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8/27/ 2026

The Honorable Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1850-P
7500 Security Boulevard
Baltimore, Maryland 21244

RE: CMS-1850-P — CY 2027 Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Proposed Rule. Comments on proposed payment reductions for interventional pain procedures and multiple-procedure discounting of neuromodulation procedures in the ambulatory surgical center setting.

Dear Dr. Oz:

On behalf of the American Society of Interventional Pain Physicians (ASIPP), representing 48 state societies and the Puerto Rico Society of Interventional Pain Physicians, and Society *of* Interventional Pain Management Surgery Centers (SIPMS), we appreciate the opportunity to comment on the CY 2027 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System proposed rule. We write principally to urge CMS to reconsider the proposed CY 2027 ASC payment reductions for eight interventional pain procedures: interlaminar epidural steroid injections (CPT 62321 and 62323), transforaminal epidural steroid injections (CPT 64479 and 64483), facet joint injections (CPT 64490 and 64493), and facet radiofrequency ablation (CPT 64633 and 64635). These procedures are important non-opioid treatment options for Medicare beneficiaries with chronic pain, particularly for patients who have failed conservative care. Continued payment reductions may adversely affect beneficiary access to these essential services.

Requested action

ASIPP respectfully requests that CMS:

1. Reconsider and reverse the proposed CY 2027 ASC payment reductions for CPT 62321, 62323, 64479, 64483, 64490, 64493, 64633, and 64635.
2. Ensure that ASC payment rates for interlaminar epidural steroid injections, transforaminal epidural steroid injections, facet joint injections, and facet radiofrequency ablation adequately reflect the imaging, monitoring, sterile supplies, staffing, and other facility resources required to furnish these procedures safely.
3. Evaluate the cumulative effect of successive payment reductions and the office-based payment cap on beneficiary access to these non-opioid interventional pain procedures, particularly in independent and rural ASCs.
4. We also urge CMS to retain the current multiple-procedure discounting exemption for neuromodulation implantation and revision codes.

I. Continued erosion of payment for epidural steroid injections, transforaminal epidural steroid injections, facet joint injections and facet radiofrequency ablation procedures

Despite the 2.4% system-wide update, CMS proposes payment reductions for eight interventional pain procedures: interlaminar epidural steroid injections (CPT 62321 and 62323), transforaminal epidural steroid injections (CPT 64479 and 64483), facet joint injections (CPT 64490 and 64493), and facet radiofrequency

ablation (CPT 64633 and 64635). The proposed reductions include approximately 3.8% for the injection procedures and 4.3% for radiofrequency ablation. These procedures are important non-opioid treatment options for Medicare beneficiaries with chronic pain who have failed conservative care. Their relative weights have declined over successive years, while the office-based payment cap further limits ASC facility reimbursement. ASIPP strongly urges CMS to reconsider these proposed reductions and ensure that ASC payment rates accurately reflect the imaging, monitoring, sterile supplies, staffing, and other facility resources required to furnish these procedures safely.

II. Retain the current multiple-procedure discounting exemption for neuromodulation implantation and revision codes

CMS proposes to apply multiple-procedure discounting to nine neuromodulation procedures that are currently designated as exempt. In Addendum AA to the proposed rule — Proposed ASC Covered Surgical Procedures for CY 2027 — the following codes move from "No" to "Yes" in column 4, Subject to Multiple Procedure Discounting:

Code	Descriptor
63650	Percutaneous implantation of neurostimulator electrode array, epidural
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural
63663	Revision including replacement of spinal neurostimulator electrode percutaneous array(s)
63664	Revision including replacement of spinal neurostimulator electrode plate/paddle(s)
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver
64553	Percutaneous implantation of neurostimulator electrode array; cranial nerve
64555	Percutaneous implantation of neurostimulator electrode array; peripheral nerve
64561	Percutaneous implantation of neurostimulator electrode array; sacral nerve (transforaminal)
64590	Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver

Under the ASC multiple-procedure discounting policy, Medicare pays 100 percent of the highest-paying covered surgical procedure on the claim and 50 percent of each additional procedure subject to the discount. Applied to these codes, the practical effect is a 50 percent reduction on the electrode or lead component of nearly every neurostimulator implantation and revision performed in an ASC — because these procedures are, by clinical necessity, reported together with the pulse generator code in a single operative session.

ASIPP respectfully submits that this change should not be finalized for four reasons:

1. Integrated therapy, not duplicative services. Neuromodulation requires both the electrode and pulse generator, each with distinct implants, supplies, and facility resources. Device costs do not decrease when the components are implanted together, and a 50% reduction may result in inadequate payment.

2. The proposal may negate the payment increases in this rule. Although CMS proposes increases for CPT 63685 and 63650, these codes are commonly performed together. Discounting the lead code by 50% may eliminate those gains and reduce total case payment.

3. The proposal may create an inappropriate staging incentive. Discounting the lead when implanted with the generator may encourage separate operative sessions, increasing anesthesia exposure, infection risk, and facility costs. Payment policy should support clinically appropriate single-session care.

4. The proposal may shift care to higher-cost hospital settings. Independent and rural ASCs may be unable to absorb reduced neuromodulation payments, limiting Medicare access and shifting cases to hospital outpatient departments with higher program and beneficiary costs.

Consequently, we request that CMS retain the current **"No" multiple-procedure discounting designation** in Addendum AA for CPT codes **63650, 63655, 63663, 63664, 63685, 64553, 64555, 64561, and 64590**.

III. Prior authorization asymmetry. ASIPP appreciates that the proposed expansion of prior authorization to additional botulinum toxin injection codes applies to hospital outpatient departments and not to ASCs, and urges CMS to maintain that distinction. ASIPP also encourages CMS to evaluate

whether existing hospital outpatient prior-authorization requirements for facet interventions and percutaneous SCS lead implantation are delaying medically necessary care.

ASIPP appreciates CMS's consideration of these comments and welcomes the opportunity to provide claims-level data or clinical input as CMS develops the final rule. Please contact us with any questions.

Respectfully submitted,

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