Disability Index (ODI). Finally, measure 220 was last reviewed for endorsement maintenance in 2019. The measure steward has presented no recent data on the reliability and validity data, nor is it clear if any new data would include specialties outside of physical therapy.

Additionally, all of the quality measures proposed for the low back pain cohort would capture all payer patients and focus on younger patients (except the High-Risk Medication measure), while the cost measures focus only on Medicare beneficiaries. As a result, any reductions in quality of care for Medicare patients that result from spending reductions for those patients will not be apparent in the quality measures.

In terms of the Low Back Pain EBCM, CMS reports in the rule that 35 percent of the other specialists who would be required to participate in ASM have only 20-29 attributed low back pain episodes. The Measure Justification Form for the LBP EBCM indicates that when the measure was tested for NPI-TINs with 20 or more attributed patients, the reliability of the measure was below 0.7 for 37 percent of the NPI-TINs, and the reliability was below 0.4 for over 4 percent of the NPI-TINs. This is unacceptably low reliability for measures that would be used for payment penalties. Because of this, a large proportion of the physicians in ASM could be inaccurately labeled as providing “high cost” care and be unfairly penalized.

Overall, the ASM is an extremely disappointing proposal that lacks clinical coherence and fails to directly engage neurosurgeons in a meaningful manner. As proposed, this model does not represent meaningful payment reform. Instead, it appears to be an unambitious attempt to apply the framework of an already tested and severely flawed program in order to fill existing gaps in specialty-focused APMs with little effort or creativity. CMS is simply expanding the MIPS bureaucracy under a new label, with mandatory participation and downside risk imposed regardless of clinical relevance. By excluding physical therapists and chiropractors, who are the top-attributed clinicians in the Low Back Pain measure, while forcing neurosurgeons into the model, CMS has designed a program divorced from actual care delivery.

We urge CMS to abandon this top-down experiment and instead work with specialties such as ours to develop voluntary, specialty-driven models that reflect real practice patterns and patient needs. Otherwise, ASM will accelerate physician consolidation, penalize independent practices, and undermine patient access to high-value specialty care.

Many specialties, including neurosurgery, have invested resources and/or met with CMS to present innovative ideas to more accurately and effectively measure and improve specialty care, yet CMS has refused to test such ideas.

We strongly urge CMS to re-evaluate the merits of the ASM and to work with specialty societies to develop more clinically relevant models. At the very least, we request that CMS exclude neurosurgeons

[14] FOTO Inc., Public Access Survey for MIPS Quality ID 220: Functional Status Change for Patients with Low Back Impairments accessed September 7, 2025, https://fotoinc.com/science-of-foto/low-back/.

from the ASM and work with our specialty to develop an alternative model that focuses on aspects of care over which the spine surgeon has more direct control.

CONCLUSION

We respectfully urge CMS to engage physicians as true partners in this rulemaking. Over time, payment and quality policies have too often been developed without sufficient physician input, and the cumulative effect has been a steady weakening of physician-led care. As a physician leader, Administrator Oz, you understand how payment policy shapes practice viability and patient access. Giving front-line clinicians a meaningful seat at the table is both practical and necessary to ensure policies work as intended.

Our goal is to put the MPFS on a sustainable path that supports competition, rewards value, and restores confidence in the program. We stand ready to collaborate on targeted, workable solutions, and we look forward to working with CMS to resolve the issues outlined above. For payment-related questions, please contact Catherine Hill, Director of Regulatory Affairs, AANS/CNS Washington Office, at chill@neurosurgery.org. For quality and clinical affairs, please contact Rachel Groman, Vice President of Clinical Affairs and Quality Improvement, Hart Health Strategies, at rgroman@hhs.com. Thank you.

Sincerely,

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