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VIA ELECTRONIC TRANSMISSION

September 14, 2026

The Honorable Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244–8016

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

Dear Administrator Oz:

On behalf of the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS), representing more than 4,000 neurosurgeons nationwide, the AANS and CNS appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) calendar year (CY) 2027 Medicare Physician Fee Schedule (MPFS) proposed rule, published in the *Federal Register* on July 16, 2026.

The proposed rule contains numerous policies with direct implications for Medicare beneficiaries' access to complex neurosurgical care, the sustainability of neurosurgical practices, and physicians' ability to participate meaningfully in quality programs. The AANS and CNS support CMS's objectives of improving payment accuracy, aligning Medicare payment with the resources required to furnish services, and promoting meaningful, clinically relevant quality measurement.

In particular, the AANS and CNS comment on CMS's proposed changes to the practice expense (PE) relative value unit (RVU) methodology, the proposed treatment of separately identifiable evaluation and management (E/M) services furnished with global procedures, the future valuation of global surgical packages, the continued application of the CY 2026 efficiency adjustment, the valuation of specific neurosurgical services, the proposed transition of G2211, and the request for information regarding Current Procedural Terminology (CPT). The AANS and CNS also address significant Quality Payment Program proposals affecting the Merit-Based Incentive Payment System (MIPS), MIPS Value Pathways, Alternative Payment Models, clinical data registries, and related requests for information. Across these payment and quality provisions, a common principle should guide CMS's decision-making: policies should be grounded in service- and specialty-specific evidence and should account for the clinical realities

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of neurosurgical practice. Where CMS relies on broad methodological or reporting assumptions, the Agency should demonstrate that those assumptions apply to the physicians and services affected, quantify their independent and cumulative effects, and provide appropriate flexibility or targeted exceptions where the record demonstrates that the underlying premise does not hold.

In summary, the AANS and CNS provide the following recommendations regarding CY 2027 Medicare Physician Fee Schedule proposals:

- **PE RVU Methodology**
  - Apply the proposed sum of work and clinical labor RVUs consistently to 10- and 90-day global services rather than excluding global services from the indirect PE allocator.
  - Retain the Indirect Practice Cost Index (IPCI) until current specialty-level practice-cost data are available and validated.
  - Provide a minimum four-year transition for material adverse payment effects resulting from the proposed PE methodology changes.
  - Publish code- and specialty-level analyses decomposing the independent and cumulative effects of the proposed PE methodology changes, including the indirect allocator, utilization assumptions, IPCI phase-out, stabilization adjustment, and site-of-service policy.
  - Demonstrate that significant payment redistributions are supported by corresponding changes in the resources required to furnish services.
  - Repeal the CY 2026 50% facility indirect PE adjustment. If CMS pursues an alternative site-of-service methodology, base it on empirical evidence of actual resource costs rather than physician ownership, employment status, or organizational structure.

- **Accounting for Overlap Between Stand-Alone E/M Visits and Global Periods**
  - Retain the current Modifier 25 framework and refrain from finalizing the proposed 50% reduction for separately identifiable office/outpatient E/M services furnished on the same day as procedures with 0-, 10-, or 90-day global periods.
  - Address concerns regarding inappropriate Modifier 25 utilization through targeted billing oversight and program integrity measures rather than an across-the-board payment reduction.

- **Global Surgical Packages**
  - Refrain from broad reductions in 10- and 90-day global surgical values based solely on postoperative visit counts, CPT 99024 data, or public use file calculations.
  - Before pursuing reductions in global surgical values, update the E/M services embedded in global packages to maintain relativity with corresponding stand-alone E/M services.
  - Use current, specialty-specific, clinically representative evidence regarding the frequency, intensity, and content of postoperative care to inform any future global revaluation.
  - Do not use postoperative utilization data to mechanically subtract assumed postoperative work from existing global RVUs; any revaluation should reflect the

total physician work associated with the service and be consistent with the magnitude-estimation methodology used to establish the original values.
    - Do not treat conversion to 0-day global periods as a substitute for a validated, resource-based revaluation and evaluate any such change for its effects on physician payment, beneficiary cost-sharing, and access to necessary postoperative care.

- **Efficiency Adjustment**
    - Require service-specific evidence demonstrating that physician work has declined before applying a recurring efficiency adjustment to individual services; generalized productivity assumptions should not substitute for evidence of reduced physician work.
    - Exempt 11 identified neurosurgical services from the CY 2027 efficiency adjustment because their recent valuation, clinically irreducible physician work, high-acuity clinical contexts, technology-dependent work, and other characteristics do not support application of the generalized adjustment.
    - Recognize that the requested 11-code exemption would have a minimal aggregate impact on MPFS spending and would not trigger a budget-neutrality adjustment to the conversion factor.
    - Establish a transparent, service-specific process through which specialties can present clinical and empirical evidence supporting exemption from the efficiency adjustment.
    - Where CMS declines an exemption request, provide service-specific evidence demonstrating that the efficiency adjustment is appropriate.

- **Valuation of Specific Services**
    - **Spinal Osteotomy (CPT Codes 22210, 22212, and 22214):** Accept the RUC-recommended work RVUs of 24.75, 23.20, and 21.72, respectively, which better reflect the contemporary intensity and complexity of these services. Support CMS's acceptance of the RUC-recommended work RVU and direct PE inputs for the spinal osteotomy family, without interpreting that support as endorsement of the separate efficiency adjustment policy.
    - **Percutaneous Lumbar Decompression (CPT Code 62287):** Accept the RUC-recommended work RVU of 7.06 rather than CMS's proposed 6.23, as the proposed crosswalk does not adequately reflect the service's technical skill, mental effort, risk, and physician work.
    - **Sacroiliac Joint Arthrodesis (CPT Codes 27278 and 27279):** Support CMS's proposal to accept the RUC-recommended work RVUs and direct PE inputs, without interpreting that support as endorsement of the separate efficiency adjustment policy.

- **E/M Visit Complexity Add-On Code G2211**
    - Provide greater evidence and clarity regarding replacement of G2211 with the proposed MOD1 and MOD2 mechanisms before implementation.
    - For MOD1, explain the clinical and resource basis for the proposed 16% adjustment and publish estimated payment impacts by E/M level, specialty, and practice type.

- For MOD2, clarify the circumstances in which the code would apply, the distinct clinical and resource characteristics it is intended to recognize, and how it would interact with MOD1 and the underlying E/M service.
- Clarify whether MOD1 and MOD2 may apply concurrently and establish safeguards against unintended duplication or inconsistent application.
- Evaluate the effects of both mechanisms across specialties and provide specialty-level impact analyses, including for physicians furnishing complex longitudinal care such as neurosurgeons.

- **Current Procedural Terminology (CPT) Request for Information**
  - Maintain CPT as the national nomenclature for physician and other professional services rather than transition to an alternative coding system that is not ready to replace CPT.
  - Pursue targeted improvements in CPT access, licensing, governance, transparency, and independent validation while preserving CPT's role as a single national coding standard.
  - Maintain meaningful participation by practicing physicians in code development and valuation, with empirical data used to test and validate—rather than displace—clinical expertise.
  - Increase transparency regarding the evidence, assumptions, comparisons, and methodologies underlying coding and valuation decisions, while narrowly tailoring confidentiality protections for legitimately proprietary information.
  - Avoid fragmentation into multiple competing coding standards that could increase administrative burden and undermine interoperability.

The AANS and CNS also provide the following recommendations regarding CY 2027 Quality Payment Program proposals:

- **MIPS and MIPS Value Pathways (MVPs)**
  - Refrain from sunsetting MIPS in 2029. CMS should continue to make MVPs a voluntary participation pathway.
  - Remove outcomes measure reporting requirements to increase flexibility in measure selection.
  - Refrain from finalizing the "core measure" policy in both the MIPS and MVP programs, given that this policy restricts measure choice and will lead to less meaningful reporting options for neurosurgeons.
  - Remove the Security Risk Analysis measure, as the measure is duplicative of existing reporting obligations.
  - Finalize the voluntary use of FHIR-based electronic prior authorization measures but defer mandatory implementation until readiness is established.
  - Align the definition of certified electronic health record technology (CEHRT) with the Office of the National Coordinator for Health Information Technology's (ONC) definition.
  - Permit virtual groups to report through the MVP program but provide additional details on operationalization before making the MVP program mandatory.
  - Finalize reweighting flexibilities, including reweighting where data aren't submitted by a third party and reweighting in extreme and uncontrollable circumstances.
  - Remove annual ONC attestations to streamline provider reporting.

- Maintain the performance threshold at 75 points.

- **Alternative Payment Models**
  - Abandon implementation of the Ambulatory Specialty Model (ASM), or at a minimum, exclude neurosurgeons. The ASM's attribution methodology does not adequately capture neurosurgeons' role in the management of low back pain and will hold neurosurgeons accountable for costs and outcomes outside of their control.
  - Refrain from finalizing the ASM's Administrative Claims-Based Low Back Pain Imaging Quality Measure due to flawed methodology.
  - Engage with specialties in selecting future ASM patient-reported outcome measures.
  - Finalize changes to align ASM with MIPS Promoting Interoperability policies, but reconsider inclusion of the Promoting Interoperability category in the ASM altogether.
  - Refrain from revising the Qualifying APM eligibility methodology.

- **Clinical Data Registries**
  - Reassess qualified clinical data registry (QCDR) data validation requirements to simplify reporting and reduce QCDR burden.
  - Retain the two-year period before requiring QCDRs to submit participation plans to CMS.
  - Require qualified posting changes to take place during the qualified posting review period but provide a limited opportunity to make material corrections outside of the review period.

- **Requests for Information**
  - **FHIR Timeline**: Transition to FHIR-based reporting but thoroughly assess readiness before making reporting mandatory.
  - **MVP Scoring**: Address fundamental flaws with MIPS and MVPs before considering scoring methodologies under a mandatory MVP framework.
  - **Star Rating Assignment Methodology**: Ensure data underpinning Medicare star ratings are sufficiently robust, reliable, and attributable to specialists, including neurosurgeons.
  - **Engaging Specialists in the Medicare Shared Savings Program**: Work directly with specialties to develop genuine, voluntary opportunities for specialty participation.

DETERMINATION OF PE RVUs

PE RVU Methodology

In this rule, CMS proposes several significant changes to the PE methodology, including revisions to the indirect PE allocator, changes to utilization assumptions, phase-out of the IPCI, a stabilization adjustment, and modifications to the site-of-service methodology. The AANS and CNS support CMS's goal of improving the accuracy and transparency of the PE methodology. At the same time, the number and pace of simultaneous changes make it difficult to isolate their independent and cumulative effects. CMS should therefore publish a standardized impact

decomposition showing, at the code and specialty levels, the baseline valuation and the independent and cumulative effects of the indirect allocator, utilization changes, IPCI phase-out, stabilization adjustment, site-of-service policy, and other material PE changes. Without this information, stakeholders cannot determine whether payment redistributions reflect actual changes in underlying resource costs or instead result from interactions among methodological assumptions.

Because PE RVUs are intended to reflect the relative resources required to furnish services, CMS should apply a consistent, evidence-based standard across all components of the methodology. Any methodological change that materially redistributes payment among specialties should be supported by evidence demonstrating that the underlying differences in resource requirements have changed. CMS should not rely on broad assumptions or methodological proxies to produce significant payment redistributions without demonstrating their resource-based justification. The Agency should also make clear what is driving each material payment change rather than requiring stakeholders to reverse-engineer the effects of a complex methodology after it is applied to RVUs. CMS should identify and quantify the effect of each major methodological change so stakeholders can evaluate whether the resulting redistribution is supported by the underlying resource data.

Indirect PE Allocator

CMS proposes to allocate indirect PE using the sum of work RVUs and clinical labor RVUs for most services, while excluding services with 10- and 90-day global periods. **The Agency has not identified a resource-based rationale for treating global services differently, creating an unexplained inconsistency in the proposed methodology.** CMS's commissioned RAND analysis evaluated the sum methodology without identifying global status as a basis for excluding these services. If CMS has determined that the sum of work and clinical labor RVUs provides a more accurate basis for allocating indirect PE, the Agency should explain why that methodology would cease to be appropriate solely because a service is furnished under a global payment arrangement. The fact that a service is subject to a global payment period does not, by itself, demonstrate that the indirect resources required to furnish that service are materially different from those associated with other services.

This distinction is particularly consequential for surgical specialties, for which 10- and 90-day global services represent a substantial share of practice. **A global period is a payment construct, not a measure of the practice resources required to furnish the underlying service.** Surgical practices continue to incur costs associated with scheduling, clinical staff, documentation, supplies, technology, compliance, billing, and administrative infrastructure in furnishing services subject to global payment. **The physician work represented by a global service also extends across the applicable global period; bundling certain services into a single payment does not eliminate the indirect resources required to support that care, nor does global status establish that those resources differ materially from those associated with services that are not subject to a global period.**

Excluding global services from the sum methodology could systematically shift indirect PE away from specialties that furnish a substantial volume of global services, even though CMS has not demonstrated that the indirect resources associated with those services are lower or otherwise different. This is particularly problematic because CMS's own commissioned RAND analysis did not identify global status as a resource-based reason to exclude these services.

Any resulting payment redistribution could therefore be driven by the structure of the allocation methodology itself—specifically, which services are included in the allocator—rather than by demonstrated differences in the resources required to furnish care.

Accordingly, the AANS and CNS recommend that CMS apply the proposed sum methodology consistently to 10- and 90-day global services. If CMS believes global services warrant different treatment, the Agency should identify the specific empirical or resource-based evidence supporting that distinction, explain why global status changes the relationship between the relevant RVUs and indirect PE resources, and quantify the resulting impact at the code and specialty levels. A payment or billing construct should not, standing alone, determine whether a service is included in a methodology intended to allocate the indirect resources required to furnish physician services.

IPCI Removal, Stabilization, and Transition

The AANS and CNS oppose CMS's proposed phase-out of the IPCI, particularly because CMS identifies its removal as a significant contributor to neurosurgery's projected decrease in RVUs without establishing that the underlying differences in specialty practice costs are no longer valid. The AANS and CNS agree that specialty-level practice-cost data should be current, reliable, and empirically defensible. However, outdated source data do not, by themselves, establish that the underlying differences in practice costs have disappeared. If CMS determines that the existing data are no longer adequate, the appropriate response is to replace them with current, validated data—not eliminate an established mechanism for recognizing demonstrated differences in practice costs before a tested alternative is available.

CMS should retain the IPCI while it evaluates and validates current specialty-level practice-cost information. **Where the proposed changes would result in substantial adverse payment redistributions, the Agency should also provide a minimum four-year transition, consistent with its prior approach to implementing major PE methodology changes**. This would allow practices to adapt to material payment changes while giving CMS time to assess whether the revised methodology produces the intended resource-based results and to identify unintended consequences.

Furthermore, the CY 2027 specialty impact table does not fully reflect the eventual magnitude of the proposed PE changes. Because CMS proposes to phase in multiple PE methodology changes and apply a stabilization adjustment, the CY 2027 estimates may significantly understate the payment redistribution that will occur once the methodology is fully implemented. To better assess the longer-term impact, the AANS and CNS reviewed CMS's code-level "Fully Implemented PE RVUs" public use file in addition to the specialty impact tables.[1] **That analysis identified numerous commonly furnished, high-volume neurosurgical services for which the PE RVUs decline by more than 30% under the fully implemented methodology.**

Reductions of this magnitude warrant heightened scrutiny. PE supports the infrastructure necessary to furnish neurosurgical care, including clinical personnel, administrative operations, information technology, equipment and supplies, compliance functions, scheduling, and other

[1] Centers for Medicare & Medicaid Services, "CY 2027 PFS Proposed Rule Fully Implemented PE RVUs," CY 2027 Medicare Physician Fee Schedule Proposed Rule, CMS-1848-P (July 2026).

fixed and variable costs**. A reduction exceeding 30% in the PE component of multiple high-volume neurosurgical services should not be accepted simply because a stabilization adjustment moderates the initial impact.** CMS should demonstrate that the underlying resources required to furnish these services have declined by a comparable magnitude. The stabilization adjustment can mitigate short-term payment volatility, but it does not validate the fully implemented payment levels toward which the methodology is moving.

The AANS and CNS support stabilization as a tool to mitigate abrupt payment redistribution, but it should complement—not substitute for—a well-designed transition and a methodology grounded in validated resource data. This is particularly important because the Agency simultaneously proposes changes to the indirect PE allocator, phasing out specialty-specific data, modifying site-of-service assumptions, and implementing other significant PE changes. CMS phased in the bottom-up PE methodology over four years beginning in CY 2007 and subsequently used a four-year transition when incorporating specialty-specific PE per hour data from the Physician Practice Information Survey beginning in CY 2010.[2,3] A similar measured, multi-year transition would give practices time to adapt while allowing CMS to evaluate the combined effects of these changes against contemporary practice-cost information and identify unintended consequences before they become embedded in the MPFS.

The AANS and CNS therefore recommend that CMS retain the IPCI until current specialty-level practice-cost data are available and validated; provide a minimum four-year transition for material adverse payment effects; and publish code- and specialty-level analyses showing both transitional and fully implemented impacts of the major PE changes. CMS should also demonstrate that the combined methodology produces payment values consistent with the MPFS's resource-based objective and that significant payment redistributions are supported by corresponding changes in the resources required to furnish care.

Site-of-Service Payment Differential

The AANS and CNS continue to oppose the CY 2026 MPFS policy reducing the work RVU component used to allocate indirect PE for facility services by 50%. CMS's rationale assumes that a meaningful portion of indirect practice costs is duplicated when a physician furnishes professional services in a facility, but the Agency has not demonstrated that the magnitude of any such duplication is consistently 50% across services, specialties, and practice arrangements. The central question is not whether some overlap may exist. It is whether CMS has empirical evidence establishing the extent of that overlap and supporting the uniform percentage selected.

Neurosurgical practices continue to incur substantial costs when physicians furnish care in hospitals and other facility settings, including clinical and administrative staff, scheduling and care coordination, documentation and health information technology, billing and compliance, malpractice coverage, credentialing, quality reporting, and other infrastructure necessary to support professional services. **The site where care is furnished does not establish which entity incurs these costs**. Many neurosurgical practices provide care across multiple settings and must maintain an infrastructure capable of supporting the provision of care in both the facility and non-facility settings.

[2] 71 FR 69624
[3] 74 FR 61738

If CMS believes duplicative payment exists, the Agency should identify and quantify the specific resources it considers duplicated, identify which entity bears those costs, and demonstrate that the magnitude of any duplication is sufficiently consistent to support a uniform adjustment. A reduction should not be based on assumptions about practice ownership, employment status, or organizational structure. If CMS pursues an alternative methodology, it should be grounded in empirical evidence of actual resource costs and should account for physicians who practice across multiple settings or organizational arrangements.

CMS appropriately recognizes in this proposed rule that physician practice arrangements have become more complex. Neurosurgeons may practice through independent groups, faculty practices, professional corporations, contracted arrangements, health-system-affiliated groups, and other structures in which responsibility for administrative and practice expenses varies. **Employment status therefore cannot reliably serve as a proxy for the resources incurred in furnishing a particular professional service.** If CMS concludes that the current facility/non-facility distinction is no longer an appropriate proxy, any replacement should be grounded in empirical evidence of actual resource costs and applied in a manner that is neutral with respect to physician ownership or employment status.

The consequences extend beyond the valuation of individual services. CMS has recognized concerns that reductions in facility PE could increase financial pressure on independent practices and contribute to consolidation. The AMA's 2024 Physician Practice Benchmark Survey found that the share of physicians practicing in private practices declined from 60.1% in 2012 to 42.2% in 2024 and identified inadequate payment rates, costly resources, and administrative burdens among factors contributing to practice sales to hospitals, private equity firms, or insurers.[4] **Further reducing recognition of indirect PE based on assumed organizational arrangements could intensify these pressures, particularly for specialties such as neurosurgery that require substantial specialized infrastructure to deliver complex care across multiple settings.**

Medicare policy should not inadvertently undermine the financial viability of independent and community-based practices in ways that accelerate consolidation of specialty care. Preserving a viable range of practice settings can promote beneficiary choice, competition, and access to specialized services. **CMS should avoid creating a feedback loop in which payment reductions make independent practice less sustainable, prompting physicians to seek employment or practices to be acquired, and the resulting shift toward hospital employment is then used to justify further reductions in physician practice expense.** Payment policy should instead remain focused on the resources required to furnish care, regardless of the physician's ownership or employment arrangement.

The AANS and CNS therefore recommend that CMS repeal the CY 2026 50% facility indirect PE adjustment. If CMS pursues an alternative to the current site-of-service methodology, that approach should be based on evidence of actual resource costs rather than organizational labels. Any revised methodology should be resource-focused, empirically validated, and, where practicable, designed to reflect the resources actually required to furnish the professional service.

[4] Carol K. Kane, PhD, American Medical Association, *Physician Practice Characteristics in 2024: Private Practices Account for Less Than Half of Physicians in Most Specialties* (2025).

ACCOUNTING FOR OVERLAP BETWEEN STAND-ALONE E/M VISITS AND GLOBAL PERIODS

Proposed 50% Reduction for Separately Identifiable E/M Services

The AANS and CNS strongly oppose CMS's proposal to reduce payment by 50% when a separately identifiable office/outpatient E/M service is furnished on the same day as a procedure with a 0-, 10-, or 90-day global period. Modifier 25 already establishes the framework for reporting a significant, separately identifiable E/M service that exceeds the usual pre- and post-service work associated with the procedure. CMS has not demonstrated that 50% of these services are duplicative, quantified the extent of any overlap, or explained why a uniform 50% reduction accurately reflects the resources associated with distinct E/M services. If the concern is inappropriate utilization of Modifier 25, that is a utilization and program-integrity issue—not evidence that legitimately reported E/M services are worth only half of their current value.

The proposal is particularly problematic in neurosurgery, where patients presenting for a procedure may have new or worsening symptoms, new diagnostic findings, medication-related issues, or other changes in clinical status that require a distinct assessment and medical decision-making—**the fact that an E/M service and procedure occur on the same date does not establish that the E/M work is routine or duplicative**. The Agency should distinguish actual overlap from clinically necessary physician work rather than presume duplication based solely on the timing of the services.

CMS's treatment of global packages elsewhere in this proposed rule further underscores the lack of an evidentiary basis for the proposed reduction. **The Agency acknowledges that 10- and 90-day global services aggregate preoperative, intraoperative, and postoperative components without complete visibility into how each component contributes to the total valuation, yet still proposes to reduce a separately identifiable E/M service by 50% based on presumed overlap with that global package without explaining how it can reliably quantify the extent of duplication when it acknowledges limitations in disaggregating the underlying global valuation**. The proposed methodology, therefore, appears to rest on assumptions that CMS has failed to demonstrate through empirical evidence.

The AANS and CNS therefore recommend that CMS retain the current Modifier 25 framework. If CMS identifies concerns regarding inappropriate use, those concerns should be addressed through targeted billing oversight and program integrity measures rather than an across-the-board reduction that would also reduce payment for medically necessary services that satisfy existing reporting requirements.

GLOBAL SURGICAL PACKAGES

History of CMS Policy and the Current RAND Approach

While CMS does not propose to change the valuation or payment of 10- and 90-day global surgical packages for CY 2027, the Agency solicits comment on potential future approaches. The AANS and CNS agree that global surgical payment warrants careful evaluation. However, postoperative utilization can inform a revaluation; it cannot, by itself, establish how much of an existing global RVU should be removed. Any future methodology should recognize that a global payment is a bundled construct whose value was established through an overall assessment of the service.

In the CY 2015 MPFS final rule, CMS finalized conversion of 10- and 90-day services to 0-day periods, under which postoperative visits would have become separately reportable and payable; Congress subsequently prohibited implementation through section 523 of MACRA. A "retain-and-revalue" approach is fundamentally different from true 0-day conversion. Under 0-day conversion, medically necessary postoperative services removed from the package could be separately reported and valued. Under retain-and-revalue, the surgeon could remain responsible for the same postoperative care while the value of the global service is reduced.[5, 6, 7] CMS should not treat these approaches as interchangeable when evaluating their payment, beneficiary cost-sharing, and access implications.

The distinction is particularly important because the E/M services incorporated into global packages have not been fully updated to reflect the increases implemented for analogous stand-alone E/M services beginning in 2021. **The AANS and CNS do not advocate for widescale conversion to 0-day global periods; however, CMS should not reduce the value of global surgical services based on observed postoperative utilization while continuing to value the E/M work included in those packages using outdated relative values**. Before determining that global services are overvalued, CMS should first ensure that the individual components of the package are valued consistently with their current stand-alone counterparts; otherwise, CMS risks attributing differences in utilization to overvaluation when those differences may instead reflect outdated valuation of the postoperative E/M work included in the global package.

The AANS and CNS have repeatedly encouraged CMS to address this longstanding relativity issue. **Physician work does not become less clinically meaningful because it is furnished during a global period.** Postoperative neurosurgical encounters may require assessment of neurologic function, wound healing, imaging, pain and medication management, functional recovery, new or persistent symptoms, and decisions regarding rehabilitation or additional intervention. CMS's current solicitation provides an opportunity to evaluate global surgical payment comprehensively by considering both the frequency and clinical intensity of postoperative care and the values assigned to the E/M services included in the package.

CMS should not use incomplete or outdated data to justify reductions while leaving a known valuation disparity unresolved. Before pursuing any reduction in global surgical values, CMS should first update the E/M values embedded in global packages to maintain relativity with corresponding stand-alone services and then evaluate postoperative utilization using current, clinically representative data. This sequence would better distinguish genuine changes in resource use from effects attributable to outdated valuation relationships.

99024 Does Not Measure Postoperative Visit Intensity

CPT code 99024 was established to identify postoperative visits that are included in a global surgical payment and therefore are not separately payable—it was not designed to describe the intensity, complexity, duration, or clinical content of the postoperative encounter. **Accordingly, the number of 99024 claims cannot, by itself, establish that postoperative care is routine, low-intensity, or overvalued.** RAND's separate survey-based study of postoperative visit level and work examined cataract surgery, total hip arthroplasty, and complex wound repair—not

[5] 79 FR 67548
[6] Medicare Access and CHIP Reauthorization Act of 2015, Pub. L. No. 114-10, section 523
[7] Medicare Payment Advisory Commission, *Report to the Congress: Medicare and the Health Care Delivery System*, June 2025, Chapter 1.

neurosurgical procedures.[8,9] **CMS should therefore exercise caution in extrapolating those findings to neurosurgical global services, where the nature and intensity of postoperative care can differ substantially.**

Postoperative cranial and spinal encounters may require detailed neurologic and functional assessment, review of imaging and other diagnostic findings, wound evaluation, management of pain and medications, assessment of new or persistent symptoms, and decisions regarding rehabilitation, additional treatment, or further intervention. The presence of a 99024 claim provides no information about whether these services were required, or the extent of physician work involved. **CMS should not equate the frequency of 99024 claims with the intensity or value of postoperative care, particularly when using utilization data from other specialties to inform the valuation of neurosurgical global services.**

RAND Arithmetic Does Not Reflect Magnitude Estimation

Global surgical work RVUs were established through magnitude estimation, which considers the overall physician work associated with furnishing the global service rather than assigning independent RVU values to discrete postoperative visits. Postoperative visit assumptions informed the overall magnitude estimate but were not separately valued as building blocks that were then added to the preoperative and intraoperative components.[10] **Therefore, it is methodologically inappropriate to reverse-engineer the original valuation by assigning an RVU amount to assumed postoperative visits and mechanically subtracting that amount from the current global work RVU.** Doing so would impose a building-block methodology on a valuation that was not developed using that approach.

More complete and clinically representative information about the frequency, intensity, and content of postoperative care can inform a future revaluation, but it does not establish that the existing global value can be decomposed into independently severable components. **CMS should use postoperative utilization data as evidence to inform and validate an overall revaluation of the global service—not as a mathematical proxy for the portion of the existing RVU that CMS assumes should be removed.** Any revaluation should consider the total physician work required to furnish the service and be supported by a methodology consistent with the way the original values were established.

Beneficiary Cost-Sharing and Access Must Be Considered

Routine postoperative care included in a global package is not separately billed to the beneficiary and therefore does not generate additional cost-sharing at each postoperative encounter**. By contrast, converting postoperative services into separately reportable and payable encounters could expose beneficiaries to new cost-sharing obligations for care currently included in the global payment.**[11] The Agency should evaluate whether these additional financial barriers could discourage beneficiaries—particularly older adults and those with limited financial resources—from obtaining clinically appropriate postoperative follow-up.

[8] 81 FR 80170
[9] RAND Corporation, *Survey-Based Reporting of Post-Operative Visits for Select Procedures with 10- or 90-Day Global Periods: Final Report* (2019).
[10] RAND Corporation, *Using Claims-Based Estimates of Post-Operative Visits to Revalue Procedures with 10- or 90-Day Global Periods: Updated Results Using Calendar Year 2019 Data* (2021).
[11] Centers for Medicare & Medicaid Services, Medicare Learning Network, Global Surgery Booklet, MLN907166.

This consideration is especially important in neurosurgery, where timely postoperative assessment may be essential to identify neurologic deterioration, wound complications, infection, hardware-related problems, or other complications before they progress to more serious and costly conditions.

CMS has not demonstrated that the available postoperative utilization data establish widespread overvaluation of 10- and 90-day global surgical services across specialties. The AANS and CNS therefore recommend that CMS not use postoperative visit counts, 99024 data, or public-use-file calculations as the sole basis for broad reductions in global surgical values. Any future revaluation should use specialty-specific, clinically representative evidence addressing the frequency, intensity, and content of postoperative care, current E/M relativities, patient complexity, beneficiary cost-sharing, and access to necessary follow-up. Conversion to 0-day global periods likewise should not be treated as a substitute for a validated, resource-based revaluation; any such change should be evaluated for both physician payment and beneficiary consequences.

PAYMENT FOR MEDICARE TELEHEALTH SERVICES

The AANS and CNS support continued Medicare telehealth flexibility when clinically appropriate and the preservation of physician judgment regarding the appropriate modality of care. Neurosurgical care frequently requires an in-person neurologic examination, imaging review, wound assessment, or procedural evaluation, but telehealth can be valuable for selected follow-up visits, consultations, medication management, and improving access to subspecialty expertise. **CMS should therefore maintain flexibility rather than adopt a one-size-fits-all approach, recognizing that the appropriate modality depends on the patient's condition, the clinical question, and the physician's judgment.** In rural and underserved areas, telehealth can also serve as an important bridge to specialized neurosurgical expertise while preserving in-person care when physical examination or procedural assessment is necessary.

Consistent with this principle, the AANS and CNS urge CMS to assign CPT codes 95970, 95983, and 95984 to permanent Category 1 or 2 status on the Medicare Telehealth Services List. CMS added these codes—which describe the electronic analysis of implanted brain neurostimulator pulse generators/transmitters (CPT 95970) and brain neurostimulator programming, both the first 15 minutes (CPT 95983) and each additional 15 minutes (CPT 95984)—to the list on a temporary Category 3 basis in the CY 2023 MPFS final rule after acknowledging both that Medicare claims data showed the services were already being furnished via telehealth and that they offered potential clinical benefit.[12] CMS nevertheless cited concerns about whether the implanted device could be connected remotely to the programmer and whether remote programming could be performed safely. CMS subsequently retained the codes on the list as Category 3 to allow additional evidence to develop to support permanent telehealth status.[13]

The additional experience CMS sought now provides a basis for permanent inclusion. Secure, HIPAA-compliant remote programming systems have been used successfully for more than a year and a half, allowing physicians to program the device while conducting real-time audio-

[12] 87 FR 69404
[13] 88 FR 78818

video assessment and obtaining patient feedback. These systems also incorporate safety safeguards, including a predefined "safe" program that the device automatically returns to if the remote connection is interrupted. **As such, the two concerns CMS identified in CY 2023—technical feasibility and patient safety—are now addressed by established technology and real-world clinical experience.** Given the above, CMS should recognize this evidence and assign CPT codes 95970, 95983, and 95984 permanent Category 1 or 2 status.

VALUATION OF SPECIFIC CODES INCLUDING POTENTIALLY MISVALUED SERVICES UNDER THE MPFS

Methodology for Establishing Work RVUs—Efficiency Adjustment

Although CMS does not propose changes to the efficiency adjustment for CY 2027, the AANS and CNS remain strongly concerned about its continued application to neurosurgical services. CMS's stated objective is to account for productivity gains over time; however, a generalized assumption that physician services become more efficient should not substitute for evidence that the physician work required to furnish a particular service has actually declined—the relevant question is therefore not whether productivity gains can occur in medicine, but whether the record demonstrates that total physician work has declined for the particular services to which the adjustment is applied. Because the MPFS is intended to reflect relative resources at the service level, a reduction in physician work should be supported by evidence of a corresponding reduction in the work of the service.

The CY 2026 final rule established a 2.5% efficiency adjustment for applicable non-time-based services and contemplated its recurring application. Because the adjustment is applied broadly rather than based on demonstrated changes in individual services, it can reduce the value of a code even when total physician work has remained unchanged or become more complex. This is particularly problematic for high-intensity surgical and procedural services, where technological change may alter how work is performed without reducing the physician work required to furnish the service. The AANS and CNS therefore recommend that any recurring reduction in physician work be supported by service-specific evidence demonstrating a corresponding decline in total physician work.

Neurosurgical procedures often require continuous, highly concentrated physician work that cannot be delegated, interrupted, or compressed without affecting safe and effective care. Many involve high-acuity or clinically unpredictable patients and require real-time interpretation of anatomy, imaging, neurophysiologic information, and changes in patient condition. Technological advances—including imaging, navigation, neuromonitoring, instrumentation, robotics, and minimally invasive techniques—may reduce the time required for discrete tasks without reducing total physician work. They may also enable treatment of more complex pathology and higher-risk patients, shifting physician effort toward preoperative planning, interpretation of increasingly complex information, technical precision, and intraoperative judgment. **The AANS and CNS do not contend that physician services can never become more efficient; rather, efficiency should be demonstrated, not presumed.**

Targeted Exemption for Specific Neurosurgical Services

The AANS and CNS recognize CMS's rationale for adopting the efficiency adjustment to account for technological advances and changes in clinical practice that may reduce physician

work over time. **However, the neurosurgical services identified in this letter do not fit that premise.** These services have either been recently reviewed and valued by CMS, involve physician work with limited opportunity for meaningful compression or delegation, or have been recognized by CMS as warranting distinct treatment because of their complexity and resource intensity. **Applying a uniform reduction without service-specific evidence of reduced physician work risks introducing, rather than correcting, valuation inaccuracies.**

The AANS and CNS are not asking CMS to reconsider the efficiency adjustment as a whole or establish a new valuation methodology. Rather, CMS should use its existing authority to exempt a limited set of services for which the adjustment's underlying assumptions are not supported by the record. **Targeted carve-outs would preserve the integrity of the MPFS by applying the adjustment where its premise is supported while avoiding reductions based solely on generalized productivity assumptions.**

CMS's Responsibility to Maintain Accurate Relative Values

The MPFS is founded on the principle that payment should reflect the physician work, practice expense, and malpractice resources required to furnish individual services. Under the Resource-Based Relative Value Scale (RBRVS), each CPT code is assigned RVUs intended to maintain appropriate payment relationships across the full spectrum of physician services. Although CMS relies extensively on recommendations from the AMA/Specialty Society Relative Value Scale Update Committee (RUC), Congress assigned ultimate responsibility for maintaining accurate Medicare relative values to the Secretary of Health and Human Services. CMS therefore retains both the authority and responsibility to accept, modify, or reject RUC recommendations and to ensure that Medicare payment reflects the resources required to furnish physician services.

Congress reinforced this responsibility through Section 3134 of the Patient Protection and Affordable Care Act (ACA), codified at 42 U.S.C. § 1395w-4(c)(2)(K), which requires CMS to establish a process for periodically identifying and reviewing potentially misvalued services under the MPFS. The statute directs CMS to develop and apply objective criteria for identifying such services and to make appropriate adjustments to their relative values. This authority is not limited to identifying overvalued services; it encompasses valuation distortions more broadly, including those that may arise when a uniform payment policy affects heterogeneous services differently.

The efficiency adjustment presents a particularly important test of this responsibility. Unlike a traditional code-specific revaluation, the adjustment applies a uniform reduction to physician work across thousands of services without determining whether physician work has actually declined for each affected service or identifying service-specific evidence of measurable productivity gains. The policy therefore risks creating systematic misvaluation where its underlying assumptions do not apply.

CMS should use its independent authority to identify services for which the efficiency adjustment is unsupported or inappropriate and apply targeted exceptions where warranted. Any reduction in physician work should be grounded in evidence that the resources required to furnish the particular service have declined—not simply in an economy-wide productivity measure or generalized assumption about technological advancement.

At the same time, CMS's independent role should complement, rather than displace, the clinical expertise that underpins the valuation process. The strongest approach is one in which practicing physicians provide the clinical context necessary to understand a service. At the same time, empirical evidence is used to test whether underlying valuation assumptions remain valid. Where the record demonstrates that the assumptions underlying the efficiency adjustment do not apply, maintaining accurate relative values requires CMS to make appropriate service-specific exceptions.

Ultimately, CMS's responsibility to maintain accurate relative values requires distinguishing between services for which productivity gains are supported by evidence and those for which they are not. Where the premise of the adjustment is not supported for a particular service, a targeted exception preserves—not undermines—the accuracy and relativity of the MPFS.

CMS's Rationale for the Efficiency Adjustment Supports Targeted Exceptions

As explained in the CY 2026 MPFS final rule and reaffirmed in the CY 2027 proposed rule, CMS adopted the efficiency adjustment based on the premise that technological advancement, evolving clinical practice, and broader productivity gains may reduce the physician work and intraservice time required to furnish certain services over time. CMS has also expressed concern that survey-based methodologies may not fully capture long-term changes in physician productivity and has indicated an interest in incorporating more empirical approaches into physician valuation.

The AANS and CNS support CMS's objective of maintaining accurate payment as medical practice evolves. That objective, however, also requires CMS to recognize when a generalized productivity assumption does not apply. An aggregate productivity measure may inform broad policy decisions, but it cannot establish that physician work for any particular CPT code has materially declined.

The CY 2027 proposed rule itself demonstrates that CMS recognizes the limitations of applying the efficiency adjustment universally. The Agency excludes categories such as time-based services, telehealth services, and newly established codes, among others, because generalized productivity assumptions may not accurately reflect their characteristics. These exclusions demonstrate that targeted exceptions are both appropriate and administratively feasible and establish that the relevant policy question is whether the characteristics of a service support application of the adjustment—not whether an entire specialty is generally eligible for an exception.

The neurosurgical services identified in this letter present a similarly compelling case. They share characteristics that distinguish them from the broader population of services subject to the adjustment:

- **Recent Valuation.** Several requested codes underwent comprehensive RUC review within the past five years, and CMS accepted the resulting work values after considering contemporary physician work, time, and clinical intensity. Applying the efficiency adjustment shortly thereafter effectively assumes that physician work has declined since that valuation, without evidence demonstrating that such a decline has occurred. A recent valuation does not categorically preclude a subsequent adjustment; rather, it

creates a heightened evidentiary burden for applying a generalized reduction so soon after CMS has reviewed and established the service's relative value.

- **Clinically Irreducible Physician Work.** These procedures require continuous, high-intensity physician involvement that cannot be delegated, abbreviated, or meaningfully compressed without potentially affecting patient safety or clinical outcomes. Their cognitive, technical, and intraoperative decision-making demands limit the applicability of generalized productivity assumptions.

- **High-Acuity and Unpredictable Clinical Contexts.** Many services are performed in emergent, urgent, or otherwise high-acuity circumstances involving life-threatening or rapidly progressive conditions. Variability in patient presentation, anatomy, pathology, and intraoperative circumstances limits opportunities for standardization and predictable workflow efficiencies.

- **Technology Enhances Rather Than Replaces Physician Work.** Advances in imaging, navigation, neuromonitoring, robotics, and minimally invasive techniques have improved precision and expanded treatment capabilities, but do not necessarily reduce physicians' workload. In many cases, they shift work toward more sophisticated planning, image interpretation, technical execution, and real-time decision-making while enabling treatment of more complex patients and pathology.

- **Non-Preventable Disease Burden.** Neurosurgeons treat conditions including cerebral aneurysms, brain and spine tumors, traumatic injuries, degenerative spinal disease, and movement disorders such as Parkinson's disease. These conditions are generally congenital, hereditary, degenerative, or the result of unpredictable events and therefore do not lend themselves to productivity assumptions based on prevention or behavioral change.

- **Regulatory and Administrative Burden.** Increasing documentation, prior authorization, quality reporting, compliance, and other administrative requirements consume physician time and practice resources and may offset efficiencies achieved through technology or changes in clinical workflow.

Taken together, these characteristics provide an objective basis for distinguishing the requested services from the broader population subject to the efficiency adjustment. The requested carve-outs are not based on specialty preference; they reflect differences in clinical complexity, physician work, valuation recency, and the applicability of the adjustment's underlying assumptions. Exempting services for which the adjustment is unsupported would therefore advance CMS's stated objective of maintaining accurate, evidence-based physician payment.

Methodology for Identifying Appropriate Carve-Out Candidates

The recommendations in this letter were developed through a structured, conservative process designed to identify services for which application of the efficiency adjustment is least consistent with CMS's stated rationale. Rather than beginning with a predetermined list, the AANS and CNS applied objective clinical and policy criteria to identify services with the strongest evidentiary basis for exclusion.

- **Step 1—Comprehensive Code Inventory.** The AANS and CNS developed an inventory of neurosurgical CPT codes across major subspecialties, including cerebrovascular, tumor, spine, trauma, pediatric, and functional neurosurgery. The review included RUC activity over the past ten years and was supplemented by recommendations from the AANS/CNS Coding and Reimbursement Subcommittee (CRC) and the Neurosurgery Executives' Resource Value & Education Society (NERVES), producing approximately 70 initial candidate codes.

- **Step 2—Code Prioritization.** Candidate services were prioritized based on clinical and payment considerations, including whether they:
    - represent substantial physician work and technical intensity;
    - have meaningful Medicare utilization;
    - remain central to contemporary neurosurgical practice; and
    - present limited opportunity for meaningful reductions in physician work through technological or workflow efficiencies.

- **Step 3—Usability Screening.** Candidates were then evaluated against additional criteria intended to identify services for which the efficiency adjustment is least likely to reflect actual changes in physician work or resource requirements. Codes were generally included only if they:
    - had undergone relatively recent valuation through the RUC process;
    - had sufficient Medicare utilization to support meaningful policy analysis;
    - were predominantly furnished by neurosurgeons; and
    - exhibited clinical characteristics inconsistent with the assumptions underlying the efficiency adjustment.

  Codes lacking contemporary valuation, having minimal Medicare utilization, or being primarily furnished by other specialties were generally excluded.

This conservative methodology resulted in a limited group of services for which the clinical and evidentiary case for exclusion is strongest. The recommendations are not intended to identify every service that might warrant an exception, but rather those for which the available record most clearly demonstrates that the efficiency adjustment's underlying assumptions are not applicable. This approach is intentionally narrow and does not depend on a specialty-wide exemption.

Overview of Requested Neurosurgical Efficiency Adjustment Carve-Outs

The table below summarizes the 11 services for which the AANS and CNS request exemption from the CY 2027 efficiency adjustment and identifies the principal evidentiary basis for each request.

CPT Code	Service	Primary Basis for Carve-Out	CMS Activity
61781	Intraoperative cranial navigation	Recent valuation; intraoperative add-on; physician-dependent work	RUC reviewed in September 2025; CMS accepted RUC value in CY 2026

61624	CNS endovascular embolization	Recent valuation; high-intensity physician work; high Medicare use	RUC reviewed April 2024; CMS accepted RUC value in CY 2025
22633	Lumbar interbody fusion	Recent valuation; high-acuity 90-day global service; high Medicare use	RUC reviewed in April 2021; CMS accepted RUC value
63030	Lumbar decompression / discectomy	Recent valuation; CMS value below RUC recommendation; 90-day global service	RUC reviewed in January 2022; CMS did not adopt RUC-recommended value
63052	Additional lumbar decompression during fusion	Recent valuation; CMS value below RUC recommendation; ZZZ add-on; high Medicare use	RUC reviewed in April 2021; CMS did not adopt RUC-recommended value
61863	DBS electrode implantation	CMS-recognized clinical distinctiveness; high-precision, physician-dependent procedure	Removed from WISeR code list
61864	DBS electrode implantation	CMS-recognized clinical distinctiveness; high-precision, physician-dependent procedure	Removed from WISeR code list
61867	DBS electrode implantation	CMS-recognized clinical distinctiveness; inpatient-only Stage 1 procedure	Removed from WISeR code list; remains on Medicare Inpatient Only list
61868	DBS electrode implantation	CMS-recognized clinical distinctiveness; inpatient-only Stage 1 procedure	Removed from WISeR code list; remains on Medicare Inpatient Only list
61885	DBS pulse generator procedure	CMS-recognized clinical distinctiveness; physician-dependent DBS procedure	Removed from WISeR code list
61886	DBS pulse generator procedure	CMS-recognized clinical distinctiveness; physician-dependent DBS procedure	Removed from WISeR code list

Specific Neurosurgical Carve-Out Requests

1) **CPT Code 61781** ***(Stereotactic computer-assisted (navigational) procedure; cranial, intradural (List separately in addition to code for primary procedure)).***[14] CPT 61781 represents intraoperative image-guided navigation used during open cranial procedures. It is reported in addition to the primary procedure and is employed by neurosurgeons during brain surgery—including resection of tumors, biopsy of lesions, and management of arteriovenous malformations (AVMs)—to enable precise, real-time spatial navigation through the complex anatomy of the brain. Its purpose is to minimize inadvertent damage to eloquent cortex and critical neural structures while maximizing the extent of tumor resection, and it is therefore a direct contributor to both patient safety and operative quality.

   Several features of this code make it an appropriate candidate for a carve-out from the efficiency adjustment:

[14] American Medical Association. *Current Procedural Terminology (CPT®) Professional Edition 2026*. Chicago, IL: American Medical Association; 2025.

- **Recent Valuation:** CPT 61781 was reviewed and valued by the RUC in September 2025.[15] In the CY 2026 MPFS, CMS accepted the RUC-recommended value in full, meaning that just one year ago, the Agency affirmatively agreed that the RVU assignment accurately reflected the work, time, and complexity involved in furnishing this service.[16] Applying an efficiency adjustment to a code whose value was so recently finalized by CMS (1) is inconsistent with the purpose of the adjustment, which targets codes where historical valuation may have outpaced current resource requirements, and (2) undermines the integrity of the Agency's own valuation decisions. Where CMS has conducted or accepted a recent valuation, there is no basis to presume that further efficiency-driven reductions are warranted.

- **ZZZ Global Period:** CPT 61781 carries a ZZZ global period designation, meaning it is a time-only intraoperative add-on code with no associated pre- or post-operative period. CMS has established a precedent for exempting time-based codes from the efficiency adjustment on the grounds that physician time cannot be compressed through productivity assumptions. That same logic applies with equal or greater force to time-only intraoperative codes. The time spent performing intraoperative navigation is irreducibly physician-dependent; it cannot be delegated, compressed, or automated, and it cannot be made more efficient through technological substitution.

- **Add-On Code Structure:** CPT 61781 is an add-on code, meaning that it is a designated service that is performed in conjunction with a primary procedure and is not reported independently. Add-on codes represent discrete increments of additional physician work, often intraoperative, that are clinically necessary but not encompassed within the base code. Because add-on codes are inherently dependent on the primary service and reflect additional, non-optional work, they are not subject to independent efficiency gains or workflow optimization.

- **Technology Costs:** Contrary to assumptions of cost compression, capital-intensive neurosurgical technologies—including stereotactic navigation systems, intraoperative imaging platforms, and hybrid operating room infrastructure—have demonstrated persistent or increasing cost profiles due to maintenance, software updates, disposables, and staffing requirements.[17] These costs are not offset by reductions in physician time and are not reflected in a uniform efficiency adjustment.

2) **CPT Code 61624** ***(Transcatheter permanent occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), including all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention, percutaneous, any method; central nervous system (intracranial, spinal cord))*.**[18] CPT 61624 represents endovascular transcatheter embolization—a catheter-based technique used to occlude blood flow in the treatment of cerebral aneurysms, AVMs, endocranial tumors, and traumatic intracranial vascular injury.

[15] American Medical Association, RUC Recommendations (Oct. 2025), available at: https://www.ama-assn.org/system/files/oct-2025-ruc-recommendations.pdf
[16] 90 FR 49266
[17] Daglioglu, E. The cost of neurosurgical technology: implications for resource utilization and health care expenditures. *World Neurosurgery*. 2019;126:e973–e980.
[18] American Medical Association. *Current Procedural Terminology (CPT®) Professional Edition 2026*. Chicago, IL: American Medical Association; 2025.

This procedure is performed by neurosurgeons through minimally invasive catheterization, requiring sophisticated real-time fluoroscopic guidance and exceptional technical precision. The risks inherent in navigating the intracranial vasculature, combined with the acute and often emergent nature of the conditions being treated, make this one of the most demanding technical services in neurosurgical practice.

Several features of this code support its inclusion as a carve-out candidate:

- **Recent Valuation:** CPT 61624 was reviewed and valued by the RUC in April 2024.[19] In the CY 2025 MPFS, CMS accepted the RUC-recommended value in full, meaning that just two years ago, the Agency affirmatively agreed that the RVU assignment accurately reflected the work, time, and complexity involved in furnishing this service.[20] As with CPT 61781, applying an efficiency adjustment to a code whose value was so recently finalized by CMS (1) is inconsistent with the purpose of the adjustment, which targets codes where historical valuation may have outpaced current resource requirements, and (2) undermines the integrity of the Agency's own valuation decisions. The short interval between the accepted valuation and the implemented efficiency adjustment leaves no basis for assuming that resource requirements have meaningfully changed.

- **Significant Medicare Utilization Volume:** With approximately 14,405 Medicare encounters in 2024, CPT 61624 reflects broad clinical use and is integral to the management of life-threatening cerebrovascular conditions.[21] It is used across multiple neurosurgical subspecialties, demonstrating the breadth of clinical contexts in which embolization is necessary. This cross-applicability underscores the code's centrality to neurosurgical practice and the magnitude of the impact that an unwarranted efficiency reduction would have on patient access to care.

- **Conditions Arising from Non-Preventable Causes:** Many of the conditions for which transcatheter embolization is indicated—cerebral aneurysms, AVMs, and traumatic vascular injuries—are hereditary, congenital, or arise from unpredictable external events. They are not amenable to prevention through lifestyle modification and fall outside traditional frameworks of preventable illness. While the AANS and CNS appreciate the Secretary's focus on policies that support preventive care and lifestyle-related health improvements, it remains important to ensure that reimbursement for these inherently unavoidable, high-acuity surgical interventions remains accurate and is not inadvertently affected by policy priorities directed at a fundamentally different patient population.

3) **CPT Code 22633 (*Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace, lumbar).***[22] CPT 22633 describes a combined posterior lumbar interbody fusion (PLIF) or transforaminal lumbar interbody fusion (TLIF)—complex spinal arthrodesis procedures performed to treat

[19] American Medical Association, RUC Recommendations (May 2024), available at: https://www.ama-assn.org/system/files/may-2024-ruc-recommendations.pdf
[20] 89 FR 97710
[21] Centers for Medicare & Medicaid Services (CMS), Physician/Supplier Procedure Summary (PSPS) Master File: Part B National Summary Data File, Calendar Year 2024.
[22] American Medical Association. *Current Procedural Terminology (CPT®) Professional Edition 2026*. Chicago, IL: American Medical Association; 2025.

symptomatic degenerative lumbar pathology, including spondylolisthesis, disc degeneration with instability, and recurrent disc herniation with mechanical back pain. The procedure involves both posterior and interbody fusion techniques in a single surgical encounter, requiring high intraoperative complexity, prolonged operative time, and comprehensive post-operative management under a 90-day global period. It is an inpatient procedure that reflects the severity and instability of the underlying spinal pathology.

Several features of this code support its inclusion as a carve-out candidate:

- **Recent Valuation:** CPT 22633 was reviewed and valued by the RUC in April 2021.[23] CMS accepted the RUC-recommended value.[24] Given that the Agency's valuation of this code is relatively recent—and reflects clinical and time-based inputs that remain unchanged—there is no empirical basis for applying an efficiency adjustment that presumes a reduction in resources since the time of valuation. Applying such an adjustment to a recently confirmed value undermines the credibility of the valuation process itself.

- **Neurosurgery as Dominant Provider:** Neurosurgery is the dominant billing specialty for CPT 22633, accounting for approximately 53.0% of total Medicare utilization.[25] The concentration of utilization within the specialty reflects both the technical demands of the procedure and the specialized training required to perform it safely. Payment reductions have a direct and disproportionate effect on neurosurgical practice viability for the patient populations who require these services.

- **90-Day Global Period—Inpatient Setting:** CPT 22633 carries a 90-day global period and is performed in the inpatient hospital setting, reflecting the clinical acuity and peri-operative management demands of the procedure. The global period encompasses extensive post-operative physician work, including management of surgical recovery, monitoring for neurological complications, and long-term follow-up—none of which can be compressed or delegated through productivity assumptions. The inpatient nature of the procedure reflects that patients undergoing this surgery frequently present with advanced degenerative disease requiring multi-day observation and medical management.

- **Significant Medicare Utilization Volume:** With approximately 34,815 Medicare encounters in 2024, CPT 22633 represents a high-volume, high-acuity service delivered to a significant portion of the Medicare population with serious lumbar pathology.[26] Many of these patients have exhausted nonoperative options before reaching surgical candidacy, and the procedure often represents the definitive treatment for debilitating mechanical instability. The scale of utilization means that even modest per-unit payment reductions translate into substantial aggregate impacts on access to care.

[23] American Medical Association, RUC Recommendations (May 2021), available at: https://www.ama-assn.org/system/files/may-2021-ruc-recommendations.pdf
[24] 87 FR 69404
[25] Centers for Medicare & Medicaid Services (CMS), Physician/Supplier Procedure Summary (PSPS) Master File: Part B National Summary Data File, Calendar Year 2024.
[26] Centers for Medicare & Medicaid Services (CMS), Physician/Supplier Procedure Summary (PSPS) Master File: Part B National Summary Data File, Calendar Year 2024.

4) **CPT Code 63030** ***(Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar).***[27] This code describes one of the most commonly performed spine procedures in neurosurgical practice—a lumbar discectomy used to relieve nerve root compression caused by a herniated intervertebral disc. The procedure involves precise removal of disc material and bony overgrowth to decompress the affected nerve root, restoring function and relieving pain in patients who have failed conservative management.

   Several features of this code support its inclusion as a carve-out candidate:

   - **Recent Valuation with CMS Deviation from RUC Recommendation:** CPT 63030 was reviewed and valued by the RUC in January 2022.[28] However, CMS did not accept the RUC-recommended value and erroneously assigned RVUs below the RUC's recommendation.[29] CPT 63030 presents not merely an efficiency adjustment applied to a correctly valued code, but an efficiency adjustment layered on top of a pre-existing undervaluation has a compounding effect that is doubly inconsistent with the Agency's statutory obligation to maintain payment accuracy and relativity.

   - **Neurosurgery as Dominant Provider:** Neurosurgery is the dominant billing specialty for CPT 63030, accounting for approximately 55.6% of total Medicare utilization.[30] This concentration of utilization within a single specialty underscores the clinical specificity of the service and the degree to which payment accuracy directly affects neurosurgical practice sustainability. Reductions to this code have a disproportionate impact on neurosurgeons and their patients.

   - **90-Day Global Period—Outpatient Setting:** CPT 63030 carries a 90-day global period, meaning that the reimbursement for the procedure encompasses all related post-operative care over a three-month period, including office visits, wound management, and clinical follow-up. This procedure is performed in the outpatient setting with no associated inpatient hospital visits, reflecting a deliberate transition toward lower-cost care environments—a shift that CMS has generally encouraged. However, the efficiency adjustment does not account for the fact that the global period bundles substantial ongoing physician work that remains physician-dependent and cannot be reduced through productivity assumptions.

   - **Significant Medicare Utilization:** With approximately 16,333 Medicare encounters annually, CPT 63030 represents a high-volume service delivered to a significant segment of the Medicare beneficiary population.[31] Many of these beneficiaries have failed weeks or months of conservative therapy before reaching the surgical threshold, and the procedure is often the definitive intervention for progressive neurological deficits.

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[27] American Medical Association. *Current Procedural Terminology (CPT®) Professional Edition 2026*. Chicago, IL: American Medical Association; 2025.
[28] American Medical Association, RUC Recommendations (Feb. 2022), available at: https://www.ama-assn.org/system/files/feb-2022-ruc-recommendations.pdf
[29] 87 FR 69404
[30] Centers for Medicare & Medicaid Services (CMS), Physician/Supplier Procedure Summary (PSPS) Master File: Part B National Summary Data File, Calendar Year 2024.
[31] Centers for Medicare & Medicaid Services (CMS), Physician/Supplier Procedure Summary (PSPS) Master File: Part B National Summary Data File, Calendar Year 2024.

Payment reductions at this scale of utilization carry correspondingly large implications for beneficiary access and neurosurgical workforce sustainability.

5) **CPT Code 63052 (*Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; single vertebral segment).*** [32] CPT 63052 is an add-on code reported in conjunction with CPT 22633 when the decompression required during posterior lumbar interbody arthrodesis extends beyond the typical dissection necessary to complete the interbody approach. It captures the additional physician work associated with a more extensive bilateral laminectomy and neural decompression—work that is clinically necessary when advanced stenosis, cauda equina involvement, or multilevel compression requires broader exposure and decompression beyond what the primary fusion code encompasses.

   Several features of this code support its inclusion as a carve-out candidate:

   - **Recent Valuation With CMS Deviation from RUC Recommendation:** CPT 63052 was reviewed and valued by the RUC in April 2021.[33] CMS did not accept the RUC-recommended value and erroneously assigned RVUs below the RUC's recommendation.[34] As with CPT 63030, the efficiency adjustment compounds a pre-existing undervaluation, creating a double reduction in reimbursement that further distances payment from the actual resources required to furnish the service. Applying an additional downward adjustment to a code that was already valued below the RUC recommendation is both inequitable and contrary to the Agency's statutory obligation to maintain accurate relative values.

   - **Neurosurgery as Dominant Provider:** Neurosurgery is the dominant billing specialty for CPT 63052, accounting for approximately 56.2% of total Medicare utilization. The add-on designation reflects a discrete and clinically significant increment of additional surgical work performed within the same operative encounter as CPT 22633.

   - **ZZZ Global Period—Add-On Code Structure:** CPT 63052 carries a ZZZ global period designation, confirming its status as an intraoperative add-on code that is never billed in isolation and has no independent pre- or post-operative period. As with CPT 61781, the ZZZ designation underscores that this code captures time-only physician work that is irreducibly dependent on continuous physician presence. CMS has acknowledged the rationale for exempting time-based codes from the efficiency adjustment; that same logic should also apply for time-only codes.

   - **Significant Medicare Utilization:** With approximately 29,580 Medicare encounters in 2024, CPT 63052 reflects broad clinical use and is integral to the management of complex lumbar stenosis during fusion surgery.[35] Because it is always reported with CPT

[32] American Medical Association. *Current Procedural Terminology (CPT®) Professional Edition 2026*. Chicago, IL: American Medical Association; 2025.
[33] American Medical Association, RUC Recommendations (May 2021), available at: https://www.ama-assn.org/system/files/may-2021-ruc-recommendations.pdf
[34] 87 FR 69404
[35] Centers for Medicare & Medicaid Services (CMS), Physician/Supplier Procedure Summary (PSPS) Master File: Part B National Summary Data File, Calendar Year 2024.

22633, any efficiency-driven reduction to this add-on code compounds the payment impact already experienced under the primary procedure code, further eroding the reimbursement available for these high-intensity surgical encounters.

6) **Deep Brain Stimulation (DBS) Codes for Parkinson's Disease and Related Movement Disorders**. CMS has already made an affirmative clinical and policy judgment about the complete DBS procedure family in a directly analogous context to the efficiency adjustment. Through its prior authorization code selection process for the Wasteful and Inappropriate Service Reduction (WISeR) Model, the Agency initially proposed to include DBS CPT codes 61863, 61864, 61867, 61868, 61885, and 61886 on the WISeR code list.[36] After further review, CMS exempted such codes from the model both before and after launch, concluding that DBS does not exhibit the characteristics—high waste risk, declining clinical necessity, or disproportionate fraud exposure—that justify administrative intervention under a waste-reduction framework.[37,38] In its WISeR Provider and Supplier Operational Guide, the Agency explained that DBS is a multi-stage, high-precision neurosurgical procedure requiring intraoperative neurophysiological monitoring and continuous, non-delegable physician presence, and noted that the Stage 1 electrode implantation codes (CPT 61867 and 61868) remain on the Medicare Inpatient Only list, reflecting the clinical acuity and resource intensity these procedures demand.[39]

   Extending that recognition to the efficiency adjustment is not a new policy direction, but a consistent application of existing CMS reasoning across policy domains. Several features of DBS CPT codes 61863, 61864, 61867, 61868, 61885, and 61886 support inclusion as carve-out candidates.

   - **CMS Recognition of Clinical Distinctiveness:** The Agency's decision to remove DBS from the WISeR Model rested on a substantive determination that these procedures are too clinically significant and resource-intensive to be subjected to a cost-reduction framework premised on assumed waste or declining resource inputs. The efficiency adjustment rests on a comparable assumption—that physician work and intraservice time have declined over time due to technological and practice efficiencies. That assumption is no more applicable to DBS than the waste-reduction rationale underlying WISeR. Services that CMS has acknowledged do not belong on a waste-reduction list are equally unsuited to a downward adjustment premised on assumed efficiency gains.

   - **Irreducible Physician Work and Inpatient Only Status:** DBS electrode implantation is performed in the inpatient setting because the procedure's complexity, operative duration, and peri-operative management demands require a hospital environment. The inpatient designation reflects a clinical judgment about resource intensity, not a billing technicality. Applying an efficiency adjustment premised on declining resource inputs to a procedure that Medicare itself classifies as requiring inpatient care is internally

[36] Centers for Medicare & Medicaid Services, Center for Medicare and Medicaid Innovation. *Wasteful and Inappropriate Service Reduction (WISeR) Model: Request for Applications.* Available at: https://www.cms.gov/files/document/wiser-model-rfa.pdf.
[37] Centers for Medicare & Medicaid Services, Center for Medicare and Medicaid Innovation. *Wasteful and Inappropriate Service Reduction (WISeR) Model: Provider and Supplier Operational Guide, Version 3.0.* Available at: https://www.cms.gov/priorities/innovation/files/wiser-provider-supplier-guide.pdf.
[38] 91 FR 17282
[39] Centers for Medicare & Medicaid Services, Center for Medicare and Medicaid Innovation. *Wasteful and Inappropriate Service Reduction (WISeR) Model: Provider and Supplier Operational Guide, Version 3.0.* Available at: https://www.cms.gov/priorities/innovation/files/wiser-provider-supplier-guide.pdf.

inconsistent. Technology has enhanced the precision of DBS but has not reduced the cognitive workload, intraoperative decision-making, or total physician time required—instead, it has increased operative complexity by enabling treatment of patients with more advanced or atypical presentations.

- **Absence of Overvaluation Evidence:** CMS has not identified DBS as overvalued, and as such, applying the efficiency adjustment in the absence of any affirmative evidence that DBS resource inputs have declined does not reflect a data-driven policy judgment.[40] It reflects the indiscriminate application of a uniform reduction to a heterogeneous pool of services—precisely the structural flaw that makes targeted carve-outs both appropriate and necessary.

- **Cross-Policy Consistency:** Where CMS has made an affirmative clinical judgment in one policy context that a service does not exhibit the characteristics targeted by a cost-reduction mechanism, that judgment should carry across policy domains. Subjecting these procedures to an efficiency-premised payment reduction while simultaneously acknowledging their clinical distinctiveness in the WISeR context would produce an inconsistency that cannot be reconciled with the Agency's own stated reasoning. Accordingly, we request that CMS expressly exempt DBS codes from the efficiency adjustment using the same rationale that led it to protect access to these procedures from prior authorization.

Cost Analysis Supports a Narrow, Targeted Exemption

The requested carve-outs are narrowly targeted and have a minimal aggregate effect on MPFS spending. Independent modeling commissioned by the AANS and CNS indicates that exempting the 11 identified neurosurgical services would increase total MPFS payments by approximately $2.05 million in CY 2026 and $2.15 million in CY 2027—well below the $20 million threshold that would trigger a budget-neutrality adjustment to the MPFS conversion factor.

Health Management Associates (HMA) estimated these impacts using CMS-published work RVUs, utilization data, and applicable conversion factors. For CY 2026, HMA modeled removal of the 2.5% efficiency adjustment using the finalized CY 2026 values and CMS utilization projections. For CY 2027, HMA used the proposed CY 2027 work RVUs and modeled removal of the same adjustment. Under the modeling, exempting the services would increase individual allowed charges by approximately $3.01 to $27.72 in CY 2026 and $2.96 to $27.26 in CY 2027, depending on the code.[41] Appendix A presents the underlying valuation and payment impacts.

These estimates demonstrate that CMS can make a targeted correction for services that do not fit the assumptions underlying the efficiency adjustment without materially redistributing payments across the broader MPFS. The requested exemptions would preserve payment accuracy for a limited set of clinically significant services while imposing no budget-neutrality adjustment to the conversion factor.

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[40] Centers for Medicare & Medicaid Services, Center for Medicare and Medicaid Innovation. *Wasteful and Inappropriate Service Reduction (WISeR) Model: Provider and Supplier Operational Guide, Version 3.0.* Available at: https://www.cms.gov/priorities/innovation/files/wiser-provider-supplier-guide.pdf.

[41] Health Management Associates, *Estimated Impact of Exempting Certain Neurosurgery Codes from the Medicare Physician Fee Schedule Efficiency Adjustment* (July 30, 2026).

For these reasons, the AANS and CNS recommend that CMS exempt these eleven services from the efficiency adjustment for CY 2027. **More broadly, CMS should establish a transparent, service-specific process through which specialties can present compelling clinical and empirical evidence for exemption from a generalized efficiency assumption.** Empirical information should complement, rather than mechanically override, physician-led clinical valuation. Where CMS declines an exemption request, the Agency should explain the service-specific evidence demonstrating that the efficiency adjustment is appropriate.

Valuation of Specific Codes—Spinal Osteotomy (CPT Codes 22210, 22212, 22214, and 22216)

- **CPT 22210, 22212, and 22214.** The AANS and CNS disagree with CMS's proposed work RVUs of 23.12 for CPT code 22210, 21.72 for CPT code 22212, and 19.53 for CPT code 22214 and recommend that CMS accept the RUC-recommended values of 24.75, 23.20, and 21.72, respectively. These services were last reviewed under the Harvard Study more than 30 years ago. Since that time, the clinical environment, technology, patient population, and operative techniques have changed substantially.

  Modern segmental instrumentation, improved spinal implants, intraoperative fluoroscopy and CT, navigation, and neuromonitoring have expanded the ability to treat complex adult spinal deformity, including older, osteoporotic, and medically complex patients. These advances may affect operative time, but they do not establish that the physician work required to safely perform the procedure has decreased. Contemporary spinal osteotomy requires substantial preoperative planning, three-dimensional understanding of deformity, intraoperative judgment, technical precision, management of neurologic and vascular risk, and coordination of multiple technologies. The valuation should reflect that full clinical context rather than treating elapsed procedural time as a proxy for total physician work.

  CMS also points to higher-level postoperative visits as a reason to question the RUC recommendations. That rationale is particularly concerning given the Agency's separate consideration of global surgical payment in this proposed rule. The postoperative care assumptions used in the current clinical valuation were part of the assessment of the contemporary service. The Agency should not discount those assumptions based on a generalized premise about postoperative utilization without demonstrating that the specific postoperative work associated with these procedures is not being furnished.

  The AANS and CNS therefore recommend acceptance of the RUC-recommended work RVUs, which better reflect the current intensity and complexity of these services and preserve appropriate relativity within the osteotomy family.

- **CPT 22216.** The AANS and CNS support CMS's acceptance of the RUC-recommended work RVU for CPT code 22216 and the RUC-recommended direct PE inputs for the family. This support should not be interpreted as AANS/CNS endorsement of CMS' separate efficiency adjustment policy.

Valuation of Specific Codes—Percutaneous Lumbar Decompression (CPT Code 62287)

The AANS and CNS disagree with CMS's proposed work RVU of 6.23 for CPT code 62287 and recommend acceptance of the RUC-recommended work RVU of 7.06. CMS proposes a crosswalk to CPT code 46707 (*Repair of an anorectal fistula with plug*), which does not

adequately reflect the physician work associated with a percutaneous spinal procedure performed without direct visualization and in immediate proximity to neural and vascular structures.

The service requires image-guided anatomic localization, interpretation of imaging, tactile feedback, precise instrument positioning, risk management, and continuous judgment to avoid injury to critical structures. The clinical consequences of a technical error can be substantial. A crosswalk should therefore reflect comparable intensity, technical skill, mental effort, and risk—not simply a numerical similarity in procedural time or a superficial procedural characteristic.

The decrease in surveyed intraservice time from 60 minutes to 37 minutes does not establish a proportional reduction in physician work. The service still requires the same anatomic precision, imaging interpretation, risk management, mental effort, and judgment, and completing a complex task in less time may increase work intensity per unit of time. CMS should therefore evaluate the full dimensions of physician work rather than treat elapsed time as a proxy for total work. The RUC-recommended value of 7.06 also better preserves relativity with other percutaneous, image-guided lumbar decompression services and should be adopted.

Valuation of Specific Codes—Sacroiliac Joint Arthrodesis (CPT Codes 27278 and 27279)

The AANS and CNS support CMS's proposal to accept the RUC-recommended work RVUs and direct PE inputs for CPT codes 27278 and 27279. This support should not be interpreted as AANS/CNS endorsement of CMS' separate efficiency adjustment policy.

E/M VISIT COMPLEXITY ADD-ON CODE G2211

Proposed MOD1 and MOD2

CMS proposes to replace G2211 with a modifier—MOD1—that would increase payment for the associated office/outpatient E/M service by 16% rather than provide a flat add-on payment. The AANS and CNS are concerned that this approach would change the distribution of additional payment across E/M levels without adequately demonstrating that a percentage-based adjustment more accurately reflects the incremental resources associated with longitudinal or complex care.

CMS should explain the clinical and resource basis for the proposed 16% adjustment, including the methodology used to derive the percentage, the expected distributional effects across E/M levels and specialties, and the relationship between the proposed percentage and the resources the Agency intends to recognize. If the purpose of the adjustment is to recognize complexity and resource costs not fully captured by the base E/M service, CMS should demonstrate that those additional resources are systematically proportional to the level of the underlying E/M service. **Before finalizing the proposed modifier, CMS should publish the estimated payment impact by E/M level, specialty, and type of practice, including the number and proportion of encounters expected to qualify for the adjustment and the change in payment relative to the current G2211 methodology.**

The AANS and CNS are also concerned about CMS's proposed additional MOD2 E/M visit complexity add-on code. CMS should provide greater clarity regarding the circumstances in which MOD2 would apply, the clinical and resource characteristics it is intended to recognize,

and how CMS expects MOD2 to interact with the proposed MOD1 modifier and the underlying E/M service. In particular, CMS should explain whether MOD2 is intended to address a distinct form of complexity or resource use that is not captured by MOD1 and, if so, provide evidence demonstrating that the proposed structure appropriately distinguishes among different types and levels of complexity. CMS also should clarify whether the two mechanisms may apply concurrently and, if so, how the resulting payment would be calculated and what safeguards would apply to prevent unintended duplication or inconsistent application.

The AANS and CNS further encourage CMS to evaluate the implications of these proposals across specialties. Neurosurgeons may provide longitudinal management of patients with complex neurologic conditions, but the clinical circumstances, intensity, and resource requirements of that care may differ substantially from those associated with other specialties and care models. CMS should therefore avoid designing a complexity adjustment that implicitly favors one specialty or model of care without evidence that the resulting distribution of payment accurately reflects the underlying resources required. **Before implementing either MOD1 or MOD2, CMS should provide specialty-level impact analyses demonstrating how the proposed changes would affect physicians who furnish complex longitudinal care, including neurosurgeons, and should consider whether the proposed framework adequately recognizes the full range of clinical circumstances in which additional complexity and resource requirements arise.**

CURRENT PROCEDURAL TERMINOLOGY (CPT) REQUEST FOR INFORMATION (RFI)

Maintain CPT as the National Standard While Addressing Access and Governance

The AANS and CNS support continued use of CPT as the national nomenclature for physician and other professional services. CPT is deeply integrated into Medicare, Medicaid, commercial insurance, electronic health records, claims systems, clinical documentation, and numerous other portions of the U.S. health care infrastructure. A single nationwide coding standard establishes a uniform and authoritative framework for describing health care services, promotes interoperability across providers and payers, facilitates accurate and consistent reporting, and ensures that new services, technologies, and evolving clinical practices can be incorporated into a common framework. Replacing that framework with an entirely different system would create substantial disruption and implementation costs without assurance that an alternative would provide greater clinical specificity or payment accuracy. **At the same time, preserving CPT as the national standard does not require CMS to treat every aspect of its licensing, access, or governance structure as immutable.** The AANS and CNS support reforms that improve access and accountability while preserving the clinical expertise and physician participation necessary to maintain an accurate and clinically meaningful coding system.

The Agency should distinguish between the value of CPT as a national coding infrastructure and legitimate questions about how that infrastructure is governed and accessed. The appropriate policy objective is modernization without fragmentation. **CMS should explore mechanisms that improve transparency, facilitate appropriate access for clinicians and other stakeholders, and support independent validation of coding and valuation assumptions, while avoiding a transition to multiple competing coding standards that would increase administrative burden and undermine interoperability.**

No Existing Alternative Is Ready to Replace CPT

The AANS and CNS do not believe that CMS has identified an existing alternative that is ready to replace CPT as the national standard for reporting physician and other professional services. ICD-10-PCS, SNOMED CT, MS-DRGs, OPPS APCs, and other coding, terminology, and payment systems serve important but different purposes. None currently provide a readily interchangeable national framework for reporting the clinical services furnished by physicians. Any fundamentally different coding framework would need to preserve clinical specificity, interoperability, and the ability to accommodate changes in medical practice before CMS could reasonably consider replacing CPT.

Practicing Physicians Must Remain Central, and Empirical Data Can Inform Validation

Determining whether services are clinically distinct and whether they meet the criteria for a Category I CPT code or are more appropriately addressed through the Category III CPT pathway requires meaningful input from practicing physicians with direct knowledge of the services and their clinical application. Likewise, empirical data can provide valuable information to test and validate assumptions about physician time, staffing, utilization, supplies, and other resource inputs. Claims data, electronic health records, time and cost data, and other empirical sources can strengthen the evidence base, particularly when they are representative, transparent, and sufficiently detailed to permit meaningful evaluation.

Empirical data, however, should inform—not replace—clinical expertise. Data sources do not independently capture all dimensions of physician work, including technical skill and physical effort, mental effort and judgment, intensity, risk, and the consequences of errors. In addition, observed differences between empirical data and physician survey results or existing valuation assumptions may reflect changes in patient population, case mix, technology, workflow, coding practices, or limitations in the underlying data. **Where empirical findings conflict with clinical evidence or established valuation assumptions, CMS should investigate the source of the discrepancy rather than presume that the empirical result is inherently more accurate.**

The AANS and CNS support independent validation of coding and valuation inputs and recognize that CMS has an independent responsibility to establish appropriate Medicare relative values. **An effective and rigorous approach requires a transparent, evidence-based process that combines the clinical expertise of practicing physicians with empirical data to provide essential clinical context, test underlying assumptions, identify discrepancies, and improve the accuracy and reliability of coding and valuation decisions.** Where reliable empirical information calls a recommendation into question, CMS should investigate the basis for the discrepancy, make the relevant data available for review to the greatest extent practicable, and clearly explain the evidentiary basis for its ultimate decision.

Neurosurgery illustrates why this balance is essential. Advances in imaging, navigation, neuromonitoring, instrumentation, robotics, and minimally invasive techniques have changed how services are furnished while expanding the range and complexity of conditions that can be treated. These advances may reduce time or manual effort associated with discrete tasks while increasing preoperative planning, image interpretation, technical precision, intraoperative decision-making, and the ability to treat increasingly complex patients. Time and utilization data alone therefore may not capture the full effect of technological change on physician work. **Valuation should account for the full range of work required to furnish a given service,**

including technical skill and physical effort, mental effort and judgment, intensity, and risk and stress associated with potential consequences to the patient.

The AANS and CNS also support greater transparency in code development and valuation. **Stakeholders should be able to understand, to the greatest extent practicable, the evidence, assumptions, comparisons, and methodologies underlying coding and valuation decisions. Greater transparency would allow specialties to identify potential methodological errors, provide more meaningful public comment, and submit targeted evidence to improve CMS's final decisions.** Limited confidentiality protections may remain appropriate for legitimately proprietary or otherwise nonpublic information, including certain materials related to emerging technologies or regulatory submissions. However, such protections should be narrowly tailored and should not prevent stakeholders from understanding the substantive evidentiary basis for CMS's decisions.

The AANS and CNS therefore recommend continued use of CPT while encouraging CMS to pursue targeted improvements in transparency, access to relevant data, governance, and independent validation. Modernization should strengthen, rather than diminish, the role of practicing physicians in describing and evaluating the services they furnish. Empirical data should be used to test and validate clinical recommendations and valuation assumptions, not to displace clinical expertise where the data do not capture the full dimensions of physician work. A transparent process that integrates clinical expertise with robust empirical validation would strengthen the credibility of CMS payment decisions and confidence that Medicare values reflect contemporary clinical practice.

CY 2027 MODIFICATIONS TO THE QUALITY PAYMENT PROGRAM REPORTING AND DATA SUBMISSION

Merit-Based Incentive Payment System and MIPS Value Pathways

Sunsetting Traditional MIPS in 2029

The AANS and CNS oppose the Agency's proposal to sunset the traditional MIPS program in 2029 and require mandatory MVP participation. **The AANS and CNS urge CMS to maintain MVPs as a voluntary pathway for clinicians, alongside traditional MIPS.** Neurosurgeons' experience with available MVPs, including the Surgical Care MVP, evidence significant flaws that demonstrate it is premature to mandate MVP reporting.

At the outset, MVPs build on the flawed framework of MIPS but with reduced measure choice and flexibility in reporting. The AANS and CNS have expressed longstanding concerns with the MIPS program, including the limited availability of clinically meaningful specialty measures, complicated scoring methodologies, benchmarking issues, administrative burden, and difficulty producing conclusions that meaningfully assess quality performance. MVPs perpetuate these problems. While MVPs change which measures are reported together, they do not alter or address fundamental concerns with whether CMS's quality reporting program meaningfully measures and improves quality of care.

In fact, CMS's proposal to require the use of MVPs and sunset the traditional MIPS program will magnify underlying problems, particularly as it pertains to the ability of neurosurgeons to find relevant measures to report that accurately capture their quality performance. MVPs layer a

more prescriptive reporting structure onto the same underlying measure inventory and scoring framework as MIPS, while narrowing clinicians' ability to select measures that meaningfully reflect their practice.

CMS should not equate the existence of an MVP for a specialty with guaranteed meaningful quality measurement for that specialty. Even within a specialized field such as neurosurgery, there are vast differences in practice and specialization that necessitate diverse measure options and flexibility in measure reporting. The two MVPs CMS identified as relevant to neurosurgery, the Surgical Care MVP and the Coordinating Stroke Care MVP, do not offer clinically relevant measures for all types of neurosurgery, nor do they recognize the wide variation in services provided by neurosurgical specialties. A cerebrovascular neurosurgeon, spine surgeon, neuro-oncologist, functional neurosurgeon, pediatric neurosurgeon, and trauma neurosurgeon may treat substantially different patient populations and perform substantially different procedures.

The Surgical Care MVP groups general surgery, neurosurgery, cardiac surgery, breast surgery, and other specialties together, failing to recognize the substantial clinical diversity that exists among surgical specialties and subspecialties. Simply aggregating measures from multiple surgical disciplines does not offer tailored, specialty- and subspecialty-specific reporting options. A measure that is highly relevant to a general surgeon may have little or no relevance to a neurosurgeon, and a measure appropriate for a spine surgeon may not meaningfully assess the quality of care provided by a cerebrovascular or functional neurosurgeon.

The AANS and CNS are disappointed that CMS finalized in the CY 2026 Physician Fee Schedule final rule its policies related to the Surgical Care MVP, despite the significant concerns raised in prior comments.[42,43] The AANS and CNS reiterate previous concerns that the use of measure 459, Back Pain After Lumbar Surgery, does not adequately reflect whether a patient achieved a successful outcome. The AANS and CNS also continue to believe that the quality and cost components of the MVP are poorly aligned. These fundamental concerns must be addressed before CMS contemplates mandatory use of the MVP for neurosurgeons.

Before making MVPs mandatory, CMS should place greater emphasis on systems of quality improvement that are developed and used by the medical specialties themselves. Specialty societies have invested substantial resources in clinical data registries and other tools designed to capture practice patterns and patient outcomes and translate those data into improvements in care. Congress created QCDRs to fill gaps in quality measurements and to ensure clinicians have measure options that are more meaningful and relevant to their specialties.[44] **Given this Congressional directive and specialties' significant investments in registries, including neurosurgery, the AANS and CNS strongly urge CMS to make greater use of QCDR measures to address persistent gaps in the MIPS measure inventory.**

[42] 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, 90 Fed. Reg. 49266 (Nov. 5, 2025).
[43] The American Association of Neurological Surgeons & Congress of Neurological Surgeons, Comment Letter on Medicare and Medicaid Programs; CY 2026 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies, Docket No. CMS-1832-P (Sept. 12, 2025), https://www.aans.org/wp-content/uploads/2025/09/AANS-CNS-CY-2026-Medicare-Physician-Fee-Schedule-Proposed-Rule-Comments.pdf.
[44] Medicare Access and CHIP Reauthorization Act of 2015, Pub. L. No. 114-10, § 101(c), 129 Stat. 87 (2015).

Removal of Outcomes Measure Requirements and High-Priority Designation

Currently, under the MIPS program, clinicians generally must report at least one outcome measure among their required quality measures. If an applicable outcome measure is not available, the clinician can instead report a high-priority measure. **The AANS and CNS support CMS's proposal to remove these requirements.** Their removal would provide greater flexibility in measure selection and allow clinicians to focus quality reporting on measures that appropriately reflect the care being delivered. The proposed core measure policy makes the same mistakes by imposing categorical measure-selection requirements that may not be applicable across diverse specialties and clinical settings.

Core Measure Designation Concerns

The AANS and CNS oppose CMS's proposal establishing "core measures" and requiring clinicians to report at least one core measure. Beginning with the 2027 performance period, CMS proposes to designate 78 existing MIPS quality measures as "MIPS core measures." Clinicians participating in traditional MIPS would be required to report at least one core measure among the six quality measures they are required to report. Clinicians participating in the MVP program would be required to report at least one core measure among the four quality measures required under the MVP.

The AANS and CNS are concerned that CMS continues to pursue policies that restrict clinicians' ability to select measures that are most relevant to their practice and patient population. While the AANS and CNS appreciate CMS's goals of reducing program complexity and increasing comparability across specialties and subspecialties, achieving these goals requires preserving sufficient flexibility for clinicians to select measures that accurately reflect the care they provide. A narrower universe of measures does not produce more meaningful reporting if the measures available are not clinically relevant.

The core measures that CMS proposes in the neurosurgical specialty measure set illustrate these problems. The Agency proposes to designate four measures within the neurosurgical specialty measure set as core measures:

- Q344: Rate of Carotid Endarterectomy (CEA) or Carotid Artery Stenting (CAS) for Asymptomatic Patients, Without Major Complications (Discharged to Home by Post Operative Day #2)
- Q413: Door to Puncture Time for Endovascular Stroke Treatment
- Q459: Back Pain After Lumbar Surgery
- Q226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Rate of CEA or CAS for Asymptomatic Patients, Without Major Complications (Q344), and Door to Puncture Time for Endovascular Stroke Treatment (Q413) are both only applicable to neurosurgeons who perform specific cerebrovascular and endovascular procedures. Back Pain After Lumbar Surgery (Q459) only applies to spine neurosurgeons. A non-spine, non-vascular neurosurgeon would have little or no opportunity to report on these measures, leaving them with one core measure reporting option: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (Q226). While this measure is a cross-cutting measure used by CMS

across multiple specialties, it is not a particularly relevant measure for neurosurgeons. The measure does not directly assess the quality of neurosurgical care or outcomes related to the procedures and conditions treated by neurosurgeons.

This limited choice is particularly concerning as CMS contemplates sunsetting MIPS and making MVPs mandatory. The proposed MVP core measures do not remedy any of the concerns the AANS and CNS raised under MIPS. For example, CMS proposes the following core measures within the Surgical Care MVP:

- Q164: Coronary Artery Bypass Graft (CABG): Prolonged Intubation
- Q354: Anastomotic Leak Intervention
- Q357: Surgical Site Infection (SSI)
- Q358: Patient-Centered Surgical Risk Assessment and Communication
- Q459: Back Pain After Lumbar Surgery
- Q047: Advance Care Plan

Measures addressing CABG prolonged intubation (Q164), anastomotic leak intervention (Q354), or back pain following lumbar surgery (Q459) will have little or no applicability to neurosurgeons who do not perform those procedures. Although broader surgical measures such as Surgical Site Infection (Q357) and Patient-Centered Surgical Risk Assessment and Communication (Q358) may be applicable to neurosurgeons, these measures do not directly assess the specialized clinical care provided by many neurosurgical subspecialists.

Finally, the AANS and CNS are disappointed that CMS did not confer with medical specialty societies prior to selecting measures for each specialty. Specialty societies are in the best position to evaluate and identify appropriate measures across a particular specialty. If CMS decides to move forward with this proposal, the AANs and CNS urge the Agency to first engage in further discussions with specialty societies to ensure that the measures selected as core measures are clinically appropriate, relevant, and sufficiently diverse for variations in practice across specialties.

Removal of Core Measures from Topped Out Scoring Cap

The AANS and CNS oppose CMS's proposed core measure policy but do support the Agency's removal of core measures from the topped out scoring cap. Subjecting these limited measures to scoring caps will restrict choice even further, unfairly penalize physicians for reporting on required measures, and remove important data points on high performance. The AANS and CNS continue to oppose CMS's policy to limit scoring on certain quality measures given the Agency's determination that performance on the measures is too high. High performance alone should not be viewed as evidence that a measure no longer provides value to the quality reporting program.

Promoting Interoperability: Security Risk Analysis Measure Removal

Beginning with the 2027 performance period, CMS proposes to remove the Security Risk Analysis measure. CMS reasoned that the MIPS measure was duplicative of existing obligations under the Health Insurance Portability and Accountability Act (HIPAA) Security Rule. The AANS and CNS support policies that reduce unnecessary provider reporting burden and appreciate

CMS's acknowledgment that the requirement was duplicative of existing HIPAA obligations. Addressing this duplication reduces the administrative reporting burdens for neurosurgeons.

Promoting Interoperability: Changes to Electronic Prior Authorization Measure

The AANS and CNS support CMS's proposals to align the Electronic Prior Authorization measure with FHIR-enabled, ONC-certified health IT functionality and to create a new Electronic Prior Authorization for Prescription Drugs measure beginning in the 2028 performance period. Standardizing electronic prior authorization through FHIR has the potential to reduce the administrative burden associated with prior authorization by allowing clinicians to initiate and transmit requests through existing electronic workflows, rather than relying on manual, duplicative, or otherwise burdensome processes. To the extent that standardized FHIR functionality can automate the exchange of information between clinicians and payers, it may also reduce unnecessary administrative work for physician practices and help minimize delays in patient care.

The AANS and CNS also support CMS's proposal to make the measure optional for the 2027 performance period. This approach appropriately gives clinicians an opportunity to gain experience with FHIR-enabled electronic prior authorization and allows CMS to assess readiness before imposing a mandatory reporting requirement. Before making the measure mandatory again beginning in 2028, CMS should evaluate whether the necessary technology is broadly available, and if tailored exceptions are necessary for clinicians facing barriers to FHIR-implementation maintain adequate flexibilities.

The AANS and CNS caution that even with technological advancements, insurer prior authorization requirements will continue to result in administrative burdens and patient care delays, and thereby urge CMS to work with Congress to pass meaningful prior authorization reform. The AANS and CNS are strong supporters of the Improving Seniors' Timely Access to Care Act (H.R. 3514 / S. 1816).[45] Introduced by Representatives Mike Kelly (R-PA), Suzan DelBene (D-WA), John Joyce, MD (R-PA), and Ami Bera, MD (D-CA), along with Senators Roger Marshall, MD (R-KS), and Mark Warner (D-VA), the Seniors' Act would modernize the MA prior authorization process by establishing electronic prior authorization requirements, strengthening transparency and accountability, and streamlining determinations for medically necessary care.

Promoting Interoperability: Definition of CEHRT

The AANS and CNS support CMS's proposal to modify the definition of CEHRT to align with decertification proposals in the Health Data, Technology, and Interoperability: ASTP/ONC Deregulatory Actions to Unleash Prosperity (HTI-5) proposed rule.[46] The AANS and CNS support CMS's efforts to align policy across agencies. CMS should recognize the increasing maturity and ubiquity of certified health IT and avoid imposing duplicative reporting or certification requirements on clinicians when functionality has become embedded in the health IT infrastructure. Streamlining the CEHRT definition is consistent with this approach and can reduce unnecessary administrative burden while allowing CMS and ONC to focus certification requirements on capabilities that meaningfully advance interoperability and patient care. In

[45] Improving Seniors' Timely Access to Care Act of 2025, S. 1816, H.R. 3514, 119th Cong. (2025)
[46] Health Data, Technology, and Interoperability: ASTP/ONC Deregulatory Actions to Unleash Prosperity, 90 Fed. Reg. 60970 (Dec. 29, 2025).

implementing this change, the AANS and CNS urge CMS to coordinate with ONC to ensure that appropriate certification and oversight of EHR developers remains in place, and that clinicians retain access to currently embedded EHR functions.

Virtual Group Reporting Via MVPs

The AANS and CNS support CMS's proposal to allow virtual groups to report through an MVP beginning with the 2029 performance period. However, the fact that virtual groups are not currently able to report through an MVP underscores why CMS should not yet make MVP reporting mandatory. Effectively, virtual groups will have no voluntary opportunity to participate in MVPs before it is required of them in 2029. The AANS and CNS are concerned that important aspects of the MVP framework are still being developed even as CMS moves toward making the MVP program mandatory.

Moreover, CMS provides insufficient detail regarding how virtual group participation in MVPs would operate beginning in 2029. For example, the proposal lacks detail in how virtual groups would select and report an MVP, how MVP eligibility and specialty assignment would be determined for the diverse clinicians and TINs that may comprise a virtual group, how subgroup requirements would apply, and how quality, cost, Improvement Activities, and Promoting Interoperability requirements would be administered and scored at the virtual group level. These specifics must be tested on a voluntary basis before making the MVP program mandatory for virtual groups.

The AANS and CNS therefore urge CMS to maintain traditional MIPS as a reporting option until CMS has demonstrated that MVPs are operationally feasible and provide meaningful reporting opportunities for all categories of MIPS participants, including virtual groups. At a minimum, CMS should provide substantially more detail regarding its proposed approach to virtual group MVP reporting and obtain stakeholder feedback on the implementation of that approach before proceeding with a mandatory transition.

Scoring Reweighting Where Data Aren't Submitted by a Third-Party Intermediary

The AANS and CNS support CMS's proposal to extend the deadline for submitting reweighting requests for the quality improvement activities and promoting interoperability performance categories where a third-party intermediary did not submit data on behalf of the clinician. The proposal appropriately aligns the timing of reweighting requests with when clinicians identify that a third-party intermediary failed to submit data on their behalf. The extension of the deadline gives clinicians time to identify, rectify, and request relief from CMS, ensuring clinicians are not penalized for third-party intermediary actions outside of their control.

Scoring Reweighting in Extreme and Uncontrollable Circumstances

Beginning with the 2027 performance period, CMS proposes to broaden the data that CMS may use in evaluating whether a clinician qualifies for Extreme and Uncontrollable Circumstances Reweighting. Rather than solely looking to the Provider Enrollment, Chain, and Ownership System (PECOS), CMS would use "whatever data is most current and reliable." The AANS and CNS strongly support this flexibility, which would better align CMS decision-making with the realities of clinical practice. This proposed change will ensure that the most up-to-date

information is referenced by the Agency when it determines whether a clinician qualifies for the exception.

Information Blocking: Removal of ONC Attestations

The AANS and CNS support CMS's proposal to remove the requirement that clinicians annually attest to compliance with ONC Health IT certification and information blocking requirements. The AANS and CNS agree that these reporting requirements are duplicative of existing oversight processes. Removing such duplication simplifies reporting for neurosurgeons and allows them to spend more time on patient care.

Maintaining the Performance Threshold at 75 Points

The AANS and CNS strongly support maintaining the 75-point threshold and urge CMS to maintain this threshold in subsequent years. The 75-point threshold offers necessary predictability while ensuring that specialists, including neurological surgeons, maintain high-quality care.

Ambulatory Specialty Model

Continued Overarching Concerns

The AANS and CNS remain concerned about the application of the ASM to neurosurgeons and urge CMS to reconsider the model as currently designed and, at a minimum, to exclude neurosurgeons.

CMS includes neurosurgeons in the model based on attribution under the Low Back Pain episode-based cost measure even though neurosurgeons were not among the specialties most frequently attributed patients during field testing. The measure was predominantly associated with clinicians such as chiropractors and physical therapists, yet CMS excludes those practitioners while mandating participation by surgeons. Similarly, none of the MIPS quality measures proposed for the Low Back Pain cohort are included in the MIPS Neurosurgery Specialty Set, raising significant questions about whether those measures meaningfully assess neurosurgical care. The AANS and CNS also remain concerned about whether the Low Back Pain episode-based cost measure is sufficiently reliable to support individual clinician-level financial accountability, particularly given the measure's field-testing results indicating limited reliability for a substantial proportion of clinicians with relatively few attributed episodes.

The AANS and CNS reiterate our concerns that the model's attribution methodology may hold physicians accountable for low back pain spending even when they are not actively managing the patient's low back pain or do not have meaningful control over the patient's subsequent care. Although CMS has established attribution criteria to identify a relationship between the physician and the beneficiary, a qualifying encounter does not necessarily establish that the physician is responsible for managing the beneficiary's low back pain over the subsequent 12 months. CMS should ensure that financial accountability is limited to care and outcomes that are reasonably within the participating physician's control.

The financial structure of the ASM further compounds these concerns. The model exposes clinicians to substantial downside risk, with payment adjustments increasing from up to 9

percent in the initial performance years to as much as 12 percent in later years. Importantly, these adjustments apply broadly to a physician's Medicare Part B services, rather than being limited to services associated with the low back pain care being evaluated. This structure will disproportionately affect small and resource-constrained practices and physicians caring for complex patients.

The AANS and CNS therefore urge CMS to abandon its efforts to implement the ASM. At a minimum, CMS should exclude neurosurgeons from the ASM while working with the specialty to develop a more appropriate approach to improving the value and outcomes of spine care.

ASM Participant Exceptions

CMS proposes to create a new exception to the ASM that would permit ASM heart failure participants who redesignate their primary specialty type through a Medicare enrollment application to certain specialty types to be excepted from ASM requirements. These specialties include cardiac electrophysiology, cardiac surgery, interventional cardiology, advanced heart failure and transplant cardiology, and adult congenital heart disease. CMS's rationale for the heart failure participant exceptions is that "these specialty types reflect highly specialized or procedure-focused practice areas that are distinct from the broader management of cardiovascular disease."

The AANS and CNS urge CMS to extend a similar exception to surgeons, including neurosurgeons and orthopedic surgeons, participating in the Low Back Pain cohort. As CMS has recognized, a physician's specialty designation does not necessarily establish that the physician routinely provides the type of longitudinal care targeted by the ASM. As with other highly specialized, procedure-focused specialties, neurosurgery and orthopedic spine surgery involve clinical practice that is distinct from the broader management of low back pain. These specialists generally become involved when a patient's condition warrants consideration of an operative intervention, often following or in conjunction with a course of nonsurgical management. Their clinical decision-making, patient populations, treatment pathways, and outcomes therefore differ substantially from those of clinicians whose practices focus primarily on the nonsurgical management of low back pain. Accordingly, the AANS and CNS urge CMS to establish an exception for neurosurgeons and orthopedic surgeons whose practices are highly specialized, procedure-focused, and distinct from the longitudinal management of low back pain.

Additionally, CMS should not have unilateral discretion to determine whether or when an otherwise qualifying exception takes **effect. Instead, the AANS and CNS urge CMS to apply the exception automatically and retroactively to the beginning of the performance year in which the qualifying change occurred. The AANS and CNS also urge CMS to eliminate the proposed one-year limitation on TIN-change exceptions.** Once a physician has qualified for an exception based on a TIN change, the exception should remain in effect in subsequent performance years unless and until the physician's NPI is reassigned to the same TIN.

Administrative Claims-Based Low Back Pain Imaging Quality Measure

In 2026 rulemaking, CMS proposed but did not finalize the inclusion of the Magnetic Resonance Imaging (MRI) Lumbar Spine for Low Back Pain, Respecified to Be Relevant to ASM Participants Treating Low Back Pain, in the low back pain quality measure set. In 2026 rulemaking

comments, the AANS and CNS opposed the measure due to its broad attribution framework, which did not adequately account for clinical circumstances or for whether a neurosurgeon controlled an imaging decision. In this rule, CMS proposes again to include the measure in the ASM low back pain quality measure set, with some modifications. **The AANS and CNS continue to strongly believe that the measure is fundamentally flawed and should not be finalized for inclusion in the ASM.**

CMS should not use a claims-based measure to hold neurosurgeons financially accountable for utilization decisions that may be outside of their direct control. The fact that a physician participates in a patient's longitudinal care does not necessarily mean that physician was responsible for the decision to order an MRI or had an opportunity to influence whether imaging was clinically appropriate. Further, an additional measure targeting a single component of utilization is not warranted. The ASM low back pain episode-based cost measure already captures utilization comprehensively and provides an appropriate mechanism to discourage unnecessary imaging, including avoidable MRI use among patients with low back pain. Adding a separate MRI-focused measure would therefore be duplicative and could unnecessarily increase reporting and performance assessment burdens without providing meaningful additional value. Indeed, the measure could also create a problematic financial incentive to delay or withhold necessary testing and treatment services.

The proposed attribution methodology is particularly concerning because it may attribute the same MRI to multiple ASM participants based on services those clinicians provided during the lookback period. Under this approach, a clinician could be attributed to an imaging event simply because the clinician participated in the patient's care, even when another clinician made the actual decision to order the MRI. Participation in a patient's longitudinal care should not be equated with responsibility for a particular imaging decision. The Agency appears to justify the broad attribution methodology in part because it results in substantially more MRIs being attributed to ASM participants, rather than demonstrating that the additional attributed physicians had a meaningful role in the decision to order the imaging. CMS should ensure that accountability for utilization is assigned to the clinician(s) who have a meaningful role in the relevant decision, rather than broadly attributing an imaging event to every ASM-qualifying specialist who provided related care.

The AANS and CNS also remain concerned that this claims-based measure may not adequately account for the clinical circumstances underlying a physician's decision to order lumbar-spine imaging. Claims data alone may not capture the clinical rationale for an imaging decision, creating a risk that appropriate imaging could be characterized as excessive utilization. This concern is particularly significant for neurosurgeons, who frequently evaluate patients with complex spinal conditions for whom advanced imaging is an important component of diagnosis and treatment planning.

The proposed 365-day lookback period raises significant concerns regarding the connection between the measured utilization and the physician's actual clinical decision-making. CMS acknowledges that the longer lookback period substantially increases the number of MRIs attributed to ASM participants. **Although CMS believes a 365-day period better reflects the longitudinal nature of low back pain management, extending attribution over an entire year makes it increasingly difficult to establish a meaningful relationship between a physician's encounter and a subsequent imaging decision.** CMS should not presume that a clinician who provided low back pain-related care many months before an MRI continued to have

responsibility for the patient's care or had any meaningful influence over the decision to obtain imaging. CMS's proposed alternative, a 120-day look-back period, does not fare better. Four months remain a significant period during which a patient's clinical condition, treating physicians, and course of care may change.

The Agency's substantial expansion of the measure denominator warrants greater transparency and specialty physician input. CMS has not identified the physicians involved in reviewing the changes, provided the affected codes, or given specialty societies an opportunity to assess them, leaving significant uncertainty about whether the revised exclusions are appropriate for evaluating individual physician performance.

CMS proposes a rolling two-year performance period for the MRI measure to increase denominator volume and reduce volatility and also considers reducing the minimum case count from 20 to 10. CMS's proposed two-year, rolling performance period is inconsistent with the one-year periods used for other ASM measures and could result in physicians being held accountable for services furnished before ASM began and being assessed twice for the same performance. CMS has not demonstrated that the extended period would improve the accuracy of performance measurement, raising concern that it is primarily intended to increase the number of physicians captured by the measure. **The AANS and CNS also oppose lowering the minimum case count, which could increase the number of clinicians whose performance is assessed based on relatively few cases and heighten the risk of unreliable or volatile results.**

Patient Reported Outcome Measures

CMS proposes removing the Functional Status Change for Patients with Low Back Impairments (Q220) from the low back pain quality measure set because the measure steward has indicated they no longer intend to maintain it. In its place, CMS proposes to include MIPS Q182, Functional Outcome Assessment.

The AANS and CNS support the removal of Q220. While the AANS and CNS appreciate CMS's recognition that Q182 is a temporary solution while it works toward developing more robust patient-reported outcome measures, concerns remain about the appropriateness of the measure for inclusion in ASM. Q182 does not actually evaluate whether patients experience improved or worsened outcomes, nor does it distinguish between appropriate and inappropriate treatment. Its value for physician-level performance assessment is further limited because relatively few ASM participants currently report the measure, and those reporting it are predominantly physical and occupational therapists. Moreover, the measure's highly concentrated performance makes CMS's decile scoring methodology particularly problematic, as very small differences in documentation can result in substantial differences in scores and potentially significant financial consequences.

Alignment with MIPS Promoting Interoperability Proposals

In alignment with its Promoting Interoperability category proposals in the context of MIPS, CMS proposes to include an Electronic Prior Authorization measure as optional for the 2027 ASM performance year and mandatory for the 2028 ASM performance year. Similarly, in accordance with its MIPS proposals, CMS proposes to remove the requirement to attest to the security risk analysis measure, to remove the ONC direct review attestations, and to revise the definition of

CEHRT. CMS also proposes extending its existing measure suppression policy, finalized in CY 2026 rulemaking, to the ASM.

The AANS and CNS support CMS's efforts to align the ASM with MIPS Promoting Interoperability category policies. This alignment is important to ensure consistency across CMS quality programs and to ensure that clinicians required to participate in the ASM are afforded the same flexibilities as clinicians reporting under MIPS. **However, the AANS and CNS question the need to include Promoting Interoperability requirements in ASM at all.** ASM participants already have strong incentives to use EHRs, e-prescribing, patient portals, electronic prior authorization, and other health IT tools when doing so improves care, supports care coordination, or reduces costs. Imposing a separate set of Promoting Interoperability measures and attestations adds administrative burden and risks substantial payment penalties without demonstrating a corresponding benefit to patients.

Improvement Activities Group Data Submission

CMS proposes to allow an ASM participant to submit data for the Improvement Activities ASM performance category at either the group or individual level. **The AANS and CNS support this policy, as it offers greater flexibility in how participating neurosurgeons or their affiliated groups can submit data.**

Rural Scoring Adjustment

CMS proposes to add a rural scoring adjustment to address unique reporting challenges faced by rural ASM participants. Rural ASM participants who qualify for the adjustment would receive an additional 5 points to their final score. **The AANS and CNS urge CMS not to finalize this proposal.** While the AANS and CNS appreciate CMS's recognition that rural practices may face unique challenges in participating in the ASM, rural status is not the only practice characteristic that may present significant challenges to achieving high performance scores. For example, clinicians who treat predominantly Medicaid populations in inner-city urban settings may face substantial socioeconomic, access, and other patient-population-related challenges that can similarly affect performance, even though those practices would not qualify for a rural adjustment. Because ASM performance is scored relative to peers, increasing a rural participant's score necessarily affects the relative standing of other participants. **Rather than implementing a rural scoring adjustment, the AANS and CNS recommend that CMS instead address differences in practice circumstances through the underlying attribution, risk adjustment, benchmarks, measure specifications, and additional relevant factors.**

Additional Scoring Concerns

The AANS and CNS continue to have significant concerns with the proposed ASM scoring and payment methodology. CMS should establish a clear performance standard before the start of each performance year, rather than using a year-end median that creates a "tournament" in which physicians can face penalties despite improving quality or reducing costs and cannot know in advance what performance will avoid a payment reduction. The Agency should also provide participants with timely, at least quarterly, performance data so they have a meaningful opportunity to improve during the performance period. Finally, CMS should increase the redistribution percentage from 85 to 100 percent and phase in downside risk, limiting the maximum payment adjustment to no more than two percent for at least the first two model

years. These changes are necessary to ensure that physicians are evaluated against an achievable, transparent standard and are not exposed to substantial financial penalties before CMS has had an opportunity to test and refine the model.

Alternative Payment Models

Qualifying Participants in Alternative Payment Models

Qualifying APM participants are clinicians who participate in Advanced APMs and meet specific payment or patient thresholds. These Qualifying APM participants are eligible to receive an increased physician fee schedule update and incentive payments. Qualifying APM participants are not required to report under MIPS and can instead satisfy their quality reporting program obligations via the APM.

Currently, Qualifying APM participant determinations are made at the NPI level. Therefore, a Qualifying APM participant is exempt from MIPS reporting and eligible to receive the increased physician fee schedule rate and incentive payments for every TIN that they bill under. CMS proposes to revise its evaluation of Qualifying APM participants by making determinations at the TIN level, rather than the NPI level. Under this revised framework, eligibility as a Qualifying APM participant will be evaluated for each TIN, replacing blanket Qualifying APM status at the NPI level.

The AANS and CNS urge CMS not to finalize this proposal, which will have a chilling effect on specialty participation in Advanced APMs. CMS should be cautious about simultaneously encouraging clinicians to undertake the substantial operational and financial commitments associated with Advanced APM participation while reducing the predictability and value of the incentives available to them when they do so. CMS has recently focused on bolstering specialty participation in value-based care models by incorporating specialty-focused participation into Accountable Care Organization (ACO) models and by soliciting stakeholder input on engaging specialists in the Shared Savings Program in this proposed rule. This proposal runs counter to these goals.

The AANS and CNS are also concerned with the logistical complexity of determining Qualified Participant (QP) status at the NPI level. Many clinicians, including specialists, may practice or bill through multiple TINs, which could result in different QP determinations for the same clinician depending on the TIN through which services are furnished. This approach could create significant uncertainty regarding the application of the QP payment incentives and impose additional administrative burdens on clinicians and practices seeking to understand and comply with the new requirements. If CMS moves forward with this proposal, the AANS and CNS urge the Agency to first seek stakeholder input regarding these and other implementation concerns and potential unintended consequences.

Clinical Data Registries

Feedback Reports at the Level of Data Submitted

In the proposed rule, CMS identified situations in which a QCDR or qualified registry provided performance feedback at a level that did not correspond with the level at which the clinician was reporting—for example, providing individual-level feedback to a clinician reporting as part of

a group, or group-level feedback when the clinician was reporting as an individual. To address this issue, CMS proposes to clarify that QCDRs and qualified registries must provide performance feedback at the same level at which the data were or will be submitted (e.g., individual, group, virtual group, subgroup, or APM Entity).

The AANS and CNS do not support CMS's proposal to require QCDRs and qualified registries to provide performance feedback exclusively at the level at which data are ultimately submitted. In practice, many practices do not determine until later in the performance year whether they will report at the individual or group level. Requiring registries to align feedback strictly with the eventual submission level would therefore require registries to provide performance feedback at both the individual and group levels to accommodate these circumstances. This would impose unnecessary administrative burdens on registries and could confuse practices that receive multiple sets of performance feedback. CMS should instead preserve flexibility for QCDRs and qualified registries to provide feedback at multiple reporting levels when appropriate to accommodate practices' reporting decisions and operational needs.

Data Validation Sampling Methodology

CMS proposes clarifications to its data validation sampling methodology for QCDRs and qualified registries. The proposed methodology would require 100 percent review of QPP participants when fewer than 10 participants are reported, while registries reporting at least 10 participants would continue to use a 3 percent sample. CMS similarly proposes patient-record sampling requirements, with all records reviewed when fewer than five exist and otherwise a sample of at least 25 percent.

While the AANS and CNS acknowledge the importance of accurate and complete data, CMS's current data validation requirements are unnecessarily complicated, costly, and burdensome for registries. The proposed data validation sampling methodology requirements compound rather than address these difficulties. CMS's validation requirements shift the costs of administering MIPS onto specialty societies and the registries they operate. **Rather than making incremental changes to the existing data validation methodology, the AANS and CNS urge CMS to undertake a broader reassessment of the data validation framework.** CMS should seek to eliminate duplicative requirements and provide greater flexibility for registries to use their established quality-control methodologies.

Third-Party Intermediaries That Do Not Submit Data

CMS proposes that, beginning with the 2027 performance period, a QCDR or qualified registry that was approved through the self-nomination process would be required to submit a participation plan if it did not submit MIPS data during the preceding year. Under the current policy, this requirement applies only when the QCDR or qualified registry has not submitted MIPS data during either of the two preceding years.

The AANS and CNS appreciate CMS's interest in ensuring that approved QCDRs and qualified registries remain available and capable of supporting MIPS participants, but believe the existing two-year standard provides a more appropriate basis for determining whether a reporting entity remains viable and capable of supporting MIPS participants. A temporary reduction or absence of MIPS submissions does not necessarily indicate that a QCDR is no longer capable of supporting MIPS reporting or that it lacks value to the specialty it serves.

Requiring an additional participation plan after only one year of non-submission could create unnecessary uncertainty for specialty societies and their registries. Therefore, the AANS and CNS urge CMS to retain the existing two-year policy.

Qualified Postings

CMS proposes to require QCDRs and qualified registries to finalize changes to their information during the annual qualified posting review period and prohibit any subsequent changes once the posting is published. The AANS and CNS understand the importance of ensuring that information presented through the qualified posting process is accurate and reliable. However, circumstances may change after the review period that are outside a registry's **control and could cause previously accurate information to become outdated or incomplete. CMS should therefore provide a limited opportunity for QCDRs and qualified registries to make material corrections or updates after publication, as necessary, to ensure that clinicians have access to accurate and current information when selecting a reporting entity.**

Requests for Information

FHIR Timeline

CMS requests feedback on its proposed transition to FHIR-based digital quality reporting under the QPP, including its consideration of a two-year transition period beginning with the 2028 performance period and mandatory FHIR-based reporting beginning in 2030.

The AANS and CNS appreciate CMS's efforts to modernize quality measurement and reporting through the transition to FHIR-based digital quality reporting. The AANS and CNS have long supported efforts to make quality reporting more seamless, automated, and less burdensome for clinicians. When appropriately designed and implemented, digital measures have the potential to improve the accuracy and timeliness of quality data, facilitate interoperability and more sophisticated analysis, and reduce the administrative burden associated with traditional quality reporting. **The AANS and CNS therefore support CMS's consideration of a phased transition that allows clinicians and reporting entities time to prepare for FHIR-based reporting.**

However, CMS should thoroughly assess readiness before making FHIR-based reporting mandatory. Successful implementation will depend on factors including EHR capabilities, vendor readiness, interoperability between systems, availability of appropriately specified digital measures, workforce capacity, implementation costs, and the ability of reporting intermediaries to support the transition. **The AANS and CNS therefore encourage CMS to use the proposed transition period to identify and address these barriers and only implement mandatory FHIR-based reporting when readiness is evident.** CMS should also create tailored exceptions for clinicians that require more time to develop FHIR-based reporting capabilities.

MVP Scoring

The AANS and CNS appreciate CMS's request for feedback on the MVP scoring methodology as the Agency prepares to transition to full MVP reporting beginning with the 2029 performance year. CMS must address fundamental flaws with the MVP framework before attempting to require mandatory participation.

The Surgical Care MVP illustrates the limitations of comparing performance across fundamentally different specialties. A composite score derived from measures that apply differently across neurosurgery, general surgery, cardiac surgery, breast surgery, and other disciplines may create an appearance of comparability without establishing that the underlying performance measures are actually comparable. Differences in patient populations, clinical complexity, procedural risk, referral patterns, and available treatment options can all affect measured performance. Without sufficient specialty-specific measures and appropriate risk adjustment, the resulting scores may say more about the characteristics of the patients and procedures captured by the measures than about the underlying quality of the physician's care.

Similarly, “normalization” may make score distributions appear more comparable, but it cannot correct for an underlying measure that is poorly suited to a particular specialty or patient population. Statistical adjustments should not be used to create an appearance of fairness where the underlying measures are not clinically comparable. **CMS should therefore first focus on ensuring that each MVP contains an appropriate and sufficiently robust set of measures before attempting to establish comparable score distributions across MVPs.**

Star Rating Assignment Methodology

The AANS and CNS urge CMS to proceed cautiously when considering revisions to the star rating assignment methodology, particularly when relying on quality measures derived from administrative claims. The AANS and CNS recognize the value of providing patients with meaningful information about physician quality, and CMS must ensure that the information publicly reported is accurate, meaningful, and sufficiently reliable to support comparisons between physicians.

Administrative claims data alone are not an appropriate measure of physician quality. Administrative claims may not capture the clinical complexity, patient characteristics, or other factors necessary to meaningfully assess the care provided by a physician. This concern is particularly relevant for highly specialized physicians such as neurosurgeons, who frequently treat patients with complex conditions and perform relatively low-volume, high-risk procedures. For certain procedures, the number of cases available to an individual physician may be insufficient to produce statistically reliable performance measures. Claims data also may not contain the clinical information necessary to appropriately account for differences among patients and procedures.

CMS should therefore ensure that claims-based measures are clinically meaningful and appropriately applicable to the specialties and physicians to whom they are attributed. Specialists have different patient populations, case volumes, clinical responsibilities, and levels of patient risk. Measures applied broadly across specialties may produce misleading comparisons when they fail to account for these differences. CMS should not hold physicians accountable for outcomes or utilization patterns that are substantially influenced by factors outside of their control.

Risk adjustment and attribution are particularly important in neurosurgery. Neurosurgeons frequently care for patients with serious and complex conditions and perform procedures in which patient-specific clinical factors can substantially affect outcomes. CMS should ensure that claims-based measures adequately account for these factors and appropriately attribute

outcomes to the physicians who can reasonably influence them. **The AANS and CNS also encourage CMS to consider whether the data underlying a star rating are sufficiently robust to distinguish meaningful differences in physician performance.** CMS should ensure appropriate reliability and minimum sample-size standards before assigning or publicly reporting a star rating for an individual physician.

Engaging Specialists in the Medicare Shared Savings Program (SSP)

The AANS and CNS appreciate CMS's recognition that greater participation by specialty physicians is necessary to advance accountable care and value-based payment. **CMS should ensure that specialists have meaningful opportunities to participate in value-based care through models that reflect the realities of specialty practice.** Central to accomplishing this goal is involving specialists, including neurosurgeons, in the planning and development of value-based care models before they are proposed or implemented. The ASM demonstrates the drawbacks of a lack of meaningful specialty engagement in model development. For neurosurgeons who have had limited opportunities to participate in value-based care models, the ASM does not provide a meaningful pathway that specialty physicians have long sought.

Meaningful specialist participation in value-based care also requires CMS to give specialists the data necessary to identify and act on opportunities to improve care. Clinicians often do not receive timely feedback on claims-based cost and utilization measures until long after services have been delivered, limiting their ability to use that information to improve care. The Agency should provide specialists with information on the utilization and costs associated with their patients on at least a quarterly basis, including patient-level information about the services included in applicable measures, the providers and sites of service involved, actual payments, and expected costs. CMS should ensure that specialists have the data, payment flexibility, and other resources necessary to meaningfully improve care before holding them accountable for outcomes and spending. Providing these supports would make specialist participation in value-based care more meaningful and help ensure that models are designed around opportunities that specialists can actually address.

The AANS and CNS further encourage the Agency to use the SSP to develop genuine, voluntary opportunities for specialty participation, rather than simply increasing the number of specialists affiliated with ACOs. CMS should work directly with specialty societies and other stakeholders to identify models and approaches that allow specialists to contribute their expertise to accountable care.

CONCLUSION

The AANS and CNS appreciate the opportunity to comment on the CY 2027 MPFS proposed rule and encourage the Agency to finalize policies that improve payment accuracy, promote meaningful quality measurement, and support the delivery of high-quality neurosurgical care without relying on generalized assumptions that do not reflect the realities of complex neurosurgical practice. Across the payment and quality provisions addressed in this letter, a consistent principle should guide CMS's decision-making: Medicare policies should be grounded in current clinical evidence, validated empirical data, and the realities of the care and reporting requirements faced by physicians. Such an approach will better support CMS's long-term objectives while reducing unnecessary administrative burden, promoting meaningful

physician participation in quality programs, and protecting beneficiaries' access to the specialized, high-acuity care that neurosurgeons provide.

If additional information would be helpful or questions arise regarding these comments, please contact Lauren M. Foe, MPH, Director of Regulatory Policy, at lfoe@neurosurgery.org.

Sincerely,

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President
American Association of Neurological Surgeons

Martina Stippler, MD
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Appendix A

Estimated Impact of Exempting Certain Neurosurgery Codes from the Medicare Physician Fee Schedule (MPFS) Efficiency Adjustment (EA)

Health Management Associates (HMA) was engaged to estimate the impact of exempting certain neurosurgery codes from the "efficiency adjustment" that was recently finalized in the Medicare Physician Fee Schedule (MPFS). Based on the methodology and assumptions outlined in the balance of this summary, we estimate that the proposed exemption would have **increased total 2026 payments[1] under the Medicare Physician Fee Schedule (MPFS) by $2.05 million.** Similarly, if CMS finalized an efficiency adjustment exemption for the codes for MPFS CY 2027, we estimate that **total 2027 payments[2] under the fee schedule would increase by $2.15 million.** In both cases, the resulting increase in total payments would not trigger a budget neutrality adjustment to the conversion factors because the change to both years' payments is less than $20 million.[3]

In the CY 2026 MPFS rulemaking cycle, the Centers for Medicare and Medicaid Services (CMS) finalized the creation of an efficiency adjustment to the intraservice portion of physician time and work RVUs for most non-time-based services. The efficiency adjustment, finalized as a 2.5 percent reduction in CY 2026, will be applied every 3 years, although the agency notes it will monitor the 3-year cadence and may refine the frequency in future rulemaking. Under current fee schedule policy, several services are exempted from the efficiency adjustment, including many time-based services (such as E/M visits, care management services, and behavioral health services), as well as remote therapeutic monitoring (RTM) services and drug administration services.

Using the modeling methodology described below, we estimated the impact of exempting the following neurosurgery codes from the fee schedule's efficiency adjustment in CY 2026 and CY 2027.

Table 1. Neurosurgery services of modeling interest

HCPCS	Medium Description
22633	ARTHRODESIS COMBINED TQ 1NTRSPC LUMBAR
61624	TCAT PERM OCCLS/EMBOLIZATION PERQ CNS
61781	STRTCTC CPTR ASSTD PX CRANIAL INTRADURAL
61863	STRTCTC IMPLTJ NSTIM ELTRD W/O RECORD 1ST ARRAY
61864	STRTCTC IMPLTJ NSTIM ELTRD W/O RECORD EA ARRAY
61867	STRTCTC IMPLTJ NSTIM ELTRD W/RECORD 1ST ARRAY
61868	STRTCTC IMPLTJ NSTIM ELTRD W/RECORD EA ARRAY
61885	INSJ/RPLCMT CRANIAL NEUROSTIM PULSE GENERATOR
61886	INSJ/RPLCMT CRANIAL NEUROSTIM GENER 2/> ELTRDS
63030	LAMINOTOMY DCMPRN NRV ROOT 1 NTRSPC LUMBAR
63052	LAM FACETEC/FORAMOT DRG ARTHRD LUMBAR 1 VRT SGM

[1] Total payments includes both non-facility and facility payments.
[2] Ibid.
[3] Note that this analysis is not intended to estimate the federal budgetary impact in the style of a Congressional Budget Office (CBO) legislative score. The proposed efficiency adjustment exemption is within CMS's statutory authority and would not require additional legislation enacted by Congress. As such, this analysis is intended to be a point estimate of PFS variables and not an estimate of the impact to the federal budget if this policy change were pursued legislatively.

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To estimate the impact of exempting these codes from the efficiency adjustment in CY 2026, we referenced a spreadsheet CMS published alongside the MPFS CY 2026 final rule.[4] Within that spreadsheet, CMS lists each code that was impacted by the efficiency adjustment, and for each impacted code, the code's CY 2026 work RVU before the application of the 2.5 percent efficiency adjustment reduction, and the CY 2026 work RVU after the application of the 2.5 percent efficiency adjustment reduction. Our modeling inputted both work RVUs for each neurosurgery code of interest, giving us our CY 2026 "current policy" work RVU (i.e., the service's CY26 work RVU with the efficiency adjustment) and the CY 2026 "proposed policy" work RVU (i.e., the service's CY26 work RVU without the efficiency adjustment). Next, we converted the modeled change to work RVUs to a modeled change in total CY 2026 payments using the following: each code's finalized CY 2026 malpractice RVU and practice expense RVUs, the finalized CY 2026 non-APM conversion factor ($33.4009), and the CY 2026 code-level utilization projections in the MPFS CY 2026 final rule.[5] In aggregate, our modeling suggests that had the codes been exempt from the CY 2026 efficiency adjustment, the increased work RVUs for these services would have equated to a $3.01 to $27.72 increase in each service's CY 2026 allowed charge. ***Appendix A*** displays the finalized and modeled CY 2026 valuation changes for the neurosurgery codes of interest.

To estimate the impact of exempting these codes from the efficiency adjustment in CY 2027, we completed a similar process but utilized the proposed CY 2027 work RVU included in the MPFS CY 2027 proposed rule as our "current policy" work RVU. Next, we modeled a 2.5 percent work RVU reduction to get our "proposed policy" work RVU (i.e., the service's CY27 work RVU without the efficiency adjustment). Like before, we converted the modeled change to work RVUs to a modeled change in total CY 2027 payments using the following: each code's proposed CY 2027 malpractice RVU and practice expense RVUs, the proposed CY 2027 non-APM conversion factor ($32.8409), and the CY 2027 code-level utilization projections published in the MPFS CY 2027 proposed rule.[6] In aggregate, our modeling suggests that if CMS exempts the codes from the efficiency adjustment in CY 2027, the increased work RVUs for these services would equate to a $2.96 to $27.26 increase in each service's CY 2027 allowed charge. ***Appendix B*** displays the proposed and modeled CY 2027 valuation changes for the neurosurgery codes of interest.

In closing, we estimate that exempting the neurosurgery codes of interest from the CY 2026 efficiency adjustment would have **increased total 2026 payments (includes both non-facility and facility payments) under the Medicare Physician Fee Schedule (MPFS) by $2.05 million.** Similarly, if CMS finalized an efficiency adjustment exemption for the codes for MPFS CY 2027, we estimate that **total 2027 payments (includes both non-facility and facility payments) under the fee schedule would increase by $2.15 million.** In both cases, the resulting increase in total payments would not trigger a budget neutrality adjustment to the conversion factors because the change to both years' payments is less than $20 million.

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[4] See "CY 2026 PFS Final Rule Codes Subject to Efficiency Adjustment 11.17.25.xlsx" file available for download at: https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notices/cms-1832-f.

[5] See the MPFS CY 2026 Final Rule's Addendum B and "CMS-1832-F_2024_Utilization_Data_Crosswalked_to_2026.xlsx" file, available for download at: https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notices/cms-1832-f.

[6] See the MPFS CY 2027 Proposed Rule's Addendum B and "CMS-1848-P_2025_Utilization_Data_Crosswalked_to_2027.xlsx" file, available for download at: https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notices/cms-1848-p.

Table 1. Modeled CY 2026 valuation increases to the neurosurgery codes of interest

HCPCS	Brief Description	Finalized CY26 Work RVU*	Modeled CY26 Work RVU under EA Exemption	% Change	Modeled Change in CY26 Facility Allowed Charges ($)
22633	Arthrd cmbn 1ntrspc lumbar	26.13	26.80	~+2.5%	$22.38
61624	Tcat perm occls/embolj cns	19.50	20.00		$16.70
61781	Scan proc cranial intra	3.66	3.75		$3.01
61863	Implant neuroelectrode	20.19	20.71		$17.37
61864	Implant neuroelectrde addl	4.38	4.49		$3.67
61867	Implant neuroelectrode	32.20	33.03		$27.72
61868	Implant neuroelectrde addl	7.71	7.91		$6.68
61885	Insrt/redo neurostim 1 array	5.90	6.05		$5.01
61886	Implant neurostim arrays	9.68	9.93		$8.35
63030	Lamot dcmprn nrv rt 1 lmbr	11.70	12.00		$10.02
63052	Lam facetc/frmt arthrd lum 1	4.14	4.25		$3.67

Source: Health Management Associates (HMA) modeling and analysis
**As reflected in CY 2026's July RVU-C table (PPRRVU2026_Jul_nonQPP.xlsx)*
Note: Modeled work RVU numbers rounded to the nearest hundredths decimal place. CY 2026 Facility Allowed Charges modeled under MPFS CY26 FR non-AAPM conversion factor of $33.4009. EA = Efficiency Adjustment.

Table 2. Modeled CY 2027 valuation increases to the neurosurgery codes of interest

HCPCS	Brief Description	Proposed CY27 Work RVU*	Modeled CY27 Work RVU under EA Exemption	% Change	Modeled Change in CY 2027 Facility Allowed Charges ($)
22633	Arthrd cmbn 1ntrspc lumbar	26.13	26.80	~+2.5%	$22.00
61624	Tcat perm occls/embolj cns	19.50	20.00		$16.42
61781	Scan proc cranial intra	3.66	3.75		$2.96
61863	Implant neuroelectrode	20.19	20.71		$17.08
61864	Implant neuroelectrde addl	4.38	4.49		$3.61
61867	Implant neuroelectrode	32.20	33.03		$27.26
61868	Implant neuroelectrde addl	7.71	7.91		$6.57
61885	Insrt/redo neurostim 1 array	5.90	6.05		$4.93
61886	Implant neurostim arrays	9.68	9.93		$8.21
63030	Lamot dcmprn nrv rt 1 lmbr	11.70	12.00		$9.85
63052	Lam facetc/frmt arthrd lum 1	4.14	4.25		$3.61

Source: Health Management Associates (HMA) modeling and analysis
**As reflected in MPFS CY 2027 Proposed Rule Addendum B*
Note: Modeled work RVU numbers rounded to the nearest hundredths decimal place. CY 2027 Facility Allowed Charges modeled under MPFS CY27 Proposed Rule proposed non-APM conversion factor of $32.8409. EA = Efficiency Adjustment.