NORTH AMERICAN NEUROMODULATION SOCIETY

111 N. Wabash Ave., Suite 100-3653,
Chicago, IL 60602

773.648.7845 | info@neuromodulation.org

September 8, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1807-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: File Code CMS-1807-P; Medicare Program; CY 2025 Payment Policies under the Physician Payment Schedule and Other Changes to Part B Payment and Coverage Policies; (July 31, 2024)

Dear Administrator Brooks-LaSure:

The North American Neuromodulation Society (NANS) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) Notice of Proposed Rule Making (Proposed Rule) on the revisions to Medicare payment policies under the Physician Payment Schedule for calendar year (CY) 2025. NANS is a multi-specialty association of more than 1,600 physicians dedicated to the development and promotion of the highest standards for the practice of neuromodulation procedures in the diagnosis and treatment of the nervous system, including neurosurgeons, orthopedic spine surgeons, anesthesiologists, physiatrists, psychologists, urologists, and neurologists. We are committed to working with CMS and other stakeholders to promote the highest quality, most efficient patient care for patients dealing with chronic pain and other conditions that may be with targeted electrical, chemical, and biological technologies to the nervous system to improve function and quality of life.

This letter includes NANS recommendations and comments regarding the following:

- The CY 2025 Proposed Conversion Factor
- Telehealth Services under PFS

The CY 2025 Proposed Conversion Factor

In the CY 2025 Proposed Rule, the Centers for Medicare & Medicaid Services (CMS) is proposing to reduce average payment rates under the MPFS by 2.93 percent compared to the average amount reimbursed for these services in CY 2024. This amounts to a proposed estimated CY 2025 MPFS conversion factor decrease of $0.93 (or 2.8 percent) from the current CY 2024 conversion factor. In 2023, Medicare physicians received a 2% pay cut. This year, physicians are seeing another 1.68% pay cut, further hindering physicians' ability to keep up with practice costs and consumer prices. And for 2025, CMS has proposed a physician payment schedule that would result in a 2.8% across the board cut.

These Medicare physician payment reductions are unsustainable. Adjusted for inflation costs, Medicare physician payment declined 29% from 2001 – 2024. During that same period, the cost of running a practice has gone up by nearly 50 percent. That is more than two decades of stagnant payment rates in the face of inflation. This unsustainable path threatens older adults' access to high-quality physician care.

Physicians need an annual inflationary update, which are provided for nearly all sites of service (hospital, OOP, and ASC) in 2025 except for physicians. Medicare's reimbursement instability results in a domino effect for physicians: fewer physicians participate in the program, more physicians are forced to sell their practices, and as noted above, costs for both the program and beneficiaries increase due to consolidation. Vertical healthcare integration has not led to decreases in healthcare costs and in many cases, it results in higher costs and worse outcomes[1]. In addition, in many cases, the cost of care is switched to higher cost centers such as (hospital outpatient departments). This dynamic directly impacts access to care, especially for low-income beneficiaries and those living in rural or underserved areas. We support the AMA in their call for the Medicare physician payment must be tied to an inflation index (Medicare Economic Index)[2]. In addition, we are aligned with the AMA's efforts to remove the inappropriate prohibition against physician-owned hospitals, as these organizations have lower costs and better outcomes for patients.

If the proposed conversion factor changes are implemented, most neuromodulation interventions would see another year of dramatic reductions in total Medicare reimbursement. These procedures are critically important to preserving the quality of life for millions of Medicare patients with disorders such as Parkinson's disease, chronic pain, spasticity, and intractable epilepsy. For instance, reducing reimbursement for non-opioid pain therapies such as neurostimulation would

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[1] *Study finds vertical integration in medicine is leading to higher costs and worse health outcomes*. (2023, March 2). Harvard Kennedy School. https://www.hks.harvard.edu/faculty-research/policy-topics/health/study-finds-vertical-integration-medicine-leading-higher

[2] American Medical Association & American Medical Association. (2024, June 17). Medicare physician pay has plummeted since 2001. Find out why. *American Medical Association*. https://www.ama-assn.org/practice-management/medicare-medicaid/medicare-physician-pay-has-plummeted-2001-find-out-why

push these patients back towards opioid based treatment plans, which have led to the tragic opioid epidemic that continues to devastate our country. Several efficacious and cost-effective pain neuromodulation treatments, which currently are reimbursed at marginal levels that barely cover overhead, face drastic reductions if the conversion factor were to be implemented as proposed. The same is true for intrathecal medication therapy on which people with cerebral palsy, stroke, spinal cord injury and multiple sclerosis rely. These collective reductions would represent a tremendous setback in the efforts by CMS and HHS to effectively address the opioid crisis in the United States and may inadvertently cause a resurgence of opioid prescribing.

NANS respectfully requests that CMS eliminate the 2.8% proposed reduction in physician payment to ensure access for Medicare patients and assist their physician partners in providing high quality, accessible care to Medicare beneficiaries.

Prior Authorization for Spinal Cord Stimulation

Epidural spinal cord stimulation has been shown time and time again to improve patients' quality of life, reduce their use of dangerous and addicting opioid medications, and reduce health system utilization. CPT code 63650 (percutaneous implantation of SCS electrode) was added to the CMS prior authorization list in CY2021 for procedures performed in the hospital outpatient department (HOPD). Since then, physician practices have wasted countless hours and dollars of staff time obtaining prior authorization for these procedures. CMS is aware of the additional costs to physician practices of prior authorization procedures, having just promulgated new rules to smooth the process out for other procedures. It is also incongruous that SCS trials and implants performed in the HOPD require prior authorization while those performed in an ASC do not. **Given the benefits of these procedures to patients and the health system, we once again request that CMS remove the requirement for prior authorization for SCS trials and implants performed in the HOPD.**

Telehealth Services under the Physician Fee Schedule (PFS)

For CY 2025, CMS has several proposals for Telehealth services under the PFS, including but not limited to:

- *Distant site practitioner:* Through 2024, CMS will continue to permit the distant site practitioner to use their currently enrolled practice location instead of their home address when providing telehealth services from their home.
- *Definition of direct supervision:* For a certain subset of services that are required to be furnished under the direct supervision of a physician or other supervising practitioner, to permanently adopt a definition of direct supervision that allows the physician or supervising practitioner to provide such supervision through real-time audio and visual

interactive telecommunications. We are specifically proposing that the physician or supervising practitioner may provide such virtual direct supervision for services furnished incident to a physician's service when they are provided by auxiliary personnel employed by the physician and working under his or her direct supervision and for which the underlying HCPCS code has been assigned a PC/TC indicator of office or other outpatient visit for the evaluation and management of an established patient who may not require the presence of a physician or other qualified health care professional. For all other services furnished under the direct supervision of the supervising physician or other practitioner, we are proposing to continue to define "immediate availability" to include real-time audio and visual interactive telecommunications technology only through December 31, 2025.

- *Interactive Telecommunications Systems:* CMS proposes that beginning January 1, 2025, an interactive telecommunications system may include two-way, real-time audio-only communication technology for any telehealth service furnished to a beneficiary in their home if the distant site physician or practitioner is technically capable of using an interactive telecommunications system but the patient is not capable of, or does not consent to, the use of video technology.

NANS supports the Telehealth proposals outlined above and in the proposed rule.

Importantly, NANS members and our patients have experienced the benefits of utilizing telehealth for the programming of deep brain and spinal cord neurostimulation systems (DBS and SCS). Despite the safe and effective provision of these services via telehealth for several years, CMS continues to maintain these codes on the list of provisional telehealth services, rather than move them to the list of services for permanent provision via telehealth. When DBS and SCS programming are provided via telehealth, patients save hours of driving time and waiting time in physician offices. Moreover, many of our patients are disabled due to chronic pain, advanced Parkinson's disease, or dystonia. It can be a tremendous hardship financially and physically for these patients to travel to their expert center for programming. Moving these services to the permanent telehealth services list would be a substantial benefit to our patients.

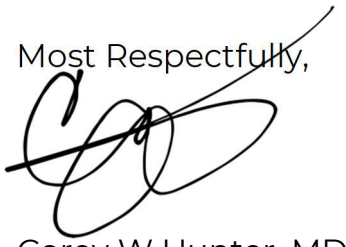
As of December 31, 2024, temporary flexibilities enacted due to the COVID-19 public health emergency will expire. These include (but are not limited to) the ability for FQHCs and RHCs to serve as a distant site provider for non-behavioral/mental telehealth services, no geographic restrictions for the originating site for non-behavioral/mental telehealth services, and telehealth services being provided by all eligible Medicare providers. We hope that Congress will extend these temporary changes through 2025[3].

[3] *Telehealth policy changes after the COVID-19 public health emergency*. (2023, December 19). telehealth.hhs.gov. https://telehealth.hhs.gov/providers/telehealth-policy/policy-changes-after-the-covid-19-public-health-emergency#temporary-medicare-changes-through-december-31,-2024

We request that CMS place DBS and SCS programming services, described by CPT codes 95970, 95971, 95972, 95983, and 95984, on the list of services permanently approved for provision via telehealth.

Thank you for your consideration of NANS comments on the CMS Proposed Rule on the revisions to Medicare payment policies under the Physician Payment Schedule for calendar year 2025, published July 31, 2024, Federal Register (Vol. 89, No. 147 FR, pages 61596-62648). We commend CMS for its continued efforts to improve care quality and access. If you have any questions about our comments, please do not hesitate to contact Keri Kramer, NANS CEO at kkramer@neuromodulation.org.

Most Respectfully,



Corey W Hunter, MD
President - North American Neuromodulation Society (NANS)
Asst Clinical Professor – Dept of Physical Medicine & Rehabilitation; Icahn School of Medicine