September 6, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1770-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: File Code CMS-1770-P; Medicare Program; CY 2023 Payment Policies Under the Physician Payment Schedule and Other Changes to Part B Payment Policies; (July 29, 2022)

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) 2022.

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 in order to improve function and quality of life.

This letter includes NANS recommendations and comments regarding the following:

- **CY 2023 Conversion Factor**
- **Practice Expense Relative Value Units**
    - **Clinical Labor Pricing Update**
- **Improving Global Surgical Package Valuation**
- **Payment for Medicare Telehealth Services**
- **Valuation of Specific Codes**
- **Physician Work and Practice Expense Relative Value Unit Recommendations for CPT codes**
    - **Somatic Nerve Injection Codes**
    - **Neurostimulator Programming Codes**
    - **E/M Payment**
        - **Split/Shared Visits**
        - **Office Visits in Global Periods**
- **Potentially Underutilized Physician Services**
- **Chronic Pain Management Reimbursement**

- **Rebasing and Revising the Medicare Economic Index (MEI)**

CY 2023 Medicare Conversion Factor

In the CY 2023 Proposed Rule, CMS announced an update to the Medicare conversion factor of $33.08 for CY 2023. This represents a 4% decrease from the current (2022) conversion factor of $34.61. This adjustment reflects a budget neutrality adjustment for changes in relative values for individual services, with significant increases in relative values for office and outpatient Evaluation and Management (E/M) services (CPT codes 99201-99215) and the fact that CMS opted to maintain budget neutrality which because of the E/M increases necessitates the large conversion factor reduction.

NANS is extremely disappointed and concerned with the drastic reduction in the Medicare Conversion Factor and strongly recommends CMS take action in the CY 2023 Final Rule to eliminate this conversation factor reduction. Many practices are still struggling to maintain financial viability due to the changes and hardships caused by the Covid-19 pandemic and their potential closure as a result of this reduction in the conversion factor would significantly impact access to care to CMS covered patients

If the proposed conversion factor changes are implemented, most pain interventions would see dramatic reductions in total Medicare reimbursement. These procedures are critically important alternatives to opioid based treatment plans which have led to the tragic opioid epidemic that continues to devastate our country, and in fact has increased during the pandemic years. Several efficacious and cost-effective pain 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. 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.

CMS has done an admirable job in adjusting rules, regulations, and payment rates in response to the current Public Health Emergency (PHE) due to the Covid-19 crisis. Yet, despite this recognition and all the efforts by CMS to increase access to care for Medicare patients, CMS is proposing the largest single reduction in payment rates to physicians and providers in many years at the same time that the economy is experiencing the highest levels of inflations in the past 45 years. This is directly contrary to the efforts and the messaging by CMS and if implemented for CY 2023 would completely undo much of the success CMS and physician stakeholders have had in navigating this unprecedented health crisis. If implemented in the final rule, a -4% reduction would cause massive shortage of access as practices reduce staff and hours to absorb the impact. This would result in less access at a time that greater access and greater flexibility is needed in caring for Medicare patients. Even if the conversion rate were to stay at the same rate as CY 2022, physicians would be confronted with a real-dollar loss in the 7-8% range due to inflation. Practices and hospitals have already incurred significant deficits in 2022 and further reducing physician payments will lead to even greater practice and hospital deficits. Practices will either be forced to lay off staff or reduce services, or both; thus, negatively impacting access for patients at a time of critical health care needs for Medicare patients.

The reduced conversion factor also represents a breaking of trust between physicians, CMS, and patients. Our collaboration and cooperation in overcoming these unprecedented times has been one of the few bright spots in the PHE. Reducing payments to physicians is an unfair and unacceptable response to this collaboration and risks future opportunities for cooperation. CMS should maintain their cooperation and collaboration by maintaining conversion factors and waiving budget neutrality in the fee schedule for all physicians and providers under the Medicare Physician Fee Schedule for CY 2023. CMS could offset the conversion factor reduction by overriding the 2% sequester cut from the ACA and the statutory 4% decrease from the American Rescue Plan Act. This 6% is on top of the conversion factor reduction and with the aforementioned increasing costs, represents an unmanageable combination of significant reductions in reimbursement with a significant increase in costs. Many practices will be forced to close their doors and Medicare patients will suffer significantly negative impacts to their health as a result.

CMS must act through the proposed rule to ensure access for Medicare patients and assist their physician partners in providing high quality, accessible care to Medicare beneficiaries by waiving all proposed physician payment reductions and instead offsetting the 6-8% real dollar loss to practices from inflation by increasing payments accordingly.

Practice Expense Relative Value Units (PE RVUs)

Clinical Labor Pricing Update
CY 2023 marks the second year of a four-year transition to the new clinical labor cost data that will be completed in CY 2025, much like the transition used in updating the supply and equipment price updates that were completed in CY 2022. In the future, CMS should update pricing data on a more frequent basis for all direct PE inputs, so adjustments will not be so dramatic. NANS understands the underlying unfairness that the real increase in clinical labor costs for physician practices is not recognized through an update to the conversion factor and calls on CMS to urge Congress to provide a positive update to the Medicare conversion factor in 2023 and all future years.

NANS also reiterates that the total direct practice expense pool increases by 30% under this proposal, resulting in a significant budget neutrality adjustment. Practice expense comprises 44.8% of the physician payment and the pool of this payment is fixed by statute. Therefore, increasing payment for clinical labor shifts funds that were previously directed to supplies and equipment. Since the overall size of the practice expense component is static, a larger proportion of that 44.8% is now clinical labor, relative to before the proposed wage rate update. By increasing the clinical labor pricing, physician services with high-cost supplies and equipment are disproportionately impacted by the budget neutrality component within the practice expense relative values. The scaling of direct expenses, to 50 cents on every dollar fully recognized as direct costs, puts a huge and unfair burden on specialties that require expensive supplies and other direct costs to care for their patients. While the increase in clinical labor is appropriate, it is not appropriate that physicians and other qualified health care professionals, notably from a few small specialties, are negatively impacted by the change.

New Clinical Staff Pre-Time Package for Major Surgical Procedures
The RUC recently determined that the addition of a pre-service clinical staff time package is warranted for major surgical procedures that are 000 or 010-day global periods yet require greater time than provided by the standard extensive clinical staff times package. The RUC considered CMS' action in the Final Rule for the 2022 Medicare Physician Payment Schedule for CPT codes 28820, 28825, 46020, 61736 and 61737 where the RUC-recommended pre-service clinical staff times were reduced from 60 minutes to 30 minutes. CMS stated, "We continue to believe that setting and maintaining clinical labor standards provides greater consistency among codes that share the same clinical labor tasks and could improve relativity of values among codes." While acknowledging that the RUC process of handling the pre-service time for code conversions on a case-by-case basis is effective and allows for the specialties to advocate for the most appropriate times for their procedures, the RUC also understands the value in establishing an additional 000 and 010-day global period pre-service time package as an option for those procedures in the facility-setting that require pre-service clinical staff time corresponding with a 090-day procedure. The RUC concurred that a new "comprehensive" category reasonably follows "extensive use" and appropriately accounts for the comprehensive care required for the patients involved in these major surgical procedures. The new pre-service package would also encompass the global conversions from 090-day to 000 or 010-day global periods. Therefore, the RUC has established an additional pre-service clinical staff time package, "Comprehensive Use of Clinical Staff" as an option for those procedures in the facility-setting that are assigned 000 or 010-day global periods yet require pre-service clinical staff time commensurate with a 090-day procedure.

NANS strongly encourages CMS to recognize and utilize this new package as appropriate.

Soliciting Public Comment on Strategies for Improving Global Surgical Package Valuation

In preparation for future rulemaking, CMS is seeking public comment on strategies to improve the accuracy of payment for the global surgical packages.

CMS continues to project broad assumptions that proceduralists are not providing the post-operative visits that are included in the global periods. However, the most common surgical procedure, cataract surgery, illustrates the flaw in conflating the valuation of the individual visits with the RAND reports on the ongoing claims reporting of 99024 *Postoperative follow-up visits, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) related to the original procedure*. The RUC's recent recommendation included three office visits in the post-operative work for cataract surgery is supported by claims reporting of 99024 and other extant data and studies. The ophthalmology survey data for the recent office visit (99202-99215) survey reflect similar time and work as the primary care data and RUC submitted overall data. It is, therefore, not appropriate to distort the relativity of the post-operative visits for cataract surgery. As the most frequently performed surgery to Medicare patients, this example should lead as an example for other surgical procedures.

Post-operative visits are a proxy for work, but CMS is punitive with how it applies this work. For example, if a patient is staying less than 23-hours in the hospital, CMS is applying a lower intensity of work to that service even though the service provided is the same as an inpatient hospital visit.

CMS and the RUC have a longstanding process to identify potentially misvalued services, including the global service period. To date, CMS and the RUC have conducted the following objective screens to identify potentially misvalued services related to global periods:

- *Post-Operative Visits Screen* – In 2014 and 2019, the RUC identified 010-day global period services with more than 1.5 office visits and Medicare utilization over 1,000 and 090-day global period services that include more than 6 office visits and Medicare utilization over 1,000. The RUC has conducted this screen two times, reviewed and provided recommendations on 62 services for the 2015-2017 and 2021-2022 Medicare Physician Payment Schedules.
- *High Level E/M in Global Period* – In 2015, the RUC identified services that have Medicare utilization over 10,000 and include a 99214 or 99215 office visit in the global period. The RUC reviewed and provided recommendations for 10 services for the 2017-2018 Medicare Physician Payment Schedules.
- *000-Day Global Services Reported with an E/M with Modifier 25 screen* - CMS developed this screen in the NPRM for 2017. This included services with a 000-day global period reported with an E/M 50 percent of the time or more, on the same day of service, same patient, by the same physician, and were not reviewed in the last five years with Medicare utilization greater than 20,000. The RUC reviewed 22 services (CPT deleted one) and provided recommendations for the 2019 Medicare Physician Payment Schedule.

NANS believes that the misvalued services process is the appropriate avenue to address any services that may have incorrect post-operative visits in its global period. A blanket approach to address all 010-day and 090-day services only targets physicians performing surgery.

NANS urges CMS to continue to rely on the Relativity Assessment Workgroup process, utilizing objective screens to identify any potential misvaluation of services with global periods. The CMS public comment process may also be utilized to identify potential misvaluations, as it has been successfully utilized for this purpose.

Payment for Medicare Telehealth Services

CMS is proposing several policies related to Medicare telehealth services under the MFS including making several services that are temporarily available as telehealth services for the public health emergency (PHE), available through 2023 on a Category III basis, to allow more time for collection of data that could support their eventual inclusion as permanent additions to the list. CMS is proposing to extend the duration of time that services will be temporarily available for the PHE for a period of 151 days following the end of the PHE to align with the timeframe of flexibilities according to the Consolidated Appropriations Act (CAA) 2022. CMS is proposing that telehealth claims will require the appropriate place of service (POS) indicator to be included on the claim, rather than modifier "95," after a period of 151 days following the end of the PHE. As finalized in CY 2022, mental health services will be available to be furnished through audio-only technology in certain circumstances after the end of the PHE. Additionally, CMS is proposing to continue to make payments for services on the Medicare Telehealth List that use audio-only telecommunications systems for 151-days following the PHE. CMS proposes to delay the requirement for an in-person visit with the physician or practitioner within six months prior to the initial mental health telehealth service for 151 days following the PHE. CMS also proposes to pay audio-visual services at the facility rate, following the PHE.

NANS supports these efforts by CMS and the proposals to maintain access to telehealth for Medicare patients. These policies have been effective in the last three years and should remain in place even beyond the end of the PHE.

Valuation of Specific Codes

While CMS accepted 75 percent of the RUC's work relative value recommendations submitted for 2023, NANS urges acceptance of all its recommendations. Significant clinical expertise was contributed to developing these recommendations, many of which were unanimously supported by the 29 voting members of the RUC. NANS is concerned about the use by CMS of flawed methodologies to arrive at valuations such as time ratios, reverse building block adjustments and incremental adjustments. Often, these systematic changes involve comparing the RUC recommended physician times to the existing CMS physician times that are proxy data and not reflective of any surveyed data from practicing physicians. The CMS/Other source of data was one CMS staffer decades ago assigning a time and should never be used as a source of "truth" when comparing actual survey data from practicing physicians.

In many scenarios, CMS selects an arbitrary combination of inputs to apply, including total physician time, intra-service physician time, "CMS/Other" physician times, Harvard study physician times, existing work RVUs, RUC recommended work RVUs, work RVUs from CMS-selected crosswalks, work RVUs from a base code, etc. This selection process has the appearance of seeking an arbitrary value from the vast array of possible mathematical calculations, rather than seeking a consistent valid, clinically relevant relationship that would preserve relativity.

NANS would like to remind CMS of both the Agency's and the RUC's longstanding position that treating all components of physician time (pre-service, intra-service, post-service and post-operative visits) as having identical intensity is incorrect and inconsistently applying it to only certain services under review creates inherent payment disparities in a payment system based on relative valuation. When physician service period times are updated in the Medicare payment schedule, the ratio of intra-service time to total time, the number and level of bundled post-operative visits, the length of preservice and the length of immediate post-service time may all potentially change for the same service. These changing components of physician time result in the physician work intensity per minute often changing when physician time also changes. NANS recommends that CMS always account for these nuanced variables. The underlying

principle of the RBRVS is magnitude estimation, and we implore CMS to use that long-standing methodology instead of inconsistent mathematical computations.

CMS provides crosswalk codes and other reference codes with similar times in support of their proposed values. However, it appears most of these comparison codes were arbitrarily selected as CMS does not provide any clinical foundation for the comparison of the surveyed codes to the crosswalk codes. Furthermore, these comparison codes often seem to have been selected solely for their similar work RVUs or service period times to the Agency's desired reduction and to justify similarly chosen time ratio comparisons. NANS recommends that CMS embrace the clinical input from practicing physicians when valid surveys were conducted, rigorous review by the specialty society committees was performed and a review of magnitude estimation and cross-specialty comparison has been conducted by the RUC.

Somatic Nerve Injections (CPT codes 64415, 64416, 64417, 64445, 64446, 64447, 64448, 76942, 77002, and 77003)

NANS appreciates that CMS is proposing the RUC recommended work RVUs for CPT codes 64417, 64447, 64448, 77002, 77003, and 76942 for CY 2023. However, NANS urges acceptance of the other somatic nerve injection codes as outlined below. In addition, NANS reiterates that CMS should consider the previous RUC recommendations for CPT codes 64400 and 64408. 64420, 64421, 64425, and 64430.

Fundamentally, NANS believes that there is a basic flaw in how CMS views the process of combining a procedure code with an imaging guidance code. The issue is not simply that a second task has been added that is performed in an overlapping fashion with the first. Adding imaging guidance significantly increases the required skill and intensity of work to perform most tasks. Blindly injecting local anesthetic just lateral to the femoral arterial pulse is easy. Guiding the needle tip into close proximity with the nerve without contacting the nerve, providing optimal effect from the local anesthetic injection, minimizing the dose of anesthetic required, producing the lowest possible rate of complications and the best outcome for the patient is much harder. Thus, adding imaging guidance necessarily increases the intensity of work of the base code nearly always increases expenses with the machine, gel and probe cover

By definition, component image guidance codes have substantial intra-service time overlap with the intra-service time of the component base surgery codes they are reported with, as the real-time imaging is guiding the surgical work of the base procedure. CMS' proposal to use a sum of sequential time ratios that simply sum the total component time for each component code included in the bundled service erroneously neglects to account for most of the intra-service work of performing the surgery and image guidance for that surgery occurring in parallel, regardless of the coding structure. When instead of being described by component coding and all of the work is newly described by a single bundled code, the portion of the skin-to-skin time that involves both performing the procedure and guiding the procedure in parallel should logically be assigned combined intensity of the same minute of parallel time described by concurrently performed component codes. The component image guidance codes were already previously valued with the understanding that the typical provider is both performing the base procedure and the image guidance themselves.

64415
CMS disagrees with the RUC recommended work RVU of 1.50 for CPT code 64415 which represents the survey 25th percentile. CMS is proposing a work RVU of 1.35, based on an intra-service time ratio calculation using the sum of the work RVUs for both codes: CPT code 64415 is 1.35 and CPT code 76942 is 0.67, and an estimated intra-service time of 15 minutes and total time of 43 minutes. NANS strongly disagrees with CMS calculating intra-service time ratios to account for changes in time.

By definition, component image guidance codes have substantial intra-service time overlap with the intra-service time of the component base surgery codes they are reported with, as the real-time imaging is guiding the surgical work of the base procedure. CMS' proposal to use a sum of sequential time ratios that simply sum the total component time for each component code included in the bundled service erroneously neglects to account for most of the intra-service work of performing the surgery and image guidance for that surgery occurring in parallel, regardless of the coding structure. When instead of being described by component coding and all of the work is newly described by a single bundled code, the portion of the skin-to-skin time that involves both performing the procedure and guiding the procedure in parallel should logically be assigned combined intensity of the same minute of parallel time described by concurrently performed component codes. The component image guidance codes were already previously valued with the understanding that the typical provider is both performing the base procedure and the image guidance themselves.

NANS would like to remind CMS of both the Agency's and the RUC's longstanding position that treating all components of physician time (pre-service, intra-service, post-service and post-operative visits) as having identical intensity is incorrect and inconsistently applying it to only certain services under review creates inherent payment disparities in a payment system which is based on relative valuation. When physician times are updated in the Medicare payment schedule, the ratio of intra-service time to total time, the number and level of bundled post-operative visits, the length of preservice and length of immediate post-service time may all potentially change for the same service. These changing components of physician time result in the physician work intensity per minute often changing when physician time also changes. The RUC recommends that CMS always account for these nuanced variables.

CMS supports its proposed work RVU with a crosswalk to CPT code 11982 *Removal, nonbiodegradable drug delivery implant* (work RVU= 1.34, 10 minutes intra-service time, and 33 minutes total time). The RUC disagrees with this crosswalk as there is no imaging guidance included with this procedure. The need for imaging guidance increases work intensity. CMS also provides support using brackets of CPT code 64486, a top key reference code in the RUC survey, and CPT code 33285. CPT code 33285 is not an appropriate comparison code because there is no imaging guidance included. CMS provides crosswalk codes and other reference codes with similar times in support of their proposed values. However, it appears all these comparison codes were arbitrarily selected as CMS does not provide any clinical foundation for the comparison of the surveyed codes to the crosswalk codes. Furthermore, these comparison codes often seem to have been selected solely for their similar characteristics to the Agency's desired reduction and to justify similarly chosen time ratio comparisons. The RUC recommends that CMS embrace the input from practicing physicians when valid surveys were conducted, rigorous review by the specialty society committees was performed and a review of magnitude estimation and cross-specialty comparison has been conducted by the RUC.

NANS supports a work value of 1.50 as bracketed by the key reference services from the robust survey. Top key reference code 64486 *Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)* (work RVU= 1.27, 10 minutes intra-service time, and 35 minutes total time) has identical intra-service and total times, yet the reference code involves less intense physician work, thus 64415 is appropriately valued higher than the top key reference code. The second highest key reference code 62323 *Injection(s), of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)* (work RVU = 1.80, 15 minutes intra-service time, and 45 minutes total time) has more intra-service time and more total time than 64415 and therefore is appropriately valued higher.

CMS also notes that the intra-service time decreased from 12 to 10 minutes and total time decreased from 40 to 35 minutes yet there is no stated rationale for an increase in intensity. While CMS acknowledges that adding imaging does bundle some additional work into the code, they do not believe that the revised code description of the service has resulted in a significant increase in intensity. NANS notes that a blind

injection is associated with a significantly lower level of work intensity than attempting to coordinate a needle's trajectory and tip location with ultrasound in order to achieve higher quality results from the injection. NANS further notes that intensity of the surveyed code should be compared to the intensity of the combined injection and imaging codes which appropriately have higher intensities. The higher intensities are appropriate because the new code describes the physician work of doing both the injection and imaging simultaneously where in the older code only describes the physician work of doing only the injection alone. In reviewing the intensities, the RUC concluded that they provided further support of the appropriateness of the recommendation of the 25th percentile.

CMS disregards the input of 86 anesthesiologists and interventional pain physicians and the RUC by proposing to base the work RVU of code 64415 on an intra-service time ratio. The RUC strongly disagrees with CMS calculating intra-service time ratios to account for changes in time and concurs that CPT code 64415 should be valued based on the survey 25th percentile. NANS urges CMS to accept a work RVU of 1.50 for CPT code 64415**.**

64416
CMS disagrees with the RUC recommended work RVU of 1.80 for CPT code 64416 which represents the survey 25th percentile, yet states that it agrees with "the RUC's proposed increment of +0.30 between CPT codes 64415 and 64416. (The RUC recommendation for CPT code 64415 was 1.50, and the recommendation for CPT code 64416 was 1.80.)" This statement implies that the RUC utilized an incremental approach in its valuation of CPT code 64416 which was not the case. NANS believes that any mathematical or computational methodology used to value the physician work for these services is inappropriate.

By definition, component image guidance codes have substantial intra-service time overlap with the intra-service time of the component base surgery codes they are reported with, as the real-time imaging is guiding the surgical work of the base procedure. CMS' proposal to use a sum of sequential time ratios that simply sum the total component time for each component code included in the bundled service erroneously neglects to account for most of the intra-service work of performing the surgery and image guidance for that surgery occurring in parallel, regardless of the coding structure. When instead of being described by component coding and all of the work is newly described by a single bundled code, the portion of the skin-to-skin time that involves both performing the procedure and guiding the procedure in parallel should logically be assigned combined intensity of the same minute of parallel time described by concurrently performed component codes. The component image guidance codes were already previously valued with the understanding that the typical provider is both performing the base procedure and the image guidance themselves.

The RUC's established valuation process is based on specialty society survey data and the use of magnitude estimation; thus, its recommendation was supported by the robust survey and by comparison to the key reference codes:

The RUC compared CPT code 64416 to the key reference codes 62325 *Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)* (work RVU= 2.20, 15 minutes intra-service time, and 45 minutes total time) and 62327 *Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)* (work RVU = 1.90, 15 minutes intra-service time, and 45 minutes total time). In both cases, the codes have identical intra-service times and similar total times, yet code 64416 involves less intense physician work and is therefore appropriately valued lower than the key reference codes.

CMS further notes that the intra-service time and total time have decreased by 25% and 10%, respectively, and does not believe that the RUC recommended an increase in the work RVU is justified. NANS notes that performing "only the injection alone" means performing a blind injection where you do not have the same feedback requiring precise needle tip location. It is not simply that one task (the imaging) is taken away. It is that the other task (needle location) becomes substantially easier, and less precise when you do not have to perform the imaging. The RUC also notes that the intensity of the surveyed code should be compared to the intensity of the combined injection and imaging codes which appropriately have higher intensities. The higher intensities are appropriate because the new code describes the physician work of doing both the injection and imaging simultaneously whereas the older code only describes the physician work of doing only the injection alone. In reviewing the intensities, the RUC concluded that they provided further support of the appropriateness of the recommendation of the 25th percentile.

NANS disagrees with CMS utilizing incremental differences for valuing services and believes that CPT code 64416 should be valued based on the survey 25th percentile. NANS urges CMS to accept a work RVU of 1.80 for CPT code 64416.

64445
CMS disagrees with the RUC-recommended work RVU of 1.39 for CPT code 64445 which represents the survey 25th percentile. CMS is proposing a work RVU of 1.28, based on an intra-service time ratio calculation using the sum of the work RVUs for both codes: CPT code 64455 is 1.00 and CPT code 76942 is 0.67, and an estimated intra-service time of 13 minutes and total time of 27 minutes. NANS strongly disagrees with CMS calculating intra-service time ratios to account for changes in time.

By definition, component image guidance codes have substantial intra-service time overlap with the intra-service time of the component base surgery codes they are reported with, as the real-time imaging is guiding the surgical work of the base procedure. CMS' proposal to use a sum of sequential time ratios that simply sum the total component time for each component code included in the bundled service erroneously neglects to account for most of the intra-service work of performing the surgery and image guidance for that surgery occurring in parallel, regardless of the coding structure. When instead of being described by component coding and all of the work is newly described by a single bundled code, the portion of the skin-to-skin time that involves both performing the procedure and guiding the procedure in parallel should logically be assigned combined intensity of the same minute of parallel time described by concurrently performed component codes. The component image guidance codes were already previously valued with the understanding that the typical provider is both performing the base procedure and the image guidance themselves.

CMS supports its proposed work RVU with a comparison to CPT code 64486 *Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)* (work RVU= 1.27, 10 minutes intra-service time, and 35 minutes total time). The RUC also used this code as its top key reference service to support the work value recommendation of 1.39. The RUC noted that both codes have identical intra-service times, yet code 64445 involves more intense physician work focused on the sciatic nerve. Similarly, of the survey respondents that selected this key reference service, 96% indicated that the survey code was identical or more intense and complex relative to the key reference service. Code 64486 is an image guided injection targeting a broad tissue plane (ie: needle tip located anywhere within the plane is acceptable) usually 3-5 cm deep, while 64445 is an image guided injection of narrow nerve 7-10 cm deep where the needle must be positioned not only at the correct depth but in close approximation to the nerve without contacting or injuring the nerve. The intensity of work for 64445 is expected to be much higher; therefore, 64445 is appropriately valued higher than the top key reference code.

CMS also provides support using brackets of CPT codes 58100 and 11982. These codes are not appropriate comparisons as CPT code 58100 is a blind procedure, that is, no imaging guidance; thus,

much lower intensity of work. CPT code 11982 also has no imaging guidance. The need for imaging guidance increases work intensity.

CMS notes that the intra-service time and total time have not changed, yet the RUC recommends an increase to the work RVU with no stated rationale for an increase in intensity. While CMS acknowledges that adding imaging does bundle some additional work into the code, they do not believe that the revised code description of the service has resulted in a significant increase in intensity. NANS notes the effect of the ultrasound imaging on the injection is not simply that a second component of work is added (imaging) as the addition of imaging also increases the intensity of work and skill level needed to complete the original task (injection). The RUC further notes that the intensity of the new survey code should be compared to the intensity of the combined injection and imaging codes which appropriately have higher intensities. The higher intensities are appropriate because the survey code describes the physician work of doing both the injection and imaging simultaneously whereas the older code only describes the physician work of doing only the injection alone. In reviewing the intensities, the RUC concluded that they provided further support of the appropriateness of the recommendation of the 25th percentile.

CMS disregards the input of 76 anesthesiologists and interventional pain physicians and the RUC by proposing to base the work RVU of code 64445 on an intra-service time ratio. NANS strongly disagrees with CMS calculating intra-service time ratios to account for changes in time and concurs that CPT code 64445 should be valued based on the survey 25th percentile. NANS urges CMS to accept a work RVU of 1.39 for CPT code 64445.

64446
CMS disagrees with the RUC recommended work RVU of 1.75 for CPT code 64446 which represents the survey 25th percentile. CMS proposes a work RVU of 1.64 which is 0.36 higher than the proposed work RVU for CPT code 64445 (1.28) and states that "the current increment between the current values of 64445 and 64446 (1.00 and 1.36, respectively) is 0.36. The RUC recommendations for these codes (1.39 and 1.75) preserved this increment." This statement implies that the RUC utilized an incremental approach in its valuation of CPT code 64446 which was not actually the case. NAS believes that any mathematical or computational methodology used to value the physician work for these services is inappropriate.

By definition, component image guidance codes have substantial intra-service time overlap with the intra-service time of the component base surgery codes they are reported with, as the real-time imaging is guiding the surgical work of the base procedure. CMS' proposal to use a sum of sequential time ratios that simply sum the total component time for each component code included in the bundled service erroneously neglects to account for most of the intra-service work of performing the surgery and image guidance for that surgery occurring in parallel, regardless of the coding structure. When instead of being described by component coding and all of the work is newly described by a single bundled code, the portion of the skin-to-skin time that involves both performing the procedure and guiding the procedure in parallel should logically be assigned combined intensity of the same minute of parallel time described by concurrently performed component codes. The component image guidance codes were already previously valued with the understanding that the typical provider is both performing the base procedure and the image guidance themselves.

The RUC's established valuation process is based on specialty society survey data and the use of magnitude estimation; thus, its recommendation was supported by the robust survey and by comparison to the key reference codes:

The RUC compared CPT code 64446 to the key reference codes 62327 *Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)* (work RVU = 1.90, 15 minutes intra-service time, and 45 minutes total time) and

62325 *Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)* (work RVU= 2.20, 15 minutes intra-service time, and 45 minutes total time). In both cases, the codes have identical intra-service times and similar total times, yet code 64446 involves less intense physician work and is therefore appropriately valued lower than the key reference codes.

CMS brackets CPT code 64446 with CPT code 64448 *Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, continuous infusion by catheter (including catheter placement)* (work RVU= 1.41, 13 minutes intra-service time, and 38 minutes total time). However, the survey code 64446 involves the sciatic nerve which is typically located 7-10 cm deep into the dermis. The femoral nerve is typically located 2-3 cm deep. Imaging guided access of, and placement of a catheter in close proximity to, the sciatic nerve necessarily requires a significantly higher degree of work intensity than the same procedure for the femoral nerve. The other bracket, CPT code 36573 *Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the insertion; age 5 years or older* (work RVU= 1.70, 15 minutes intra-service time, and 40 minutes total time), requires imaging guidance to intentionally puncture a vein located roughly 1cm deep to the dermis and then place a catheter. CPT code 64446 requires imaging guidance to place a catheter adjacent to a nerve located 7-10 cm deep without contacting or injuring the nerve. The intensity of work for 64446 is expected to be much higher than for 36573 due to the complexity of the technique.

CMS further notes that the intra-service time remained the same and total time increased by 10% and believes that the RUC recommended increase in the work RVU is "disproportionate to the change in time." In selecting the 25th percentile, the RUC considered how time and intensity was affected. The RUC noted that it was important to compare the recommendation to not just the current injection code alone but compare it to the combined injection and imaging code. The RUC noted that intra-service time for CPT code 64446 stayed the same and considered that when surveying this code with imaging now bundled, the intra-time would not be expected to increase significantly because for most of the intra-time the imaging and the injection physician work is occurring simultaneously. NANS further notes that the intensity of the survey code should be compared to the intensity of the combined injection and imaging codes which appropriately have higher intensities. The higher intensities are appropriate because the new code describes the physician work of doing both the injection and imaging simultaneously whereas the older code only describes the physician work of doing only the injection alone. In reviewing the intensities, the RUC concluded that they provided further support of the appropriateness of the recommendation of the 25th percentile.

NANS disagrees with CMS utilizing incremental differences for valuing services and believes that CPT code 64446 should be valued based on the survey 25th percentile. NANS urges CMS to accept a work RVU of 1.75 for CPT code 64446.

Affirmation of RUC Recommendations
The RUC affirmed its recent RUC valuations for the remaining codes in the Somatic Nerve Injections family as outlined in the table above. These codes were recently reviewed by the RUC and, unlike 64415-64417 and 64445-64448, there were no changes to their code descriptors. CMS acknowledged the RUC's reaffirmations as part of its recommendations while stating that they are not reviewing the values of these codes at this time.

Neurostimulator Pulse Generator/Transmitter (CPT codes 95976, 95977, 95970, 95983, 95984)

CMS has received a request to add CPT codes 95976, 95977, 95970, 95983, and 95984 describing electronic analysis/programming of implanted neurostimulator pulse generators/transmitters to the Medicare Telehealth Services List. NANS agrees with CMS that this is inappropriate for codes 95976 and 95977 as there is no currently available technology to perform these services (simple and complex programming of implanted cranial nerve neurostimulator pulse generators/transmitters via telehealth. If such technology becomes available in the future and proves to be safe and appropriate, NANS would support reconsideration of this request.
NANS disagrees with CMS proposal to not promote CPT codes 95970, 95983, and 95984 to category 1 or 2, instead leaving them in category 3. CMS justifies this proposal with several unfounded reservations about these services when performed via telehealth. These CPT codes describe the electronic analysis (95970) of implanted brain neurostimulator pulse generators/transmitters, as well as the first 15 minutes (95983) and each additional 15 minutes (95984) of brain neurostimulator programming. CMS expresses concern about whether the connection between the implanted device and the analysis/calibration equipment (the neurostimulator programmer) can be done remotely. However, systems have been in successfully in use for over a year and a half that allow for a stable secure 2-way telehealth connection for brain stimulator pulse generator programming. These systems route through a secure HIPAA-compliant server and allow the managing physician or QHP to remotely control all essential functions of the patient device while providing real time audio and video to allow for patient assessment and feedback. Moreover, CMS expresses a concern about patient safety if the programming is incorrect or if another problem occurred. These are valid concerns that have been addressed in the development and deployment of existing remote brain neurostimulator programming systems. These systems ensure that the patient controller has a "safe" program (set of stimulation parameters). In the event of an interruption in the remote connection, the device automatically reverts to this "safe" program so that the patient is not left with a potentially problematic set of programming parameters. NANS believe that the successful track record of these remote programming systems performing brain stimulator programming both safely and reliably merits the inclusion of CPT codes 95970, 95983, and 95984 in category 1 or 2 of the Medicare Telehealth Services List

Evaluation and Management (E/M) Visits

NANS again recommends that CMS apply the office E/M visit increases to the office visits, hospital visits and discharge day management visits included in the surgical global payment, as it has done historically. threshold for time-based reporting varies.

Split (or Shared) Services

NANS appreciates CMS proposing to delay, until January 1, 2024, the requirement that only the physician or qualified health professional (QHP) who spends more than half of the total time with the patient during a split or shared visit can bill for the visit. We urge CMS to allow physicians or QHPs to bill split or shared visits based on time or medical decision-making. The CPT/RUC Workgroup on E/M will convene to address clarification and definitional requirements for split or shared visits.

NANS also appreciates CMS proposing to delay, until January 1, 2024, the requirement that only the physician or qualified health professional (QHP) who spends more than half of the total time with the patient during a split or shared visit can bill for the visit. CMS cites the concerns raised by the AMA and 46 national medical specialty societies in our March 29th letter that adopting this policy change would drastically disrupt team-based care and interfere with the way care is delivered in the facility setting. We urge CMS to allow physicians and QHPs to bill split or shared visits based on time or medical decision-making.

We understand that CMS believes time-based billing is auditable; however, CMS has a long history of auditing E/M services based on documentation in the medical record substantiating appropriate billing based on history, exam, and medical decision-making. We see no reason why CMS would be unable to continue to use these same program integrity levers to audit split or shared visits billed on the basis of time or medical decision-making.

We strongly urge CMS not to disrupt team-based care in the facility setting and to revise the split or shared visit policy to allow the physician or QHP who is managing and overseeing the patient's care to bill for the service. We look forward to providing additional input following the CPT/RUC Workgroup on E/M's meeting on split or shared visits.

Office Visits Included in Codes with a Surgical Global Period
As stated in previous communication with the Agency and reviewed above, NANS strongly believes it is appropriate to apply the increased 2021 valuation of the office E/M visits to the visits incorporated in the surgical global packages and disagrees with the CMS decision to not apply the office E/M visit increases to the visits bundled into global surgery payment. NANS also believes that the increases in the hospital visits and discharge day management services should be applied to the surgical global period.

CMS has incorrectly maintained that the visits in the global package codes are not directly included in the valuation. Rather, the work RVUs for procedures with a global period are generally valued using magnitude estimation.

We agree that RUC survey methodology uses magnitude estimation to develop work RVU recommendations that are relative to other codes in the physician fee schedule. However, the basis of the fee schedule—the work done during the Harvard study—is a building block method that used time and intensity that was directly surveyed and/or extrapolated to develop the initial work RVUs in the first fee schedule in 1992. The RUC's method of "magnitude estimation" has consistently identified and used component comparisons of pre, intra, and post times along with number and level of visits to assess relativity. The RUC also uses total time (including total E/M time) to compare relativity between codes with different global periods.

To maintain the relativity which was established in 1992, CMS has twice (1998 and 2007) adjusted the work RVUs and time for global codes to account for adjustments to work and time for office visit E/M codes. The issue that CMS raises in this rule regarding MACRA legislation to review the number and level of visits in global codes is not related to maintaining relativity across the fee schedule based on current data in the CMS work/time file.

By failing to adopt all the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC)-recommended work and time values for the revised office visit E/M codes for CY 2021, including the recommended adjustments to the 10- and 90-day global codes, CMS improperly proposes to implement these values in an arbitrary, piecemeal fashion.

It also violates the basic operating payment methodology in the Medicare Physician Fee Schedule and implies that the same work done by different types of physicians and for different reasons have different value. We do not believe CMS intends this, however, if global payments are not adjusted, CMS opens the door to specialty-based payments for services which could lead to a wholesale revaluation of all services in the MPFS based on the "value" of each specialty type. This would be unsustainable and have profoundly negative impacts on patient care.

It is highly inappropriate for CMS to continue to not apply the RUC-recommended changes to global codes. If CMS finalizes the proposal to adjust the inpatient E/M code values, the agency should also apply these updated values to the global codes along with the updated 2021 outpatient visit codes. It is imperative that CMS take this crucial step.

Request for Information: Medicare Potentially Underutilized Services

In the proposed rule, the Agency announced it is soliciting comments on potentially underutilized Medicare services. The Agency indicates they are considering using their statutory authority to promote review of families that services that are underutilized by Medicare beneficiaries and asking for comments on what some of these services are and how to create additional incentives that might increase utilization and increase access to Medicare beneficiaries.

NANS commends this initiative and proposal and the thinking behind it. NANS believes there are many services that are underutilized by Medicare beneficiaries and the barriers to access for these services has resulted in lower quality care for Medicare patients. NANS recommends CMS strongly consider increasing financial incentives to providers who treat Medicare patients suffering significant pain and functional decline with non-opioid pain management treatment. The opioid epidemic has only grown since the COVID-19 pandemic started in 2020 and our society critically needs to advocate for interventions that are non-opioid based and allow patients to obtain relief from chronic pain. CMS has failed to do this in the past several years and has in fact put up greater barriers to access for pain interventions. Specifically, CMS has implemented limitations on injections and nerve blocks in the spinal region and other areas of the body that provide significant pain relief for patients and are viable alternatives to opioid prescriptions. We urge CMS to consider lifting these limits immediately. We also urge CMS to review the assigned RVUsfor pain interventional procedures such as facet joint radiofrequency which CMS reviewed for CY 2021 and instead of increasing the assigned RVU actually implemented deceases. These decreases only serve to increase underutilization of these important opioid procedures.

NANS appreciates the opportunity to comment on underutilization of vital services and recommends CMS consider increased financial incentives for treatments that when done clinically appropriately and consistently can reduce opioid addiction and overdoses and the rising mortality that the crisis has caused.

Chronic Pain Management Reimbursement

In the proposed rule, CMS proposes two G-codes (GYYY1 and GYYY2) for chronic pain management for Medicare patients. Specifically, CMS proposed the codes to include a bundle of services furnished during a month that we believe to be the starting point for holistic chronic pain care, aligned with similar bundled services in Medicare, such as those furnished to people with suspected dementia or substance use disorders. CMS is proposing to include the following elements in the Chronic Pain Management (CPM) code: diagnosis; assessment and monitoring; administration of a validated pain rating scale or tool; the development, implementation, revision, and maintenance of a person-centered care plan that includes strengths, goals, clinical needs and desired outcomes; overall treatment management; facilitation and coordination of any necessary behavioral health treatment; medication management; pain and health literacy counseling; any necessary chronic pain related crisis care; and ongoing communication and coordination between relevant practitioners furnishing care, such as physical and occupational therapy and community-based care, as appropriate. GYYY1 is for the first 30 minutes of Physician/QHP time per calendar month and GYYY2 is for each additional 15 minutes of Physician/QHP time per calendar month.

CMS cites multiple federal reports that urge better support for person-centered pain management, including the 2016 National Pain Strategy and the 2019 HHS Pain Management Best Practices

Inter-Agency Task Force Report. It also notes the intersection between the problems with pain care and the worsening epidemic of drug overdose deaths, primarily due to illicitly manufactured fentanyl, other synthetic opioids, and methamphetamine. CMS also notes that untreated and inappropriately treated pain may translate to increased Medicare costs as more patients experience functional decline, incapacitation, and frailty.

NANS is grateful to the agency for their long overdue recognition of the opportunity to address the opioid crisis, which has devastated untold number of American and Medicare beneficiaries, by actively incentivizing alternate chronic pain management treatments. This approach appropriately recognizes the real clinical need for pain management services. It also seeks to rebalance the treatment options way from opioid based prescriptions to repeated and prolonged treatment through mental health and chronic pain relief. NANS members have been at the front lines in responding to the opioid crisis for our patients and believe that it is absolutely appropriate and necessary to provide separate and/or additional reimbursement for these services.

NANS however, believes the reimbursement proposed by CMS to be inappropriately low and urge CMS to adjust the proposed RVUs of 1.45 for GYYY1 and 0.50 for GYYY2 higher in the final rule. The total amount of work intended to be captured with this code is significant and requires a significant investment of time by physicians, QHPs and clinical staff. CMS cited CPT code 99425, Principle Care Management Initial, as the appropriate crosswalk for GYYY1 and 99425, Principle Care Management Additional as the crosswalk for GYYY2. We believe better crosswalks exist and recommend GYYY1 be crosswalked with CPT code 99414 at 1.92 work RVUs and GYYY2 be crosswalked with CPT code 99212 at 0.70 work RVUs. These established patient visits have similar times to those assigned to the proposed G-codes and reflect the relative complexity of these patients and services.

NANS also is concerned that the proposed G-codes could lead to underutilization of important non-opioid pain management options because providers are not clear on the rules around use of the G-codes. For example, it appears that the G-codes, as proposed by the Agency would be allowed to be used with standard E/M or pain interventions codes. However, we believe it is important that if the agency moves forward with the proposal that they describe in detail how the proposed G-codes would interact with other physician service codes and ensure that the proposed codes enhance rather than inhibit vital face-to-face physician encounters as well as interventional procedures. The language and guidance in the proposed rule gives us pause about how these proposed codes might be treated when billed with other services and without more detailed language we have reservations about moving forward as currently written. The agency can and should address this in the final rule with specific guidance that explicitly allows other services to be billed with the proposed codes.

If CMS fails to increase the proposed reimbursement for the G-codes and finalizes their proposed work RVUs, we believe adoption and utilization of the codes by providers will be slow and not meet CMS's laudable goals. If CMS is sincere about incentivizing wholistic and healthy chronic care management they should provide greater reimbursement for these codes than proposed.

We also feel strongly that the agency should convene all essential stakeholders in open and honest meetings, organized by the agency, to hear stakeholder input about the best way for the agency to encourage rather than limit non-opioid pain management. Thus far, the agency has not convened such meetings, and we believe that it is vital for the agency to reach out and directly engage with physician, facility, therapeutic, and patient stakeholders on the issue of whether

these proposed G-codes will improve patient care as well as on the issue of how to best develop and evolve any coding and reimbursement strategies. As one of the leading physician stakeholders in this effort, NANS welcomes the opportunity to participate in these types of meetings and engagements. Prior to implementation of these G-codes we believe these meetings with stakeholders should occur so appropriate input can be provided.

Rebasing and Revising the Medicare Economic Index (MEI)

The MEI, first implemented in 1975, has long served as a measure of practice cost inflation and a mechanism to determine the proportion of payments attributed to physician earnings and practices costs. The MEI measures changes in the prices of resources used in medical practices including, for example, labor (both physician and non-physician), office space and medical supplies. These resources are grouped into cost categories and each cost category is assigned a weight (indicating the relative importance of that category) and a price proxy (or proxies) that CMS uses to measure changes in the price of the resources over time. The MEI also includes an adjustment to account for improvements in the productivity of practices over time.

From 1975, when payments reflected the usual, customary and reasonable charge payment methodology, through 1993, the year after implementation of the Resource Based Relative Value Scale (RBRVS), the physician earning component was 60% and the practice expense component, including professional liability insurance (PLI) costs, was 40%. These initial weights were derived from data obtained from the AMA. In the nearly 50 years since the initial establishment of the MEI, data collected by the AMA has served as the consistent source of information about physicians' earnings and their practice costs.

In 1993, the MEI components were updated, using AMA data and then proportioned to 54.2% Physician Work, 41% Practice Expense and 4.8% PLI. Currently, the allocation is 50.9% Physician Work, 44.8% Practice Expense and 4.3% PLI. The CMS proposal is to dramatically shift payment allocation away from physician earnings (work) to practice expense: 47.3% Physician Work, 51.3% Practice Expense and 1.4% PLI using non-AMA data.

MEI History

	1975-1992	1993	Current	Proposed
Physician Work	60%	54.2%	50.9%	47.3%
Practice Expense	40%	41.0%	44.8%	51.3%
Professional Liability Insurance	(incl with PE)	4.8%	4.3%	1.4%

The current MEI weights are based on data obtained from the AMA's Physician Practice Information (PPI) Survey. This survey was last conducted in 2007/2008 and collected 2006 data. As discussed below, the AMA is actively engaged in a process to collect these data again.

CMS proposes to update the MEI weights using 2017 data from the United States Census Bureau's Service Annual Survey (SAS). However, the Agency clarifies that they will not implement these new weights in 2023 as they must first seek additional comments due to significant redistribution. The proposed shift in payment weights from physician work to practice expense principally favors Diagnostic Testing Facility (+13%), Portable X-Ray Supplier (+13%), Independent Laboratory (+10%) and Radiation Therapy Centers (+6%) to the detriment of Cardiothoracic Surgery (-8%), Neurosurgery (-8%), Emergency Medicine (-8%), and Anesthesiology (-5%). Modest increases occur to specialties who provide services in the office with extremely expensive disposable supplies embedded into physician

payment. Primary Care would face decreases (Family Medicine (-1%), Geriatrics (-2%), Internal Medicine (-2%) and Pediatrics (-2%).

In summary, this proposal redistributes physician payment from physician work to the business side of healthcare. This proposal is particularly unfortunate as physicians face uncertainty about the Medicare conversion factor and continue to suffer from burnout. The Administration should be doing more to emphasize the importance of physicians, rather than directing resources away from their individual contributions.

Thank you for your time and consideration of NANS comments. We greatly appreciate the opportunity to participate in efforts to more efficiently and accurately capture current care delivery. We commend CMS on its continued efforts to improve care quality and access. If you have any questions on our comments, please do not hesitate to contact Chris Welber, MBA, NANS Executive Director at cwelber@neuromodulation.org.

Sincerely,

Salim Hayek, MD
President
North American Neuromodulation Society (NANS)