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September 14, 2026

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS-1848-P — Medicare Program; CY 2027 Revisions to Payment Policies Under the Physician Fee Schedule; Request for Information on Current Procedural Terminology (CPT)

Dear Administrator Oz:

On behalf of the American Society of Interventional Pain Physicians (ASIPP), representing 49 state societies and the Puerto Rico Society of Interventional Pain Physicians submits, representing interventional pain physicians and their patients nationwide, We appreciate the opportunity to comment on the Request for Information (RFI) on the role of Current Procedural Terminology (CPT) included in the CY 2027 Physician Fee Schedule proposed rule (CMS-1848-P).

ASIPP has direct, extensive experience with the CPT code development and valuation process, and that experience has repeatedly exposed problems that CMS's RFI rightly seeks to examine. We offer the points below, drawn from our own dealings with the CPT Editorial Panel, the AMA/Specialty Society RVS Update Committee (RUC), and the associated licensing structure, and we also identify where we believe CMS's inquiry — and the current system — are on the right track.

1. Licensing and access costs impede education and patient care, not just innovation. AMA's copyright over CPT codes requires a licensing agreement before the codes can even be reproduced in educational materials such as textbooks written for physicians in training. Royalty obligations attach to books distributed even when they are given away free of charge to fellows, residents, and other trainees, meaning organizations pay royalties on copies that generate no revenue at all. Separately, access to CPT-linked educational databases can carry corporate licensing fees exceeding $13,000 — a cost that is prohibitive for many specialty societies and training programs. These costs fall hardest on the educational and non-profit uses that most directly serve patient care, which is the opposite of what a national coding standard should produce.

2. The code-development process has treated similarly situated specialty societies inconsistently. ASIPP invested substantial time and resources developing and presenting new epidural injection codes to the CPT Editorial Panel, in good faith and at the Panel's request. After being asked to revise our submission, we learned within a day that a competing organization's code proposal had already been approved, with an invitation for ASIPP to "participate" in codes we had no role in developing. A process that asks one applicant to keep revising while approving a competing proposal in parallel, with no visibility into why, undermines confidence that the CPT process treats specialty societies equitably.

3. Committee composition and survey methodology raise conflict-of-interest and validity concerns. In the coding of peripheral nerve stimulation devices, a small number of committee participants — including physicians who do not perform the procedure and others positioned to compete with the affected technology — were able to force reconsideration of codes a full year after those codes had already cleared the CPT Editorial Panel and the RUC, while ASIPP itself was removed from the discussion. We do not read this as deliberate misconduct so much as a structural flaw: a volunteer committee process with no firewall against participants who hold a direct competitive or financial stake in the outcome. Separately, the RUC physician-time survey methodology is widely regarded among our members as burdensome and unreliable, which discourages participation and, in turn, yields valuation data that likely understates real-world physician work.

4. Selection of CPT committee membership. The current membership selection process appears to favor individuals affiliated with a limited number of major professional societies. Qualified physicians and other stakeholders who are not members of these organizations have little or no meaningful opportunity to be considered for appointment. This approach may exclude important perspectives and does not ensure broad, balanced representation across the specialty. We recommend establishing a more open, transparent, and inclusive nomination and selection process that provides qualified individuals from all relevant professional organizations, including smaller and specialty-specific societies, a fair opportunity to participate.

5. Transparency of the code change application process. To maintain its integrity and trust in the recommendations being made to CMS, the entire code change application process should be transparent and available to all interested parties. This means:

a. The Code Change Application (CCA) submitted should list all of the authors who contributed, including staff and specialty society advisors. Where AMA staff submit a CCA, the staff and any supporting specialty advisor or specialty representative taking part in the drafting or submission should be made public.

b. All submitted comments should require authoritative references (e.g., FDA clearance and Instructions for Use (IFU) citations); comments should not differ from FDA-cleared product definitions and defined surgical procedures (i.e., off-label comments).

c. All interested parties should have access to all submitted comments. Today, specialty society comments are not made available or transparent to all participants.

d. These measures would support continued transparency, oversight, and compliance — that is, a compliant process that yields trusted recommendations to CMS for code development.

6. Recommendations submitted to CMS outside the AMA CPT process. Interested parties routinely exercise their right to submit recommendations to CMS outside of the AMA CPT process. Making all AMA CPT processes transparent and available, including full transparency of the CCA process, allows the public to compare and contrast the information used within the AMA CPT process against information that similar participants may submit directly to CMS outside of the CPT process — again supporting a transparent framework that CMS can depend on in policymaking.

7. Oversight of AMA interpretive platforms. Currently, fee-for-service AMA interpretive platforms (CPT Assistant, CPT Knowledge Base, and RBRVS DataManager) are not subject to oversight or public input, yet these platforms drive policy. Conflicts of interest should be disclosed for all active participants who develop and deliver content within these platforms. Establishing a clear, public, and transparent

editorial process would help these interpretive platforms provide compliant and trusted information to practicing physicians and the public.

8. A more active FDA role in the AMA CPT process. The FDA should review its own clearance process and take a more active role in the AMA CPT process:

a. The FDA should review technology and procedure (IFU) standards for terminology.

b. The FDA should work within the AMA CPT process and with CMS to ensure that on-label clearances for technologies and procedures are consistently maintained.

c. The FDA should review its policies on "brand name" versus "technology nomenclature" within its clearance process — alignment across FDA, AMA CPT, and CMS is critical for physicians and patients.

We want to be clear about what ASIPP is not asking for. We do not support abolishing the CPT Editorial Panel, the RUC, or physician-led code development. Two aspects of this RFI and the underlying system give us confidence that reform, not replacement, is the right path:

- CMS is asking the right RFI questions. We are encouraged that Question 4 seeks objective, evidence-based alternatives to the current RUC valuation methodology rather than assuming today's process is the only workable one, and that Question 1's call for documented licensing harms, and Question 2's interest in medical-necessity-linked coding models used elsewhere, are exactly the kind of evidence the episodes above are meant to supply.
- Physician-led coding, done right, remains the right foundation. ASIPP supports a specialty-informed, physician-led process for developing and valuing procedural codes; our concerns are with its governance, cost structure, and susceptibility to conflicts of interest — not with the premise that physicians who perform a procedure should help define how it is coded and valued.

ASIPP appreciates CMS's willingness to scrutinize a process that directly affects patient access to interventional pain care, and we welcome the opportunity to provide additional documentation of the specific episodes described above to support any resulting policy changes.

Sincerely,

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