



# New York Society of Interventional Pain Physicians

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**August 19, 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**

Dear Administrator Oz:

The New York Society of Interventional Pain Physicians (NYSIPP) appreciates the opportunity to submit comments regarding the Centers for Medicare & Medicaid Services' (CMS) Calendar Year 2027 Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System proposed rule.

NYSIPP represents physicians who provide evidence-based interventional treatment to patients suffering from chronic pain. Our members care for Medicare beneficiaries across New York, including individuals living in rural and underserved communities where ambulatory surgical centers (ASCs) can play an important role in providing timely access to interventional pain and neuromodulation procedures.

NYSIPP is concerned with CMS's proposal to change the ASC multiple-procedure discounting indicator from "No" to "Yes" for several neurostimulation procedures, including:

- **CPT 63650** — Percutaneous implantation of neurostimulator electrode array, epidural
- **CPT 63655** — Laminectomy for implantation of neurostimulator electrodes, plate or paddle
- **CPT 63663** — Revision or replacement of percutaneous spinal neurostimulator electrode array
- **CPT 63664** — Revision or replacement of spinal neurostimulator electrode plate or paddle
- **CPT 63685** — Insertion or replacement of spinal neurostimulator pulse generator or receiver
- **CPT 64553** — Percutaneous implantation of neurostimulator electrode array
- **CPT 64555** — Percutaneous implantation of peripheral nerve neurostimulator electrode array
- **CPT 64561** — Percutaneous implantation of sacral nerve neurostimulator electrode array

NYSIPP respectfully requests that CMS **not adopt the proposed change and instead retain the current "No" multiple-procedure discounting designation for these services.**

## **Neurostimulation Services Represent Distinct Components of an Integrated Treatment**

Neurostimulation systems are composed of multiple components that work together to provide a therapeutic benefit. In many cases, electrode placement and pulse generator implantation occur during the same surgical encounter because both are necessary elements of the overall treatment.

These services should not be viewed as duplicative simply because they are performed during the same procedure. Each service involves distinct clinical work and requires separate resources.

For instance, a permanent spinal cord stimulation procedure may include placement of one or more epidural electrode arrays reported under CPT 63650 in addition to implantation of a pulse generator reported under CPT 63685. The electrode array and generator serve different functions but are dependent upon one another to deliver the intended therapy.

The fact that these components are placed during a single encounter does not eliminate the resources required for either service. Each may require separate equipment, implantable components, supplies, specialized technical expertise, and procedural work.

A multiple-procedure reduction therefore risks treating clinically distinct services as though the resources associated with performing them overlap to a greater extent than they actually do.

## **Device Costs Must Be Accounted for Separately From Procedural Efficiencies**

Neurostimulation procedures are particularly sensitive to payment reductions because of the substantial cost of the devices and supplies involved.

ASCs are required to acquire the necessary implantable components and procedural supplies before providing the service. Depending on the procedure, these expenses may include neurostimulator electrodes, pulse generators, connectors, anchors, tunneling equipment, sterile supplies, and other associated materials.

These costs do not decrease merely because multiple components are implanted during the same operative session. The cost of an additional electrode, pulse generator, or other implantable component remains a significant expense to the facility.

Accordingly, applying a multiple-procedure reduction to these services could result in a reduction to payment that does not correspond to actual resource savings. Instead, the reduction could affect reimbursement intended to account for expensive implants and supplies.

CMS should ensure that any payment methodology recognizes the unique cost structure of device-intensive procedures. Before applying a multiple-procedure reduction, CMS should

demonstrate that the resulting ASC payment remains sufficient to reasonably account for the cost of the implanted devices, supplies, and resources necessary to safely provide the service.

## **The Proposed Change Could Threaten ASC Participation in Medicare Neurostimulation Care**

ASCs operate under different financial circumstances than hospital outpatient departments. Many ASCs have relatively limited operating margins and do not have the broader service lines available to hospitals to offset losses associated with individual procedures.

A significant reduction in reimbursement for one component of a neurostimulation procedure could make certain cases financially impractical for an ASC to perform.

This may be particularly problematic for independent ASCs, physician-owned facilities, rural centers, and facilities with substantial Medicare patient populations. If reimbursement does not adequately account for the cost of the complete neurostimulation system, some facilities may be forced to reconsider whether they can continue offering these services to Medicare beneficiaries.

Such an outcome would reduce patient choice and could limit access to care in communities where ASCs provide an important alternative to hospital-based treatment.

## **Reduced ASC Reimbursement Could Drive Care to More Expensive Settings**

CMS has recognized the important role ASCs play in providing appropriate procedures in a lower-cost setting. When clinically appropriate, ASC-based care can provide high-quality services while reducing costs to Medicare and, in many circumstances, beneficiary cost-sharing compared with hospital outpatient departments.

The proposed payment change could undermine these objectives.

If the reimbursement associated with neurostimulation procedures becomes insufficient to cover the cost of providing the service, ASCs may have less ability or willingness to perform these procedures. Cases could consequently move to hospital outpatient departments even when an ASC would otherwise be an appropriate setting.

This would create the possibility of an unintended consequence: a payment policy designed to account for perceived efficiencies could ultimately increase Medicare spending by encouraging procedures to move into a higher-cost setting.

## **Beneficiary Access Could Also Be Adversely Affected**

Patients who undergo neurostimulation treatment often have significant and persistent pain that has not adequately responded to previous treatment. Many have already attempted

multiple conservative and interventional approaches, including physical therapy, medications, injections, surgery, and other therapies.

Reducing the availability of ASC-based neurostimulation services could create several challenges for these patients, including:

- Longer wait times for treatment;
- Greater travel distances to obtain care;
- Delays in medically necessary treatment;
- Increased beneficiary cost-sharing;
- Reduced availability of services in rural and underserved communities; and
- Continued reliance on medications, including opioids, while awaiting treatment.

These potential consequences would be inconsistent with efforts to improve access to appropriate care, encourage treatment in the lowest-cost clinically appropriate setting, reduce unnecessary opioid exposure, and maintain beneficiary choice regarding where care is provided.

### **Revision and Replacement Procedures Require Particular Consideration**

The proposed multiple-procedure discounting change is also concerning when applied to revision and replacement procedures reported under CPT 63663, CPT 63664, and CPT 63685.

Patients may require more than one component of a neurostimulation system to be addressed during the same operative encounter. For example, an electrode system may require revision while the pulse generator simultaneously requires replacement because of battery depletion, malfunction, infection, recall, incompatibility, or another clinical circumstance.

Performing these related services during one operative encounter may reduce the patient's exposure to anesthesia, lower infection risk, avoid an additional surgical episode, and reduce the overall burden associated with repeated procedures.

A payment methodology that discounts these services could unintentionally encourage facilities to separate related procedures into multiple encounters. Such an approach could be less efficient from both a clinical and economic perspective.

Medicare payment policy should support the completion of medically necessary, related procedures during a single encounter when clinically appropriate rather than creating financial incentives that could encourage unnecessary staging.

### **CMS Should Conduct Additional Analysis Before Implementing the Proposed Change**

Given the potential financial and access implications, NYSIPP believes CMS should conduct a detailed analysis before changing the multiple-procedure discounting indicators for these neurostimulation codes.

At a minimum, CMS should evaluate:

1. The expected payment impact of the proposed change on common neurostimulation procedure combinations;
2. The percentage of ASC reimbursement attributable to implantable devices and other supplies;
3. Whether the resulting payment would adequately cover the acquisition cost of implanted components;
4. The impact on independent, physician-owned, and rural ASCs;
5. The potential for cases to shift from ASCs to hospital outpatient departments;
6. The resulting impact on Medicare beneficiary cost-sharing and access to care; and
7. The clinical and operational rationale for considering these services duplicative for payment purposes.

This analysis is important to determine whether the proposed discount accurately reflects actual efficiencies or instead creates an unintended payment shortfall for highly device-intensive procedures.

Without a transparent evaluation of these factors, CMS cannot fully assess the potential consequences of the proposed policy.

## **NYSIPP Recommendations**

For the reasons outlined above, NYSIPP respectfully recommends that CMS:

1. **Retain the “No” multiple-procedure discounting designation** for CPT codes 63650, 63655, 63663, 63664, 63685, 64553, 64555, and 64561.
2. Recognize that electrode placement, pulse generator implantation, and related revision or replacement services represent **clinically connected but independently resource-intensive components** of neurostimulation treatment.
3. At a minimum, ensure that the portion of ASC payment attributable to implantable devices and nonduplicative supplies is protected from any multiple-procedure reduction.
4. Conduct and publicly release a detailed financial analysis of the proposed change before implementation, including an assessment of common combinations such as CPT 63650 and CPT 63685.
5. Evaluate the potential effects on Medicare beneficiaries, rural communities, independent and physician-owned ASCs, site-of-service decisions, Medicare expenditures, and beneficiary cost-sharing.
6. Engage with interventional pain physicians, neuromodulation specialists, ASC representatives, patients, and other stakeholders before finalizing the proposed policy.

## **Conclusion**

NYSIPP supports Medicare payment policies that appropriately recognize legitimate efficiencies while ensuring continued access to high-quality, clinically appropriate care. However, the proposed change to multiple-procedure discounting for neurostimulation services does not adequately recognize the distinct clinical work, implantable devices,

supplies, technical expertise, and other resources associated with each component of these procedures.

Reducing payment for these services could make certain neurostimulation procedures financially difficult for ASCs to provide, potentially limit beneficiary access, and encourage the migration of care to more expensive hospital outpatient settings. The proposed policy could also create unintended incentives to divide related procedures across multiple encounters, increasing the burden on patients and potentially increasing costs to Medicare.

For these reasons, the New York Society of Interventional Pain Physicians strongly urges CMS **not to finalize the proposed “Yes” multiple-procedure discounting indicators for these neurostimulation CPT codes** and instead retain the existing “No” designation.

Thank you for your consideration of these comments. NYSIPP would welcome the opportunity to provide CMS with additional clinical, operational, or economic information regarding these procedures and their importance to Medicare beneficiaries.

Sincerely,

A handwritten signature in black ink, appearing to read "Robert Tiso", with a stylized flourish at the end.

Robert L. Tiso, MD  
Chairman, Advocacy Consortium  
Past President  
New York Society of Interventional Pain Physicians (NYSIPP)